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**NEW ZEALAND NURSE MIGRATION TO THE UNITED STATES:
WHAT MAKES THEM GO? WHAT WILL BRING THEM BACK?**

A Thesis presented in partial fulfilment of the requirements for the degree of

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ABSTRACT

Within the next ten years there will be a considerable global nurse shortage and as many countries consider a variety of ways to both recruit and retain their nursing workforce, nurse migration is coming under increased scrutiny as both contributing to and solving the problem. New Zealand is a significant importer of nurses yet also loses a substantial number of its nurses to overseas positions. Within nurse migration research there are few qualitative studies that look at the reasons behind the decision to migrate and the experience of nurse migrants travelling from one developed country to another. This qualitative study utilizing an interpretive descriptive research design was employed to study the reasons why nurses leave New Zealand to work abroad, specifically to California, U.S.A. and sought also to explore what kept the nurses in the United States. Six face to face interviews were conducted. From the data, thematic analysis was employed to identify a variety of themes related to the decision to migrate, the early 'settling in' period, and reasons that may influence the nurses decision to remain in California. Factors identified that contributed to the nurses leaving New Zealand were the opportunity to travel while working, accessible recruitment agencies and hospitals, and past travel experiences. Adjustment difficulties in the United States were mitigated by the presence of other expatriates in close proximity, financial support from hospitals, and continual travel opportunities. Firmly ensconced in California the majority of the nurses had no immediate plans to return to New Zealand citing work and educational opportunities within the US and a favourable Californian lifestyle as primary reasons for staying. In addition the ability to retain a strong connection to their families in New Zealand through technology and frequent trips home contributed to their length of stay in the United States. Supporting family left at home was considered to be a possible reason for returning to New Zealand on a more permanent basis while a type of circular migration where the 'best of both worlds' could be enjoyed would also be considered by the nurses. This small study highlights the need for further research on nurses leaving and returning to New Zealand. Only by gaining a better understanding of the migrating nurse's motivation for travel and impetus for return can health policy makers develop strategies for recruiting and retaining experienced New Zealand nurses.

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CHAPTER 1. INTRODUCTION

Introduction

With an increasing worldwide demand for nurses along with a growing shortage of available personnel, senior health officials throughout the world are looking at ways to recruit and retain the necessary number of nurses needed to care for their populations. In 2006 the World Health Organization estimated a worldwide shortage of 4.3 million health personnel (Organization for Economic Cooperation and Development [OECD], 2010). With 50 percent of the current international nursing workforce eligible for retirement by 2020, along with declining enrolments in nursing education programmes and difficulty retaining practicing nurses, it is becoming increasingly apparent that globally healthcare systems are facing critical staff deficits (Clark, Stewart & Clark, 2006; Jackson, Mannix & Daly, 2001; World Health Organization, 2010).

The nursing shortage stems from an imbalance between nursing supply and demand (Clark, Stewart & Clark, 2006; Kingma, 2001; Kingma, 2006; Kline, 2003; Marchal & Kegels, 2003; International Council of Nurses [ICN], 2007). Simply put there are not enough nurses working to meet the healthcare needs of the world's population. Nursing literature identifies many factors that contribute to this disparity.

An aging population has led to an increased demand for health services and it's rapidly advancing medical technology (Buchan & Sochalski, 2004; Clark, Stewart & Clark, 2006; Dumont & Zurn, 2007; Kingma, 2006; OECD, 2010; Zurn & Dumont, 2008). In addition healthcare restructuring along with cost containment measures have made it difficult for society to meet these demands which also adversely affects the working conditions of nurses (Bach, 2003; Kingma, 2006; OECD, 2010; Trossman, 2002). This increase in demand for services, asserts Marchal and Kegels (2003) has not been met by appropriate measures to both retain and increase the number of healthcare workers.

While demand for nurses may be determined by a health systems organization and how its services are utilized, supply is influenced by the balance between the flows in and out of the profession (Marchal & Kegels, 2003). In many countries, enrolment numbers in nursing schools are down as economics dictate the number of places available along with a dwindling and aging faculty base (Clark, Stewart, & Clark, 2006;

Kline, 2003). Nurses are leaving hospitals acknowledging decreased job satisfaction related to an inability to provide quality care to their patients and a lack of support and recognition in the workplace (Bach, 2003; Cain, 2002; Clark et al., 2006; Jackson, Mannix & Daly, 2001; Kingma, 2006; Trossman, 2002). Increasing bureaucracy, higher patient turnover, and an ever greater workload contributes to higher numbers of nurses 'burning out' and a loss of experienced nurses from the profession (Aiken, Buchan, Sochalski, Nichols & Powell, 2004; Marchal & Kegels, 2003). While there are still trained nurses available, in many countries in the world they are simply not willing to work under some of the conditions they find themselves in (Cain, 2002; Kingma, 2006; New Zealand Department of Labour, 2005) Consider the average age of a nurse is climbing and thus as nurses retire; the shortage will grow worse (Clark et al., 2006; Zurn & Dumont, 2008).

Nurses also choose to leave their places of employment and travel elsewhere for a variety of reasons. Many of them are venturing abroad, joining a rapidly increasing number of international migrant workers.

Employing nurse migrants

Healthcare is extremely labour intensive thus the delivery of effective care depends on adequate numbers of well qualified staff (Buchan, Parkin & Sochalski, 2003). When countries are unable to obtain sufficient numbers of nurses to care for their populations from within their own borders, they have increasingly over the last several decades looked further afield. Since the early 1990's nurse migration has been a significant issue in international health policy (Buchan et al., 2003). Recruiting and employing foreign nurses to fill nursing 'gaps' has become almost commonplace for the majority of developed countries in the world (Kline, 2003). This has led to increasing competition between countries for workers (Dumont & Zurn, 2007). This migration of health professionals to developed countries is expected to increase (Bach, 2003; McElmurry et al., 2006).

The importing of nurses to fill healthcare vacancies is a quick fix (Buchan et al., 2003), a band-aid for the complex problem of nurse retention.

Kingma (2006) writes:

Instead of developing a strategic plan to retain their nurses by paying them more and giving them adequate working conditions and authority within their institutions, hospitals and healthcare systems play a numbers game with the expanding international labour market – a strange version of musical chairs where there are always more empty seats than players. (p.3)

The importing of foreign nurses doesn't address the underlying problem of nurse retention in both source and recipient countries (McElmurry et al., 2002, Trossman, 2002). It has been suggested that the growing dependence on foreign trained nurses is largely the result of health care and staffing policies that have failed, a failure by hospitals to understand and appreciate their nurses working conditions and a gross under investment in nursing as a whole (Aiken, Buchan, Sochalski, Nichols & Powell, 2004; Brush, Sochalski & Berger, 2004).

Jackson, Mannix and Daly (2001) propose that the strategy to manage nursing shortages by recruiting overseas is not sustainable and perhaps ethically doubtful. Indeed, the OECD (2010) suggests that countries need to be less dependent on foreign health personnel to fill their needs. It proposes that by improving retention of domestic workers and by coaxing back those that have left for foreign shores, countries can better resolve healthcare worker shortages.

In order to promote and better distribute healthcare, it is important to understand the movement patterns of nurses as well as the causes and consequences of these movements (Kingma, 2001). Only by studying their reasons for moving abroad, the extent of permanence of movement (Buchan, Seccombe & Ball, 1994) and what factors keep them from returning to their home countries can we hope to retain these nurses and become less dependent on those trained abroad.

Highlighting the New Zealand story

The skilled health labour workforce in New Zealand as elsewhere is now very much internationalised and highly mobile (de Road, 2001; Nursing Council of New Zealand, 2010). While this may increase the pool of labour, it also means New Zealand has to compete for labour on a global scale (de Road, 2001). New Zealand is a significant exporter of nurses and has the highest proportion of migrant nurses in the world

(Walker, 2009; Zurn & Dumont, 2008). Within the 34 countries that make up the Organization for Economic Cooperation and Development, the OECD, New Zealand has the highest percentage of foreign born nurses and foreign travel nurses with the second highest expatriation rate (Hawthorne, 2011). In 2011, of the more than 40,000 nurses in the country, 21 percent were foreign trained (Nursing Council of New Zealand, 2011). The same year, the numbers of newly registered New Zealand nurses were almost evenly split between New Zealand educated graduates and internationally qualified nurses (Nursing Council of New Zealand, 2011).

While foreign trained nurses make up a large percentage of New Zealand nurses currently practicing, the country is also losing nurses in large numbers. As reported by the states and territories nursing registration authorities, the number of New Zealand trained nurses registering for the first time in Australia, number approximately 800-1200 every year with the average nurse who crosses the Tasman having nine years of experience (Cassie, 2008). Australia is not the only country to benefit from New Zealand nurses travelling abroad. The number of health professionals leaving New Zealand has doubled between the years 1992 and 2006 with a constant negative net migration for nurses born in New Zealand (Zurn & Dumont, 2008). Along with twenty five percent of nurses graduating each year leaving our shores, it has been estimated that there is still a substantial number of New Zealand born nurses currently working abroad (Zurn & Dumont, 2008).

O'Connor (2004) believes that New Zealand health services will have to rely on overseas nurses to fulfil staffing gaps for many more years. She bases this opinion on the decreasing numbers entering the profession, the attrition numbers during the three year nursing programmes, numbers leaving the profession and of significance for this study, the numbers leaving to travel overseas.

There is a concern that if present approaches to the workforce dilemma continue, then New Zealand will be unable to meet consumer healthcare needs (North, 2010). In her analysis of nursing workforce data, North (2010) examined the Nursing workforce strategy of 2006 and identified several key suggestions for "aligning the nursing workforce with health service requirements" (p.46). Some of the proposals North looked at included considering the diverse ethnic nature of society compared to the composition of the nursing workforce, the necessity of increasing recruitment into nursing and the retention of New Zealand nurses in the New Zealand workforce. She believes there is a

need to better understand the dynamics of nurse migration if New Zealand is to aim for self sufficiency which is currently threatened by the high numbers of emigrating New Zealand nurses and the difficulty in retention of foreign trained nurses.

The reliance on foreign trained nurses to augment their nursing numbers places New Zealand in a delicate position, state Zurn and Dumont (2008), as with increasing shortages worldwide other OECD countries are also looking to recruit. They believe the retention of health professionals within the country is a key issue because turnover rates for nurses are so high in New Zealand. In addition, the large number of potential returnees is also an avenue that has not been adequately explored. Despite efforts that are beginning to get underway to better understand why people leave and how many people come back and when, strategies to attract health workers back have not captured much attention so far (Zurn & Dumont, 2008).

Study aim

The aim of this qualitative study was to explore the reasons New Zealand nurses leave New Zealand and what keeps them in their destination country. Furthermore the study sought to explore what these nurses gained from their overseas experiences. By beginning to identify the factors that cause New Zealand nurses to leave and not return for long periods of time, this research aimed to contribute to knowledge in relation to the New Zealand experience of nurse migration and encourage further exploration of this group of New Zealand nurses. Measures could then be identified and implemented with an aim to retain the New Zealand trained nurses or to coax them back much sooner in a productive role.

Research questions

1. What are the factors that cause New Zealand nurses to leave the country?
2. What, if anything, is gained by the international nursing experience?
3. What would it take to bring these nurses back to New Zealand to work?

Researcher position

Personal journey to migration research

I am one of the thousands of nurse migrants. More than twenty years ago I left New Zealand to travel and work in the United States. While initially I had planned to be out of the country for only a few years, I am now firmly established in the United States. In the last decades I have met many nurses from all around the world who have travelled to the United States to live and work. Some of these nurses, like me, have stayed. Others have gone on to other places to work and some have returned to their home countries. I have always been interested in listening to the stories these nurses tell about their migration journeys, specifically the factors and decisions they made prior to choosing to leave their family and home and travel abroad. In the workplace I find myself working alongside nurses and physicians who have been educated overseas who offer unique perspectives and skills.

In the US, I listen to the stories of new nursing graduates and the difficulties they faced in the education process and now in trying to find a good job. I teach various classes to new and experienced nurses and hear their stories about the complexity of their current workplaces and the struggles they have in practice. I read a lot about an aging nurse workforce and the repercussions this will have in ten years and wonder how the nursing workforce will be shaped in the near future.

As I see the changing demographics of the nursing population and talk with my New Zealand friends about living and working in the United States I am intrigued by the decisions we have made that have influenced where we are now. As I began to look at the research surrounding nurse recruitment and retention, I gained some understanding of the role migration plays in discussions around this topic and I wanted to explore this subject more. In particular I was interested in nurses that migrate from one developed country to another as I perceived a large gap in the research. Being a New Zealander studying at a New Zealand university while living abroad, I naturally wanted my research to have a New Zealand focus while still being reflective of where I am in my life right now.

Influences on the research design

Anecdotal tales and media stories suggest a variety of reasons why nurses leave their country of origin and venture abroad to work. Actual research on the subject is limited. Stories with the voices of the nurses are even scarcer. Wanting to have the nurses' journeys heard as part of the research process was important to me as a researcher. While valuing the information quantitative studies may bring, I feel you cannot negate the stories in qualitative research that produce rich information about people's lives and can also provide robust data for analysis. Long ago I was heavily influenced and immersed in the social sciences so I naturally gravitate towards qualitative research. This topic exploring the experiences of New Zealand nurses migrating to the US seemed particularly suitable to a qualitative study.

Nature of the study

Research for this study was undertaken using an interpretive descriptive qualitative research design with narrative components. Data was obtained from face to face interviews and a detailed thematic analysis was conducted with an aim towards discovering the motivations and driving forces behind the nurses' migration decisions. A more detailed description of the research design can be found in chapter three.

Organization of the study

The presentation of this study is divided into seven chapters. Chapter one introduces the study, the problem of nurse retention and how the migration of nurses contributes to this issue. The purpose of the study along with research questions and assumptions are described along with my own background and interest in nurse migration. An introduction on how the topic is explored is also included in this chapter.

Chapter two reviews current literature related to nurse migration in general and specifically to the New Zealand context. Both international and Australasian studies exploring factors influencing the migration of source countries' nurses are examined and research gaps are identified.

Chapter three details the research design. The rationale behind employing an interpretive descriptive qualitative approach to the study along with a brief overview of the underlying theoretical perspective begins the chapter. The remainder of the chapter discusses the methods used in the study including participant selection, data collection and analysis and concludes with ethical and trustworthiness considerations.

Chapter four is the first of three analysis chapters exploring the findings from the study. The chapter begins with a brief introduction to the research participants including some basic demographic information. It then continues by investigating the reasons why the nurses left New Zealand to work abroad. Themes highlighted are 'the big overseas experience', the travel bug, and opportunistic recruitment.

Chapter five examines how the nurses acclimatized to a new country and how this process of 'putting down roots' may have contributed to subsequent migration decisions. Themes examined in this chapter are home is all around, fitting in and venturing out.

Chapter six is the last of the analysis chapters. Themes considered in this chapter are living the California dream, the work ladder, it's a small world, and it's been a long time. These themes identify the reasons why the nurses have stayed as long as they have abroad.

Chapter seven discusses the results of the study. The themes are discussed in relation to previous research and the relevance to the current issues concerning both nurse migration and retention in and out of New Zealand are considered. The need for further research is highlighted while addressing any limitations of the study. Recommendations and implications conclude this chapter and the research.

Summary

The focus of this study is on the migration of NZ nurses to the US; in particular the reason why the nurses chose to move abroad and why they have not returned. This introductory chapter has served to briefly introduce the significance of the topic within the wider context of NZ nurse retention while showing the importance of the study. A discussion on my background and interest in the subject highlighted the reason why this research was conducted and a brief overview focusing on how the topic will be explored introduces some of the theoretical and methodological components of the study.

The following chapter considers the literature related to nurse migration and identifies gaps in the knowledge.

CHAPTER 2. LITERATURE REVIEW

Introduction

The subject of nurse migration is extensive and well documented in books, journal articles, policy statements, opinion pieces and newspaper commentaries. An extensive four month search through much of the literature available yielded a plethora of information yet also showed gaps in knowledge and areas of research that have not been well addressed. This chapter will introduce the nurse migration issue in general terms focusing firstly on the international arena. Discussions in the literature centred on statistical dilemmas, migration pathways, factors influencing why nurses migrate, ethical considerations and return migration are presented. Specific literature that discusses the US as a destination country for nurse migrants is then investigated and the New Zealand setting is explored in more detail. The following section of the chapter identifies the need for more research on nurse migration. Studies that specifically focus on the nurse experience of migration are investigated in depth and any gaps in knowledge on the topic identified.

Approach and parameters

Between February and May of 2012, a wide-ranging search related to nurse migration was conducted, primarily through online databases. Known sources of migration information were accessed firstly through a broad Google search. By doing this, policy statements and general information was able to be sourced through such organizations as the World Health Organisation, International Council of Nurses, The International Center of Nurse Migration, and the Organisation for Economic Cooperation and Development. In addition government agencies in New Zealand such as District Health Boards and the Department of Labour along with specific nursing organisations, notably the Nursing Council of New Zealand and the California Board of Registered Nursing, were accessed.

Multiple online databases including Google scholar, CINAHL, Scopus, Web of Science, Medline, JSTOR and ERIC were utilized to find publications. The time period

employed for the literature review was from 1992 to 2012. Key search words used included nurse/nursing, with Zealand and overseas or mobility or travel or abroad or migration. For literature related to nurse retention and migration the key words nurse/nursing and Zealand and retention were utilized. Proquest dissertations and Massey University thesis/dissertation databases were accessed to find potential unpublished sources of data on the topic. Several recommended books mentioned in literature were also sourced and provided additional information.

Much of the literature was very general and provided good background and introductory information for this study. However to a large extent the focus was on statistical data and while this information was pertinent it merely provided the background for what is the purpose of this study, which is the experiences of the migrant or migrating nurses themselves. Therefore only those articles and studies that focused on these nurses' experiences were explored in depth and critiqued for this study.

The context: Nurse migration in general

Statistical dilemmas

It has been estimated that the international migrant population numbers around 191 million, around three percent of the world's population (Haour-Knipe & Davies, 2008; Kingma, 2006, Kingma, 2008b). Almost half of these migrants are now women (Badkar, Callister, Krishman, Didham & Bedford, 2007; Kingma, 2006). Highly skilled and educated workers represent an increasing percentage of these migrant numbers (Kingma, 2006). While widely acknowledged that historically women followed their spouses who were searching for work, there have in recent decades been increasing numbers of women who are migrating either alone or as the primary 'breadwinner' of the family (Kingma, 2008b).

The rapid growth of international trade with decentralization of many of the production processes has led to a system of international globalization (Clark, Stewart & Clark, 2006; ICN, 2007). Worker migration has been said to be a "result of the interplay of economic, social, cultural, political and legal forces" (Clark et al., 2006, p.42) and certainly when considering the reasons why women migrate all of these factors are significant. Migration is made easier by globalization supported by factors such as trade liberalisation, international capital flows, easier transportation and rapid

communication systems; all of which have assisted in recruiting workers from abroad (Buchan, Parkin & Sochalski, 2003; ICN, 2007; Lowell & Findlay, 2005).

Nurses comprise an occupational group that has the skills and ability to cross borders and work in many areas of the world. Discovering just how many nurses have migrated and their patterns of migration is not an easy task. There is no international system for recording 'skilled' emigration (Lowell & Findlay, 2005). Accurate data is difficult to ascertain, scarce and limited for a variety of reasons (Bach, 2003; Blythe & Baumann, 2009; Buchan & Sochalski, 2004; Buchan, Parkin & Sochalski, 2003; Dumont & Zurn, 2007; Trossman, 2002, WHO, 2010). While some countries strive to keep accurate records of the movements of nurses in and out of their borders, others are more limited or varied in the resources used to obtain the information (Bach, 2003). There is often no way of determining short term versus long term versus permanent migration numbers (Bach, 2003; Haour-Knipe & Davies, 2008) therefore the length of the nurse migrants' stay will remain largely unmeasured (Dumont & Zurn, 2007). In addition, ambiguity in data sources and varying definitions used in collecting the data contribute to imprecise information gathering (Dumont & Zurn, 2007). Just the word 'nurse' can mean many things in different countries and cultures (Buchan, Parkin & Sochalski, 2003). Dumont and Zurn in their study on immigrant health workers conducted for the OECD also found that when countries collected data on immigrants there was often no differentiation between place of birth and place of training. Thus the definition of a foreign nurse varied from country to country.

Kingma (2006) suggests that merely recording a nurse's professional registration doesn't always show their employment status. Many nurses choose to keep their registration current while not always working so it is difficult to know just when they start practising or even if they are still nursing (Buchan & Sochalski, 2004). Other nurses who work in federalised countries may be employed in several States and thus would be 'counted' a number of times in the national numbers (Bach, 2003; Buchan, Parkin & Sochalski, 2003; Kingma, 2006; WHO, 2010). For example, Buchan, Parkin and Sochalski report that 15 percent of US nurses have multiple registrations across different states.

If nursing licenses are not renewed in a source country there is no way of knowing where or if that nurse is working (Kingma, 2006). Thus, a nurse who immigrates to the United States [US] from Australia may renew her license in the US in California, Texas and Oregon but not renew her practicing certificate in Australia. For all

intensive purposes she is counted three times in any US national nursing census but not counted in any Australian nursing statistics that year.

Nevertheless there are international estimates of the number of nurses who migrate. Much of the information is gained through immigration records and varying nursing licensing and registration boards along with empirical modelling (Buchan & Sochalski, 2004). Since 2000 within the OECD countries there has been an increase in the migration flows of health professionals (Dumont & Zurn, 2007). More than ten percent of employed nurses within the OECD were foreign born (Dumont & Zurn, 2007). In a study that looked at a profile of nurses migrating to Australia, Ireland, Norway, The United Kingdom [UK] and US, Buchan & Sochalski (2004) found that all five countries had an increase in the numbers of nurses entering each country. As well, of the number of nurses being added to each country's register, the proportion of foreign graduates to new domestic trained nurses was also increasing in each of the countries.

Migration pathways

Most nurse migration occurs from developing to developed countries (Clark, Stewart & Clark, 2006; ICN, 2007; Marchal & Kegels, 2003; McElmurry et al, 2006; OECD, 2010). Historically, as Marchal and Kegels (2003) note, the migration patterns have been diverse as nurses' travel from all parts of the globe to the industrialised West. Many of the developing countries healthcare workforce numbers have been severely depleted as nurses have left to seek better work elsewhere. Massive recruitment campaigns aimed at foreign nurses by developed countries have thus delayed local measures to improve recruitment, retention and long term human resource planning (ICN, 2007).

The impact and cost to these developing countries has been in many cases quite disastrous as countries find themselves with a decreasing ability to provide care and vital services for their citizens (Clark, Stewart & Clark, 2006; Marchal & Kegels, 2003). Africa, India, China and the Philippines provide vast numbers of nurses to other countries (OECD, 2010). Marchal and Kegels (2003) suggest that in Africa the suffering is the worst. There is an estimated shortage of 600,000 registered nurses in the area (Clark et al., 2006). With the HIV epidemic in Africa still deeply entrenched, of those nurses who do remain many are HIV positive (Clark et al., 2006). Dumont and Zurn (2007) report that 36 out of 45 African countries currently have acute nursing staff

shortages. In the year 2000, for example Ghana lost twice the number of new nurses that graduated that year to overseas facilities (Buchan & Sochalski, 2004). In fact, there would need to be an increase of 139 percent in the number of nurses in order to meet the area's current health care needs (Dumont & Zurn, 2007). While the absolute numbers of nurses leaving such countries in Africa may not be large it is important to consider that in terms of percentage it is very significant, especially when you consider that the average ratio of nurses per inhabitant is ten times higher in Europe than in Africa or the South East Asian areas (Haour-Knipe & Davies, 2008) and almost eight times more in the US (Brush, Sochalski & Berger, 2004).

The Pacific islands are another area where the supply of nurses is less than the demand. Many of the Pacific nurses' travel primarily to Australia and New Zealand leaving their home countries depleted of valuable health care workers (Haour-Knipe & Davies, 2008). Haour-Knipe and Davies report that 56 percent of Fiji's nurses work abroad along with 62 percent of Samoan and 58 percent of Tongan nurses. Negin (2011) agrees, affirming there are more Samoan, Tongan and Fijian born nurses and midwives in Australia and New Zealand than in each domestic workforce.

The Philippines situation differs as there is a long standing history of nurses travelling from that country primarily to the US (Brush, 1994). In fact for the US the Philippines is the largest source country for nurses by far (National Center for Health Workforce Analysis, 2010). Decades of trade relations, governmental policies and history between the countries have provided many nurses and families with opportunities to emigrate. Certainly there are many nursing schools in the Philippines whose main task is to graduate nurses for overseas (Brush, 2008; Dumont & Zurn, 2007). Bach (2003) reports that of the approximately 7000 nurses who graduate each year from Philippine nursing schools, 70 percent will leave the country. With the average wage for a Filipino nurse at home being 75-200 US dollars a month compared to three to four thousand dollars in the United States, there is certainly a significant pull towards migrating abroad (Bach, 2003).

There are an estimated 110,000 migrant Philippine nurses who make up 15 percent of all immigrant nurses in OECD countries (Dumont & Zurn, 2007). Bach (2003) asserts with ten percent of all Philippine citizens working abroad it could be considered to be an industry. For the Philippine government this emigration is a deliberate policy that is sanctioned (Buchan, Parkin & Sochalski, 2003; Clark, Stewart & Clark, 2006,

Haour-Knipe & Davies, 2008). Recently the Philippine government has attempted to actively manage migration flows by utilizing the Philippine Overseas Employment Administration to formulate and oversee migration (Bach, 2003). This administration maintains Bach, attempts to market workers, counter illegal migration, negotiate agreements for workers, regulate private sector recruitment agencies and protect workers by assessing employers, inspecting contracts and holding seminars for potential migrants.

In recent years India has emulated the Philippine example. There is a significant increase in the number of 'for profit' global nursing programmes to prepare nurses specifically for the US, UK and Australia (Brush, 2008) and in 2004, India surpassed the Philippines in the number of nurses admitted to the UK register (Brush, 2008). China also has recently become an increased source for recruitment with an estimated 1.2 million nurses trained (Kingma, 2008a).

For many nurses working abroad, the opportunity to send remittance money back home to family members is a strong motive to migrate. Overall, migrant workers send home almost 75 to 200 billion US dollars a year (Kingma, 2006). Kingma suggests that for some countries it is a substantial percentage of the gross domestic product. Indian migrants are estimated to send 11.5 US billion back home, Mexicans 6.5 billion and Egyptian workers over 3 billion (Bach, 2003). Remittances from nurses working abroad to family members remaining in the Philippines, for example, are considered to be valuable sources of income for the country (Buchan, Parkin & Sochalski, 2003). The transfer of funds from foreign workers back to their home countries can be advantageous for the nurses, their families and countries but it has been suggested that the overall value to the economy and source country's health system is uncertain (McElmurry et al., 2006) as remittances do not outweigh the net loss of nursing capacity (Marchal & Kegels, 2003).

While historically there was for the most part a one way exchange from developing to developed countries, recent years have shown new directions and patterns in the flow of migrant healthcare workers (Brush, 2008). Traditional nurse recruitment patterns from one Western country to another following strong colonial ties, such as nurses travelling from Australia, New Zealand and South Africa to the UK, are still present but nurses are now travelling all over the globe (Brush, 2008). It is also worth

noting that the US, UK and Australia are the three countries that import the most nurses but they also have significant expatriation rates (Kingma, 2001). Certainly in the case of the UK, Australia and also Canada, it has been suggested that they are importing nurses in effect to fill vacancies caused by their own nurses migrating elsewhere (Kline, 2003).

For the large part, “host countries have at least twice as many nurses for their populations as the source countries have” (Aiken, Buchan, Sochalski, Nichols & Powell, 2004, p.71). The US, UK and Australia are major recipient countries of nurse migration (Kline, 2003; McElmurry et al, 2006). Foreign nurses have for a long time been part of the US healthcare workforce but recently these numbers have increased rapidly (Clark, Stewart & Clark, 2006). Between the years 2001 and 2007 the number of foreign trained nurses passing licensure quadrupled (OECD, 2010). Dumont and Zurn (2007) note that the US has received almost fifty percent of all foreign nurses working abroad.

Travel arrangements between countries have made emigrating for work easier (Bach, 2003). The Trans Tasman Mutual Recognition Agreement between New Zealand and Australia, the Nordic passport free area in northern Europe and the advent of the Economic Union have made journeying abroad for work much easier. The recent Japanese Philippines Economic Partnership agreement for example, is enabling 1000 Filipino nurses to journey to Japan for work (Brush, 2008).

Why do nurses move?

Migration theory has been evolving for many years and establishing just why nurses migrate, notes Kingma (2006) is a complex process and no theory has been able to encapsulate all of the factors that shape the decision to move away from one's home country. Why a nurse will choose to migrate, the choice of destination and the length of time spent away is a personal decision influenced by many variables. There are however a number of factors that facilitate the flow of nurses between source and destination countries (Kingma, 2008b). Long standing trade and economic ties, a history of colonial and cultural relationships and established transnational émigré communities with networks of friends and relatives all help to smooth the nurse migration process (Kingma, 2006; Kingma 2008b, Mambo, 2009; McElmurry et al., 2006). Economics, politics, poverty and age are all dynamics that may hasten any decision made to emigrate (Kingma, 2006). These ‘push’ and ‘pull’ factors that drive a nurse to travel abroad are many and varied (International Center of Nurse Migration, 2008).

One of the key researchers and authors working on the topic of nurse migration is Mireille Kingma (2006). She has identified and classified several key reasons why nurses migrate including economic imperatives, quality of life, career advancement, to accompany partners, for adventure and for survival. In addition she makes a distinction between temporary and permanent migration and also those who return home whom she calls return migrants.

Economic migrants are those nurses who leave home in search of better paying jobs. The search for a higher standard of living, better quality of life and improved socio economic opportunities for the family unit are strong incentives for many of the nurses migrating (Kingma, 2001, Kline, 2003). A rise in income along with housing opportunities to benefit either themselves or the family is a big draw for the nurse migrant as well as added benefits such as social security, health insurance and retirement income (Haour-Knipe & Davies, 2008). Economic factors are a big draw for those who travel from developing to developed countries (Clark, Stewart & Clark, 2006). Clark et al. state that after adjustment for the cost of living, a nurse's salary in Australia is double what a nurse may receive in South Africa, and 25 times what a Zambian nurse receives.

While the pursuit for a better lifestyle is a prime motivator, nurses also migrate to look for 'decent employment' in a better organizational environment (International Center of Nurse Migration, 2008; Kingma, 2001). Whether it is because of job shortages, working conditions or just the opportunities for higher education and career advancements, many nurses are relocating for a more rewarding professional life and greater practice opportunities (Bach, 2003; Kingma, 2001; Kline, 2003). Job satisfaction along with a better organizational climate and career opportunities encourage nurses to venture abroad (Haour-Knipe & Davies, 2008).

Nurses also leave for safety and political reasons because they do not feel secure in their current environments (International Center of Nurse Migration, 2008; Kingma, 2001). Occupational hazards related to biological, chemical, physical, social and sensory hazards without the necessary protective equipment make nursing a dangerous job (Kingma, 2001). Violence in the workplace is also a significant safety issue (Kingma, 2001). Outside of work, nurses face other hazards. Violence, war, civil unrest and political uncertainty and persecution along with epidemics such as the HIV crisis in sub-

Saharan Africa are strong push factors encouraging migration (Bach, 2003, Haour-Knipe & Davies, 2008; Kingma, 2001).

Some nurses also travel for adventure and working abroad enables them to see the world (Haour-Knipe & Davies, 2008). This is especially true for nurses from isolated countries that travel to areas such as Europe where travel movement between countries and cultures is easier.

The ethics of nurse migration

The process of travelling abroad and settling in a new environment where often culture and language are so different from home is not an easy transition. Bach (2003) suggests that migration health workers are “strongly influenced by the regulatory frameworks of individual governments that control the training, recruitment and deployment of health professionals” (p.15). There are many hurdles to overcome in both the immigration process and for a period of time after arrival in the new country. Relocation is an expensive proposition and along with the travel expenses, nurses face requalification exams, licensing procedures that are often lengthy, complex and costly, and complex immigration procedures on their overseas journey (Bach, 2003; Kingma, 2006).

On entering the new country, there are other barriers to face. There is often a different language to learn, different clinical practices to master and extended training to ensure clinical practice is appropriate for the new practice setting (Bach, 2003; Clark, Stewart & Clark, 2006; Kingma, 2006). Nurse migrants will frequently find themselves on probationary wages and accepting a work position well below their home country position (Clark et al., 2006) while their skills and previous experiences fail to be recognized (Bach, 2003). Amongst European OECD countries, Dumont & Zurn (2007) state that there is a higher percentage of foreign workers in night shift positions, working weekends and working more than forty hours a week, compared to domestic workers. Both Kingma (2008) and Bach (2003) maintain foreign nurses are often exploited, abused and discriminated against whilst sometimes working for less money than those of their local colleagues.

The allegations of potential abuse of foreign workers along with the ethical considerations related to the depletion of health care workers from some source countries have led many organizations to develop codes of practice and policy

statements revolving around nurse migration. Almost every organization believes an individual nurse has a right to travel and work wherever he/she wishes (Clark, Stewart & Clark, 2006; ICN, 2007; Trossman, 2002; WHO, 2010). But organizations are also concerned with the repercussions of the decisions of nurses to migrate. There is tension between allowing individual nurses the right to migrate while taking into account the wider implications of depleting a country of a much needed health care worker (Haour-Knipe & Davies, 2008; Rosenkoetter & Nardi, 2007). Thus as Walker (2009) notes, the right of a nurse to emigrate often collides with political and social obligations.

In the World Health Organization global Code of Practice on the international recruitment of health personnel, it is asserted that the health system of both source and destination countries should derive benefits from the migration of nurses and that any recruitment of nurses should be properly managed (WHO, 2010). The Commonwealth Code of Practice (The Commonwealth, 2003) seeks to provide guidelines for the international recruitment of nurses, discouraging targeting nurses from countries with severe nurse shortages. The code also suggests full and accurate disclosure of source job requirements and contractual obligations while advocating for foreign nurses to have the same rights as domestic nurses in their adopted countries. While these international codes and guidelines have been present now for several years, it is still unclear whether recruitment practices have changed.

Individual countries are also developing their own codes with designs to moderate international recruitment of nurses. In the UK, the Department of Health has a code of practice for National Health Service employees which list among its key points, holding recruitment agencies to code compliance, the non-targeting of developing countries for active recruitment and the allocation of the same legal protection and access to training for all employees regardless of where they trained (Buchan, 2007). The American Nurses association, while believing nurses have the right to go where they want, advises against luring nurses away from countries that have a greater need for them (Trossman, 2002). The association also speaks out against the misuse of overseas nurses in nursing homes and the use of Registered nurses as nursing assistants for lower salaries (Trossman, 2002).

While codes of practice are designed to ensure a level of employer transparency there is no legal basis or enforcement and monitoring opportunity and the focus is on the public sector excluding private employers (Bach, 2003). The challenge is in balancing

the rights of the individual with the needs of a country. As Buchan and Sochalski (2004) write, there is a “need to respect the right of the individual to move but ... must also create an ethical environment where there is no pressure to leave” (p.591).

Return migration

In recent years, there has been a call for more research on those nurses who choose to return home after a period of time working abroad (Kingma, 2006; McElmurry et al., 2006). The International Organization for Migration believes that given the choice many migrants would prefer to be ‘circular’ rather than permanent migrants (Kingma, 2006). The centre for nurse migration states that fifty percent of nurses will return to their country of origin but the longer they stay abroad the harder it is to return (International Center of Nurse Migration [ICNM], 2008). In addition, they believe return migration is more likely to take place if family members are left behind in the source country and when return processes are made easier including negating the causal factors that may have forced the nurse to leave initially (Haour-Knipe & Davies, 2008; ICNM, 2008).

In a search through the literature few studies focused on return migration were found. This finding is supported by Haour-Knipe and Davies (2008) who in their own literature search for studies on return migration found that findings were usually anecdotal only. In addition there were no studies that look at return migration in or out of the US with only a few studies that have focused on nurses from Jamaica, Tonga, South Africa and the Philippines. Among these studies the primary factors that contributed to the decision to return home were non economic and often related to family concerns. In making the decision, the age and educational level of any children was a consideration along with family members left at home. Other non economic factors for returning home include a love of homeland, family and friend ties, climate factors, lifestyle and lack of discrimination or prejudice that the nurses have faced in their destination country (Gmelch, 1980).

Among the advantages for countries when welcoming home returning migrants is the resupply of highly educated personnel (Lowell & Findlay, 2005). Most return migrants are more productive and transfer technology, new ideas, skills and practices to the workplace (Gmelch, 1980; Lowell & Findlay, 2005). The key human resource challenge is ensuring that migrants returning home find jobs that use the skills they have

gained while abroad (Bach, 2003) and acknowledging their accomplishments (Haour-Knipe & Davies, 2008). From a broad literature search along with references from major authors studying return migration, Haour-Knipe and Davies (2008) have identified several factors that may facilitate return migration such as policies encouraging dual nationality and tax free importation of personal goods and dollars earned abroad.

The information on returnees, their motivations, characteristics, and migration patterns, is however still scarce (Gmelch, 1980; Haour-Knipe & Davies, 2008; Kingma, 2006). Yet accurate data related to the number of nurses migrating and returning to their country of origin and the potential impact they have on the labour market along with health related outcomes for patients in both countries is essential in characterising the scope of nurse migration (Kingma, 2006; McElmurry et al., 2006).

The United States as a destination country

For more than fifty years hospitals in the United States have been importing nurses from abroad (Brush, Sochalski & Berger, 2004; Polsky, Ross, Brush & Sochalski, 2007). In 2004 it was estimated that four percent of the 2.7 million Registered nurses in the United States were foreign trained (Aiken, Buchan, Sochalski, Nichols & Powell, 2004; Xu & Kwak, 2007). This equates to approximately 90,000 nurses. In 2007 a study was undertaken by Xu & Kwak where characteristics of internationally educated nurses [IEN's] were compared to US educated nurses. Secondary analysis databases from the National Sample of Registered Nurses between 1977 and 2000 found that the average age for IEN's was 43.7 years which is fairly consistent with all nurses. Twenty six percent of IEN's came from the Pacific region and were located mostly in urban areas. They also found that the IEN's were prepared at a higher educational level, more likely to hold more than one job and worked longer hours. Most IEN's were direct care providers and many worked in Intensive Care Units.

The National Center for Health Workforce Analysis (2010) sends a survey out every four years to a small percentage, approximately one to two percent, of actively licensed nurses in each state of the United States. Part of this survey shows the characteristics and employment of IEN's. The 2008 survey estimated the number of IEN's in the United States had increased to over 165,000; 5.4 percent of the current United States registered nurse population. Over a quarter of these nurses had received

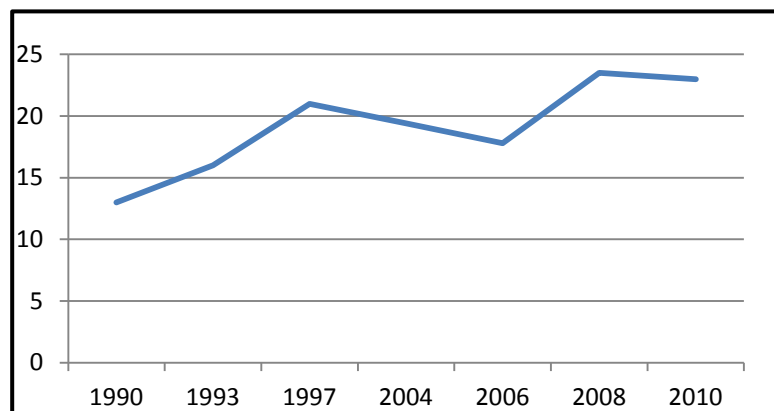
their United States nursing license after 2004 however most nurses did not get this US license till four or more years after completing their initial RN training in their own country. A third of the IEN's were very experienced, having at least ten years of nursing post graduation behind them. Much like the study by Xu and Kwak (2007) found, the nurses were more likely to work in a hospital setting fulltime. Almost 50 percent of the IEN's were from the Philippines with the second highest percentage, 12 percent, from Canada. India and the United Kingdom were a distant third and fourth. Almost two thirds of the IEN's were located in California, New York, Florida or Texas.

Polsky, Ross, Brush and Sochalski (2007) maintain the number of foreign born nurses employed in the US grew four times faster than the number of US born nurses during the ten years between 1990 and 2000. In 1990, they noted there were approximately 113,000 foreign trained nurses and ten years later there were 181, 000. In the same period of time while the majority of the nurses were from Asia, notably the Philippines, the number of Canadian nurses doubled and African nurses tripled (Polsky et al., 2007). Other authors estimate the number of foreign trained nurses in the US now to be closer to 330,000; 12 percent of the nursing workforce (Dumont & Zurn, 2007).

Certainly recent migration inflow figures show a trend towards increasing diversification of source countries for nurses (Dumont & Zurn, 2007). While decades ago most of the nurse migrants were from Canada and the UK, since the 1960's there has been a switch in recruitment to the Philippines and other Asian countries (Bach, 2003). More recently there has been a further diversification of source countries. India and the Philippines are still the main countries that supply the US with nurses but there is a definite increase in flow from smaller countries (Dumont & Zurn, 2007). Brush (2008) agrees, citing increased numbers of Chinese, Indian, Arabic, Nigerian, Korean and Kenyan nurses.

In a study for the California Board of Registered Nursing, Spetz, Keane and Herrera (2011) explored the composition of nurses working in California. Out of a potential pool of over 350,000 California certified nurses, a stratified random survey was sent to 10,000 nurses. Of the 6224 nurses that responded to the survey, a response rate of 62 percent, they found that 23 percent were educated outside of the USA. This was a significant increase from previous surveys done since 1990 when 13 percent were foreign trained.

Graph One: Percentage of foreign trained nurses in California



Data from Spetz, Keane & Herrera (2011): California Board of Registered Nursing survey,

This considerable increase in the number of nurses immigrating to the US is driven by a significant nurse shortage. Buchan, Parkin and Sochalski (2003) report the shortfall of US nurses is due to a 40 percent increased demand for nurses with only a six percent increase in supply. This demand for nurses has led to the expansion of organised international nurse recruitment (Aiken, Buchan, Sochalski, Nichols & Powell, 2004; Brush, Sochalski & Berger, 2004; Ross, Polsky & Sochalski, 2005). In 2007 there were 273 United States companies actively recruiting nurses mostly from developing countries (Pittman, Folsom & Bass, 2010). Fifty percent of foreign nurses are thought to use these recruiting agencies (Pittman, Folsom & Bass, 2010). Significant 'pull' factors such as free travel, licensure and room and board coupled with extensive learning and practice opportunities appeal to foreign nurses particularly those from developing countries looking for a better way of life (Brush et al., 2004; Ross et al., 2005).

Prior to 1990 the flow of migrants was predominantly based on familial connections with a smaller percentage employment based so as not to harm US workers (Lowell, 2001). Lowell notes that the Immigration Act of 1990 increased the overall number of permanent migrants and tripled the number of employment based admissions while making the transition from temporary to permanent migrant easier. Yearly approximately 65,000 professional workers, which include nurses, may enter on a H1B visa with a six year maximum stay while additional workers from Canada and Mexico are able to easily migrate with the advent of the North American Free Trade Agreement Act (Lowell, 2001).

More recent stringent requirements for licensure and restrictive immigration policies particularly in the last ten years have made it more difficult to enter the US to work as a nurse (Aiken, Buchan, Sochalski, Nichols & Powell, 2004). To ensure safe patient care 80 percent of the US State nursing boards require a Commission Graduate Foreign Nursing Schools (CGFNS) certificate prior to applying to take their state board exams (Davis & Nichols, 2004). This certificate ensures home country credentials are reviewed and a qualifying exam certifies English proficiency and nursing knowledge and proficiency (Brush, Sochalski & Berger, 2004; Singh & Sochan, 2010). It has been proven to be a good predictor of the likelihood that a foreign nurse will pass the State RN Licensing Board exams (Bach, 2003; Davis & Nichols, 2004).

The New Zealand position

The 2006 New Zealand census showed that 22 percent of all New Zealanders are foreign born (Hawthorne, 2011). The New Zealand government encourages skilled migrants to their shores to replace the many New Zealanders that travel abroad. New Zealand also cultivates international students with the aim towards encouraging these young people to enter the New Zealand workforce as skilled workers (Hawthorne, 2011). New Zealand has a long history of young qualified New Zealanders going overseas for their 'overseas experience', commonly called the OE (Cassie, 2008; North, 2007). "Travelling overseas is viewed as a positive thing and an integral part of the lifestyle choices of many young New Zealanders" (Zurn & Dumont, 2008, p. 18). The precise number of New Zealanders living abroad is difficult to calculate but the Department of Labour estimated figures in 2001 of approximately 465,000 (Haig, 2010). Almost three quarters of them reside in Australia and in the five years after 2001, over 100,000 more New Zealanders left for Australian shores (Haig, 2010). This number is three times higher than those returning (Haig, 2010).

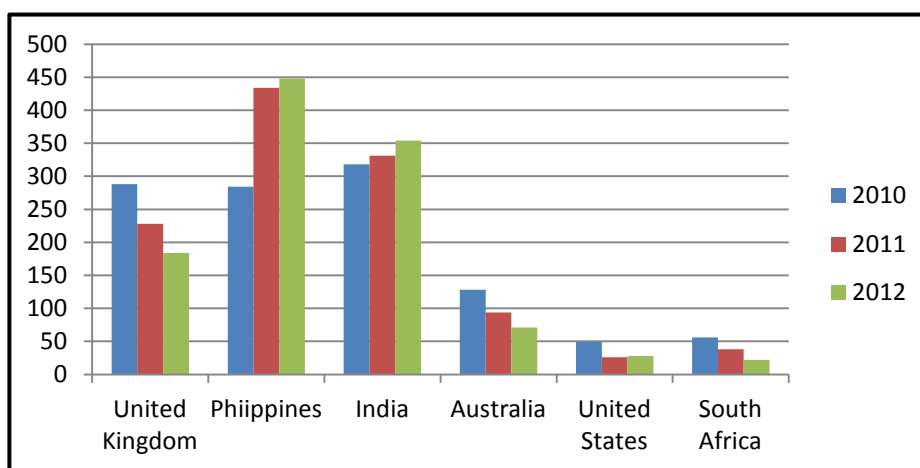
The New Zealand migrant nursing numbers

New Zealand [NZ] has for many years accepted migrant health professionals to augment its supply of healthcare workers and has one of the highest percentages of migrant nurses in the world as well as a significant expatriation rate (District Health

Boards of New Zealand and Ministry of Health, 2006; Hawthorne, 2011; New Zealand Department of Labour, 2005; North, 2007; Walker, 2009; Zurn & Dumont, 2008).

In fact, since 1994 NZ has relied on overseas nurses to supplement the pool of NZ trained nurses (New Zealand Department of Labour, 2006; North, 2010). In 2010 the Nursing Council of NZ released data from a study on the NZ nursing workforce. They found that almost a quarter of all nurses working in NZ were internationally qualified; that is they had been trained abroad and immigrated to NZ. The largest proportion of these immigrants, 42 percent, had come from the UK with almost 15 percent from South East Asia (Nursing Council of New Zealand, 2010). Recent Nursing Council numbers from 2011 and 2012 show this demographic is changing even from 2010. Of the 1232 internationally qualified nurses who qualified for NZ registration for the first time in 2012, a third of them were from the Philippines, a quarter from India and only 15 percent were from the UK (Nursing Council of New Zealand, 2012).

Graph Two: Numbers of new International Nurse Migrants to New Zealand



Nursing Council of New Zealand (2010), Nursing Council of New Zealand (2011), Nursing Council of New Zealand (2012)

NZ is also a major destination for Pacific Island nurses. Using 2006 census data in Australia and NZ, Negin (2011) estimates there are over 3400 Pacific island born nurses working in Australia and NZ. The majority of these are Fijian. This 'brain drain' from the islands has led to critical shortages of nurses in the islands. Indeed, Negin

writes that there are more Pacific nurses and midwives in Australia and NZ than there are in the domestic workforces of Samoa, Tonga and Fiji.

Internationally the retention of all foreign nurses is a major challenge and certainly NZ seems to have difficulty retaining migrants (Callister, Badkar & Didham, 2011; Hawthorne, 2011). Hawthorne (2011) quoting the results of a survey by the NZ Nursing Organization in 2009, suggests that over a quarter of these nurses are unsure of their future plans and that many are considering a return to their country of origin. The District Health Boards of NZ and Ministry of Health (2006) estimate that only just over a quarter of foreign trained nurses in New Zealand will stay until retirement.

Walker (2009) states that for New Zealand nurses, the benefits of having nursing vacancies filled by international nurses are tempered by the difficulties these nurses face such as cultural and linguistic differences, unfamiliar clinical protocols and scopes of practice and the varying policy and procedures of workplace environments. After new graduates, international nurses were the most expensive to train on the job until they could be fully productive (North, 2007). The mobility of the nurse employee affects an employer's expected return on any investment in education and training in the workforce arena (DeRoad, 2001).

For the immigrant nurses there were many factors that impacted on the process of becoming competent and confident nurses within the NZ practice environment (Woodbridge & Bland, 2010). In a literature review of the years 2002-2009, Woodbridge and Bland sought to identify key issues of concern for migrant nurses. They found for some, there were barriers to gaining recognition of past education, while for many others the different working environment required multi-faceted transition programmes. As well, extensive cultural differences along with language competency including NZ slang were significant hurdles to overcome.

In 2008 the number of foreign born nurses in NZ was matched by the number of NZ born nurses living abroad; estimated to be about 7500 (Zurn & Dumont, 2008). Zurn and Dumont (2008) report that "over time the number of health professionals leaving New Zealand has increased" (p. 40), doubling in the years between 1992 and 2006. In the year 2000, 23 percent of NZ born nurses were working in another OECD country and by 2005 NZ had the second highest expatriation rate in the OECD, behind Ireland (OECD, 2010; Zurn & Dumont, 2008). The Department of Labour (2005) states that the

percentage of NZ trained nurses living overseas has increased but the actual numbers are unknown as some individuals are no longer registered in NZ. Using Nursing Council data on verifications of NZ registered nurses by overseas licensing boards, North (2007, 2010) estimates that in the years between 2001 and 2006 there was a loss of 1700 to 2000 nurses a year. In the same five year time period the number of verifications of NZ registered nurses exceeded the output of graduate nurses within the country. This loss of nurses contributed to nursing being placed on the occupation skills shortage list by the Department of Labour (New Zealand Department of Labour, 2005; North, 2007).

After many years of net losses, 2004 was the first year in a long time that the number of nurses coming in to the country surpassed the numbers of nurses leaving; albeit by a small margin (Cassie, 2005). Of the over 1100 nurses who left the country that year, 447 went to Australia and 448 went to the UK. These countries remain the main destinations for nurses emigrating although a wide range of countries including Saudi Arabia, US, Canada and Ireland are also popular destinations (Callister, Badkar & Didham, 2011; New Zealand Department of Labour, 2005; Zurn & Dumont, 2008). Emigration to Australia is facilitated by the Trans Tasman Mutual Recognition Agreement which was signed in 1998 enabling Australians and New Zealanders to travel freely to live and work in either country with a reciprocal job without extra training or qualifications except registration (Kingma, 2006, North, 2010; Zurn & Dumont, 2008). Approximately 1200 nurses a year move to Australia, far more than the number of Australians that reciprocate (Cassie, 2008).

There are various estimates of the number of NZ nurses who return to NZ to work as nurses after migrating abroad. The New Zealand Department of Labour (2005) estimated only 13 percent of nurses returning to NZ return to a nursing position. Examining a cohort of 2911 nurses who were working overseas in 2001, the District Health Boards and NZ Ministry of Health found 86 percent of them returned to NZ at some point between 2002 and 2008 but by 2008 only 28 percent of the nurses were still working in NZ as nurses (Health workforce information programme team, 2009). It is unclear whether the remainder of the nurses returned overseas to work or remained in NZ but were not working as nurses.

In November 2008 with the change of government, the National Party introduced their immigrant manifesto which sought to encourage return migration and reduce the net loss of New Zealanders overseas (Hawthorne, 2011). Policies related to increasing

the level of employer responsibilities and obligations along with prioritising skilled migration were implemented by the government (Hawthorne, 2011). It remains to be seen if these new policies will help bring skilled workers, including nurses, home.

Initiatives to retain the New Zealand workforce

The 2005 Multi employer contract agreement, known as MECA, raised the salaries of nurses in NZ by a substantial amount. It was hoped that by augmenting wages, there would be enough of an incentive for nurses to stay in the country and to stay employed as nurses (Cassie, 2005). The new graduate nursing programmes and the promise of safe staffing initiatives still in progress are other measures considered to aid in NZ nurse retention (Cassie, 2008). In 2007 NZ signed the Islamabad Declaration on strengthening nursing and midwifery whose main goal was for each country to establish policy and practices to ensure self sufficiency in workforce production within the limits of its own resources (Walker, 2009).

De Road (2001) questions whether these measures are enough to keep nurses in the country. By looking at the labour supply issues she asks just how much influence wages have on a nurse's decision to migrate. What other factors are involved? Does NZ have to look at matching overseas education and training, changing occupational regulation regimes and employment relations, and the models of care? (De Road, 2001). In a recent large longitudinal web based e cohort study with 7604 participants from Australia, NZ and UK, researchers discovered that little has changed for some nurses (Huntington et al., 2011). They found that workplace conditions and organization within a complex work environment were still a major concern for nurses and a significant challenge for retention.

Zurn & Dumont (2008) agree that an increase in wages does not necessarily lead to a substantial increase in labour participation, at least in the short term. They believe that the growing number of stakeholders in the development of policy for the health workforce has contributed to fragmentation and duplication in workforce planning and that a better understanding of the migrant workforce both entering and exiting the country is essential. North (2010) concurs stating that along with researching older nurses to keep them in nursing longer and developing an understanding of all the factors that will encourage retention of all nurses, there is a need to understand the dynamics of

NZ nurse migration. She asks: “what are the levels and reasons for dissociation of NZ RN’s from the NZ nursing workforce?” (North, 2010, p. 227).

The need for qualitative studies on nurse migrants

Understanding the migrant workforce is not just a matter of knowing the immigration and nurse registration numbers. There is consensus in the literature that more knowledge about the nurse migrants themselves is imperative. There is a need to move beyond statistical accounts towards including the voices and concerns of the migrants (Kingma, 2006). Mambo (2009) suggests that when studying nurse migration, the ability to entertain a better understanding of the migrant is lost if the personal experience of the migrant is omitted. Buchan and Sochalski (2004) propose that along with better quantitative data such as year first graduated and length of stay, more qualitative data is needed from the nurse migrants, such as the reasons for leaving or coming to a country along with career plans and cultural adaptation issues. This information, they argue, is needed in order to support policy analysis of nurse migration. Bach (2003) summarizes it best when she writes,

Much of the analysis of the impact of health workers migration focuses on the quantitative dimension, but much less attention has been paid to the qualitative effects, positive or negative, of overseas employment for the workers themselves ... whether the experience of employment fulfils their expectations, the degree to which they consider migration a temporary or a more permanent decision and under what circumstances they would consider return. (p. 30)

The following section in this chapter discusses research, mainly qualitative, from a wide ranging literature search that focused on the experiences of nurses once reaching their destination country. These studies concentrate primarily on how the nurses adapted to the new environment. There were few studies that considered in depth why they left their home countries or their plans for returning home. There were no studies that addressed the New Zealand migrant nurse as the primary target for investigation although New Zealand nurses did occasionally appear in various studies as part of multinational groups being studied.

Research on the nurses' experience

Adapting to a new environment

Many of the studies had as their focus, the nurse migrant who had travelled from a developing to a developed country. The main purpose of the majority of these studies was to identify the challenges these nurses faced in their new workplace environments. Emerging from the data reported in various studies were similar findings and themes centred around language issues, the adjustment to different nursing roles, styles and practices, a lack of recognition of overseas qualifications and skills, bureaucracy related to migration and nursing licensure and discrimination (DiCirro-Bloom, 2004; Hawthorne, 2001; Magnusdottir, 2005; Omeri & Atkins, 2002; Smith, Fisher & Mercer, 2011; Walker, 2008; Yi & Jezewski, 2000).

In studies by Hawthorne (2001), Magnusdottir (2005), and Yi and Jezewski (2005) it was identified that learning a new language posed a significant hurdle to overcome for many of the nurses interviewed. These studies also showed that even for those nurses who had initially felt they had a good grasp of the language, colloquialisms and new technical language presented a significant obstacle to being able to practice comfortably in a new environment.

Adjusting to a different practice environment proved more difficult and took longer than initially expected for many of the nurses participating in several other studies. Gerrish and Griffith (2003) followed 17 overseas nurses from four countries over a 12 month period to consider how successful an adaptation programme in a large acute National Health Service trust in the United Kingdom (UK) was in terms of retaining nurses. Using focus groups and individual nurse interviews along with interviewing ward managers, mentors, managers and educators they tracked the nurses' progress through a 12 week study course and integration process. They found for the majority of nurses the course was useful but all of them required much longer than the 12 weeks initially anticipated; the mean time being just over five months. Similar findings were reported by Magnusdottir (2005) who studied 11 foreign nurses in Iceland. Through the use of unstructured interviews and thematic analysis she identified the process of adaption to the different work environment as being a significant obstacle and harder than anticipated for many of the nurses interviewed.

These findings were supported by several other studies in the US and Australia. In the US, Yi and Jezewski (2000) interviewed 12 Korean nurses to examine the cultural challenges the nurses faced. They found that accepting US nursing practice along with adopting US styles of problem solving strategies and adapting to US interpersonal relationship styles with physicians, patients and fellow nurses to be significant barriers for the nurses. In Australia, Smith, Fisher and Mercer (2011) had similar results from their work when they interviewed foreign trained nurses who felt only partially prepared to work and were very unfamiliar with the practice of Australian nursing.

Frustrations nurses faced in getting their overseas qualifications and experiences accepted by recipient countries were very evident in several studies. Singh and Sochan (2010) interviewed 12 nurses enrolled in two professional bridging programmes in Canada in an attempt to identify the difficulties foreign nurses faced in Canada. They found the education bridging process was difficult with much repetition of study that had already been done. In addition, the programmes were expensive with the credentialing system difficult and fraught with disparities and complicated processes. In Australia, Hawthorne (2001) also considered barriers confronting overseas qualified nurses. In a large study where 719 overseas qualified nurses were surveyed, 231 interviews were analysed and 29 extended interviews conducted, she found that the biggest problem for most of the nurses was the recognition of their overseas registration.

Several other Australian studies focusing on foreign trained nurses and their working experiences within the country showed similar results. Omeri and Atkins (2002) interviewed five nurses from five countries about their everyday experiences working in Australia. The researchers discovered the nurses found the registration and employment search very painful and with a limited degree of choice in nursing roles being available. In addition, they felt there was a lack of recognition of the skills and experience they had, thus they felt their professional worth was devalued. This frustration in the inability to be able to use the skills they had utilized in their home countries was also a finding in a study done by Smith, Fisher and Mercer (2011) where they interviewed 13 nurses working in two large metropolitan hospitals.

The difficulty in gaining nursing licensure in a new country was a theme echoed in a New Zealand study by Walker (2008) who surveyed foreign trained nurses in order to look at their New Zealand nursing experiences. The biggest issue the nurses faced was the bureaucracy involved in gaining their NZ practicing certificates and in the migration

process along with the considerable investment with the mean migration costs just less than \$NZ 10,000. This bureaucratic barrier was also identified as a significant concern in Hawthorne's (2001) study.

Discrimination, prejudice, back stabbing and miscommunication along with feelings of loneliness and being an outsider were also identified as barriers to integrating into a foreign nursing working environment in many of the studies (Hawthorne, 2001; Magnusdottir, 2005; Omeri & Atkins, 2002). Diccico-Bloom (2004) studied immigrant nurses from Kerala, India who were employed in the US. She wanted to explore their experiences as nurses, non white females and immigrants thus her focus was more on racial issues related to the marginalisation of women of colour and the way race, gender and migration interrelate. Key themes that emerged from this study were related to cultural displacement and racial discrimination and supported previous studies with similar results (Hawthorne, 2001; Magnusdottir, 2005; Omeri & Atkins, 2002).

Of significance with all of these studies is that the vast majority were focused on the nurse migrant moving from an undeveloped country to a developed country and/or from one country to another where culture and language were very different. In several of the studies (Omeri & Atkins, 2002; Walker, 2008) exclusion criteria was such that English speaking nurses were not able to be part of the studies. It could be argued therefore that those nurses who travel from one country to another where language and culture are similar yet different are not represented. Also, the focus for these studies was primarily on the experience of the nurses once they reached their destination and did not address the reasons for the decision to migrate in any depth nor did they seek to determine what kept these nurses abroad. The next section focuses on those studies where the decision to migrate is explored in some detail.

Studies focused on 'push' and 'pull' factors

Few researchers have attempted to study in any detail, the reasons why nurses leave their homes and venture abroad. Anecdotal stories and inferences are present throughout migration literature but the 'stories' from the nurses themselves are not present in any significant number in research. Certainly there have been attempts to capture the information through surveys and statistical data bases but limited information can be gathered by such methods. This is demonstrated quite well in a study McGillis et al. (2009) conducted looking at Canadian educated nurses working in

the US. They wanted to explore why nurses leave Canada, remain overseas and when they might return. Using a retrospective exploratory research design they looked at public data files from the US NSSRN 1996, 2000 and 2004 surveys along with information from the Canadian Institute for Health. They were able to gather statistical information on where the nurses worked; their qualifications, work status and sex but little information was able to be obtained on the motivation behind the nurses' migration. The authors themselves argued that the opportunity to follow the nurses was not possible and while the study did suggest that Canadian media reports citing nurses leaving Canada to cross the border because of better opportunities, working conditions, pay, scheduling, paid education, career opportunities, stable fulltime work and job security may be correct, the research did not provide the evidence to support this.

Nevertheless there are a few qualitative studies that have considered the reasons why nurses migrate and provide some insight into the decision making process these nurses apply. When asked in these different studies why they choose to migrate, the responses of the nurses are very similar and the answers given support current migration theory. The motives behind the travel decision were varied but generally were related to financial reasons, improving their professional skills; job shortages in the home country; dissatisfaction with the hospital system they came from, the opportunity for further travel, improving family lifestyle and furthering their education (Brown & Connell, 2006; Hardill & MacDonald, 2000, Allen, Bryan & Smith, 2005; Isaksen, 2012; Sidebotham & Ahern, 2011).

The findings in several of the studies however showed a much more complex picture behind the reasons for the nurses' migration. In a UK study that focused on overseas nurses' motivation for working in the country, Larsen, Allen, Bryan and Smith (2005) asked sixty seven foreign nurses in focus group interviews, why they came to the UK and what they expected to gain by working there. They found that each nurse had in fact a range of motivations for choosing to migrate. Even those who travelled for financial reasons also wanted to improve their professional skills and experience a different way of life. Most wanted to branch out and see the world, travel and expose family members to a different culture. The possibility for better education and further study was another impetus for many of the nurses. Regardless of their individual reasons for migrating, most of the migrant nurses felt that their UK colleagues did not understand or acknowledge their motivations for travelling abroad to work. They were

all considered to be economic migrants whether to gain money for survival or to travel. An interesting finding in this study was that with time and experience behind them, the motivation to travel abroad had changed and the nurses saw themselves differently. As the authors write, 'the nurses shared a global perspective on life, seeking their opportunities and life chances across the national borders of their home countries' (Larson et al., 2006, p. 364). This study highlights the multifaceted intricate nature of the decision process that migrant nurses apply when deciding to travel abroad to work.

A study by Hardill and MacDonald (2000) also shows the "complex interweaving of economic and non-economic factors involved in individual decision making on the part of the nurses" (p. 690). Sixteen foreign nurses in one UK hospital were interviewed by the researchers who were focused on the dynamics of migration and the experience of living and working abroad. While the reasons for migrating were varied and related to travel, employment conditions and financial reasons, several of the nurses also identified family considerations as being integral to the migration decision process. Sidebotham and Ahern (2011) had similar results from their Australian study on 18 UK midwives who had migrated to Queensland, Australia between 2000 and 2007. For the majority of participants the main reason for leaving the UK was to improve the family lifestyle. But other significant factors contributed to the decision making process. For some the perception of an adventure overseas coupled with push factors related to the disillusionment with UK working conditions created additional incentives to leave the UK. For others, workplace harassment and/or dissatisfaction with wages factored into their decisions. Whatever the reasons for travel, it is acknowledged in the study that the complex interaction of many factors contribute to nurses' migrating.

The only study found related to the New Zealand perspective was a survey of Tongan, Fijian and Samoan nurses, some of whom had moved to Australia and New Zealand (Brown & Connell, 2006) with the focus of the study being on remittance. In a small part of the study however, the authors did discover that the major reason for these nurses migrating was financial and in fact many of these nurses had chosen a nursing career so they could migrate. Of those who did return home the decision was made based on family and social issues, not financial issues. These findings support previous studies related to return migration. No studies could be found that focused on the New Zealand nurse leaving the country or returning from abroad.

Summary

This literature review has shown that while a great deal of information exists related to nurse migration, much of it is not supported by statistical data or research. The difficulty gaining precise numerical nurse migrant data is well documented and many organizations such as the World Health Organisation (WHO) and International Council Nurses (ICN) advocate for better record keeping internationally. Quantitative studies, most involving surveys, are becoming more prevalent as countries begin to understand the importance of the role of nurse migration in the retention of their nursing staff. Many of these studies however are focused on the experience of the nurse migrant once they get to the recipient country and only a small amount of research is focused on the nurse migrant's decision making process prior to leaving the source country. In addition, the voice of the nurse migrant is not being heard. There are few qualitative studies that allow the nurse migrant to express in their own words how they feel about leaving their homes to travel abroad, why they make the decision to travel and what aspects of nursing and their life in their home country as well as their occupant country would have to change in order for them to return home. Qualitative studies that do look at the experiences of the nurse migrant are primarily focused on those nurses that are moving from a developing or 'third world country' to a developed country. The factors motivating these nurses to move and the issues they face on arrival to a new country may be quite different to those nurses travelling from one developed country to another. Yet studies that explore the decision making process of a nurse that moves between two developed countries are scarce.

Despite a large proportion of NZ nurses currently working abroad, it appears there are virtually no studies available that explore why nurses have left the country and the forces that keep them away. Anecdotally it is assumed that nurses are still on their great 'overseas adventure' in search of better wages but the voices of these migrant nurses have not been heard in any qualitative enquiry. This study will begin to fill a gap in the knowledge needed to understand NZ nurse migrants and to potentially help with strategies for retaining nurses in NZ.

CHAPTER 3. RESEARCH DESIGN

Introduction

As has been stated in previous chapters, the aim of this study is to fill a gap in the knowledge related to the experience of the nurse migrant moving from one developed country to another, namely from New Zealand to the United States. Studies focusing on the reasons for migration are scarce and the voice of the migrant is rarely heard. Therefore a qualitative study was employed utilizing an interpretive descriptive model with elements of narrative inquiry in order to better understand the nurse migrant and to ensure their stories were told. This chapter will detail the methods used during the study beginning with a general discussion on qualitative research and paradigms. The design of the study will then be addressed followed by a discussion on the research participants and the identification of ethical concerns. Data collection and data analysis decisions are then examined and the issue of trustworthiness is addressed.

Theoretical perspective

Qualitative research

The origins of qualitative research can be found almost a century ago in social science, specifically in anthropology and sociology (Conrad, 2004). The focus of this type of research was on the “subjective and interactional aspects of social life” (Conrad, 2004, p. 6608). In the last several decades qualitative research has become prevalent among many disciplines and now has a prominent place in health science and nursing research practices. At its foundation is the notion that we as humans do not exist in a vacuum and are connected with culture, history and a belief system that impacts on our perception of reality (Crossan, 2003, Holloway & Wheeler, 2010). In addition, as Crossan explains, there are very intricate relationships between individual behaviours and attitudes. Thus the philosophical underpinnings of qualitative research reflect the beliefs, values and assumptions of humans who interact and exist within an environment (Munhall, 1994).

Qualitative research can be defined as the “systematic collection, ordering, description and interpretation of textual data generated from talk, observation or documentation” (Kitto, Chesters & Grbich, 2008, p. 243). Research with a qualitative focus aims to produce knowledge that has at its core the human experience and seeks to understand the meaning behind human actions and words and give insight into behaviour that is multifaceted (Beanland, Schneider, LoBiondo-Wood & Haber, 1999; Carter & Little, 2007; Sandelowski, 2004; Schwandt, 2003). It is focused on the social world instead of the world of nature (Liamputtong, 2010) and is centred around the idea that situations, impressions, and opinions are best described and evaluated by the individuals who experience ‘the moment’ at the time and can vocalise the experience in their own words (Holloway & Wheeler, 2010).

Researchers who conduct this type of research are interested in the way individuals view and seek to understand their world through behaviours and interactions in their ‘natural’ setting (Creswell, 2009; Crossan, 2003; Golafshami, 2003; Kitto, Chesters & Grbich, 2008). The goal of the researcher is thus to learn what is meaningful or relevant to the study participants, and to consider it through the participant’s eyes from their point of view (Neuman, 1997). The emphasis is on careful and detailed accounts of an individual or groups life experiences as explained by the research participants to gain some degree of insight (Gillis & Jackson, 2002). Because of this, qualitative research designs are intended to have the researcher as an insider while committed to the participant’s point of view (Gillis & Jackson, 2002) with a focus on meaning and interpretation (Liamputtong, 2010).

There are a wide number of research approaches under the ‘umbrella’ of qualitative research (Parahoo, 2006). The strategy of inquiry used in this study is interpretive description with elements of narrative inquiry. Interpretive description and narrative inquiry are briefly described below along with the rationale that supports why these approaches were chosen for this study.

Interpretive description

Interpretive and descriptive research have roots in many disciplines including philosophy, history, anthropology, sociology and psychology (Holloway & Wheeler, 2010). The sociologist, Max Weber is generally considered to be influential in the development of the methodological approach that utilizes an interpretive perspective

(Gillis & Jackson, 2002). By stressing the importance that individuals place on both their own actions and on others around them he believed that reality then was based on perception and an understanding of behaviour (Gillis & Jackson, 2002). Thus the paradigm of interpretivism is concerned with how ordinary people manage and make sense of their lives (Neuman, 1997). Neuman explains that social reality and purposeful action based on people's own definition and understandings as they engage with the world in which they live helps them to construct meanings around their experiences based on their own perspectives. What is meaningful and relevant to the study participants is then the goal of research and certainly considering the participant's point of view through their own eyes is crucial (Neuman).

Descriptive studies have as their goal to systematically summarize a particular series of events in a way in which they can be easily understood (Sandelowski, 2000). Gillis and Jackson (2002) depict descriptive research as being concerned with accurate descriptions of some aspect of society with a goal of answering questions. It is, as Sandelowski (2000) describes "especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers" (p.337).

An interpretive descriptive design seemed to be the preeminent choice for this study as understanding migrant nurses' decisions and the events around their lives as seen and interpreted through the nurses' own eyes was considered to be essential. In addition as this study sought to explore the question of why nurses choose to migrate and stay away as a precursor to beginning dialogue on New Zealand nurse retention, it was important to identify common patterns amongst the nurse's experiences.

The foundation of interpretive description is the smaller scale qualitative investigation of a clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding (Thorne, Kirkham, & O'Flynn -Magee, 2004, pp. 55).

In interpretivism the focus is on subjective experiences and perceptions and thus the behaviour of human beings is only understood when studying the circumstances in which the behaviour takes place and the thought processes (Parahoo, 2006). As Parahoo

discusses, the methods used then must be interactive and flexible. In interpretive descriptive studies the research questions which have been developed out of a gap in past knowledge, drive the sampling and minimally structured and open ended data collection methods occur concurrently with data analysis (Sandelowski, 2010; Thorne, Kirkham, & O'Flynn -Magee, 2004). Data collection and analysis methods are discussed further in later sections of this chapter.

Narrative Inquiry

Narrative inquiry is concerned with stories. As long as there has been spoken word and perhaps even before that, humans have been telling stories. Telling stories about our life experiences is the way in which we can experience, understand and share our lives with each other (Bury, 2001; Ollerenshaw & Creswell, 2002; Sandelowski, 1991). A personal narrative, states Ochs and Capps (1996) is a view of how a person reflects upon an event in the past with the perspective of the present. It is both a way of knowing, a way of telling (Eisenberg, Baglia & Pynes 2004) and an attempt to understand how people work out events as well as what they value (Riley & Hawe, 2005). It is a first person, personal version of the past, not perhaps revealing absolute truth but reflective of past actions guided by feelings and beliefs within a particular social context; a subjective edited account of an event at one particular moment in time (Bury, 2001; Ochs & Capps, 1996; Ollerenshaw & Creswell, 2002; Sandelowski, 1991,1994). It is specifically this interpretation of the past influenced by events of the present and told by the storyteller rather than concrete facts that the narrative researcher is interested in (Riessman, 1993).

Thus a narrative study is concerned with the ways in which an individual or group will experience, describe and account for an action, life experience or event over time (Connelly & Clandinin, 1990; Creswell, Henson, Plano, Clark & Morales, 2007). Once seen only in literary studies, narrative analysis and study is now seen throughout all social science disciplines (Ollerenshaw & Creswell, 2002; Riessman, 1993). Health professional researchers use narrative studies as a means to understand the experiences within a cultural framework or setting and also to look at the difference between healthcare ideology and what the individual actually experiences. (Holloway & Wheeler, 2002). By listening to stories which Sandelowski (2004) describes as actionable research texts, we can gain access to and understand the experiences of individuals.

Polkinghorne (1995) has identified two types of narrative inquiry; one in which data analysis produces stories and the second where data consists of stories but the analysis produces paradigmatic typologies of categories resulting in themes that hold across the stories. It is this second type of narrative inquiry that was utilized for this study and is explored further in the analysis section of this chapter.

In narrative research the collective story is important. By reflecting upon the thoughts of a group of people who have had similar experiences, a nurse researcher can portray a type of pattern or whole picture of the event, and thus recognise the needs of a group, and improvements can be explored (Holloway & Wheeler, 2002). It is, as Ochs and Capps (1996) explain, precisely because personal narratives shape how we feel about events and how we define ourselves through our contact and involvement with others, that it was felt that narrative inquiry was well suited as an adjunct to this interpretive descriptive study investigating the story of how and why New Zealand nurses with similar journeys came to the United States and stayed for protracted periods of time.

Reflexivity

The philosophical viewpoint of a researcher regarding the generation of knowledge along with their personal experiences will influence the way in which he/she approaches the research method or design (Carter & Little, 2007; Creswell, 2009; Poole & Jones, 1996). It is this theoretical positioning of the researcher which includes ontology, epistemology or how they know what is known, and value inclusion or axiology that will guide and shape the way in which a study will be conducted (Caelli, Ray & Mill, 2003; Creswell, Hanson, Plano, Clark & Morales, 2007; Dodd, 2008). With an interest in sociology and a belief system that encompasses the view that everything a person sees and does is based on their own past experiences and often reflected not only in their own decisions and actions but also in the actions of others around them, undertaking a qualitative study is a natural fit for me. In addition, I believe that quantitative studies particularly in nursing, while providing important factual information and data to support research based practice, cannot explore the 'whole picture' as explicit personal experiences and understanding is essential in this field.

As Sandelowski (2004) writes:

For individuals with no personal experience of a target event qualitative research findings offer a window through which to view aspects of life that would have remained unknown. For individuals with personal experience of a target event, qualitative research findings offer a mirror that allows them to look back on and reframe their experience (p.1371-1372).

With this epistemological perspective, a social constructivist philosophy best reflects the way in which I view the world. This philosophy or worldview is centred on the premise that the way in which people create knowledge and understanding of the world around them is from the interactions they have with each other and their surroundings (Caelli, Ray & Mill, 2003; Creswell, 2009; Grbich, 1999). The goal of research is thus to examine the intricacies of the participants viewpoints of the particular situation that is being investigated (Creswell, 2009). This purely subjective way of realizing meaning in the lived experience is particularly pertinent to this study on migrant nurses. The main research question of what caused New Zealand nurses to leave the country to travel abroad is after all based on the participants' perceptions of their own experiences at the time, in particular the factors affecting and influencing the migration decision. Thus the study question, along with my personal beliefs, influenced the research paradigm and informed the study design (Creswell, Hanson, Plano, Clark & Morales, 2007).

The following sections in this chapter detail the search for research participants, the methods used for data collection and analysis and the steps taken to ensure all ethical concerns and the trustworthiness of the study were considered.

Research Participants

Participant selection for this study was influenced by several different factors. The research question was concerned with the migration decisions of New Zealand nurses and the study was conducted in the country where I currently reside, the United States. Geographically, the United States is a very large country and due to the fact that I am currently still working as a nurse in California, for logistic reasons it was decided at

the beginning of the study process to limit the selection of potential study participants to New Zealand nurses currently working in California.

The foremost criterion in considering a sample collection method is its representativeness of the population to be studied (Beanland, Schneider, LoBiondo-Wood & Haver, 1999). In qualitative studies, it has been suggested that purposeful selection of participants can best help the researcher understand the problem or issue being studied because sampling is criteria based and specified in advance (Creswell, 2009; Holloway & Wheeler, 2010; Liamputtong, 2010). It is hoped with the deliberate selection of specific individuals that 'information rich' stories can emerge.

Certainly for this study, the selection criteria for participant inclusion limited the potential number of nurses who could be included. To be included in the study participants had to be New Zealand educated nurses currently working in California. As I wanted to interview nurses whose migration stories were not familiar to me, I chose to interview nurses I did not know very well. This was because I felt that I would have preconceived expectations of data that could emerge from including those nurses I knew well in the study. By making this decision I excluded several close New Zealand friends currently living in California.

The difficulty with this decision, I found, was in trying to locate other New Zealand nurses. There is no data base for New Zealand nurses in California and certainly the California Board of Nursing would not have that data available except for nurses who were newly arrived and newly licensed in the State. For the most part and certainly initially, snowball sampling was the primary means of obtaining participants. Miller and Brewer (2003) describe snowball sampling as a method of identifying respondents who are then used to refer researchers to other potential participants. This form of opportunistic emergent sampling is good for gaining access to hidden populations and used frequently for studies where the number of respondents is few, random selection is not needed and where potential participants are known to have knowledge of experience of a topic (Holloway & Wheeler, 2010; Liamputtong, 2010; Miller & Brewer, 2003).

New Zealand friends in California initially gave me contact information for several potential participants. Some of these participants in the study I knew of and/or had met before but I had limited regular social interaction with them. I had never heard their stories of how they came to the United States and thus it was felt they could be included in the study. Some of these participants were able to refer me to another

potential participant. Several of these referrals resulted in additional participants. With some of the referrals I received no response from my inquiries and with others though they responded they did not participate in the study. This was either due to logistical reasons or they chose not to be part of the study.

The number of participants in a study is determined by the scope, nature, methodology and data saturation (Holloway & Wheeler, 2010; Liamputtong, 2010). It was my original intention to limit the number of participants in the study to six to ten with an aim of obtaining eight. Qualitative studies are often centred around small samples in order to gain meaningful rich data (Thorne, Kirkham, & O'Flynn-Magee, 2004) and it was felt that this was a realistic number in order to get good data with the given time constraints. I initially felt I would have no difficulty finding that number of New Zealand nurses in California but instead the task was quite daunting. It took several months to find six participants and despite repeated attempts to find more nurses willing to participate, I was unsuccessful. Despite having only six nurses to interview I was however able to obtain a significant amount of data to base an analysis upon.

After initial contact by email, potential participants were sent information sheets (Appendix A) which provided detail about the study along with an introductory paragraph identifying myself and the reasons why I was conducting the research (Appendix B). Ample time was given to review the information and they were asked to contact me by phone or email if they were interested in being a participant. The majority of people contacted did agree to be involved but I did not receive replies from several potential participants. It is unknown if they were able to review the information or not, or what influenced their decision not to be part of the study as I felt it intrusive to contact them multiple times if they did not respond after the information sheet had been sent.

The nurses were assured confidentiality would be strictly maintained and that pseudonyms would be used throughout. All participants were asked to choose their own pseudonym but every one of them declined to do so, so I assigned a pseudonym after each interview. Participants were informed that the interviews would be audio recorded but were also given the opportunity to be interviewed without being recorded; all agreed to be recorded. Prior to the interview, all participants were advised again of the details of the study, the reasons I was undertaking the research and were given the opportunity to ask any questions. Several participants had questions regarding the post graduate

study I am pursuing in New Zealand and the choice of topic. All questions were answered to the best of my ability and all participants then expressed their readiness to be a participant in the study.

Data collection

Data collection in qualitative descriptive studies is usually focused on the who, what and where of experiences (Sandelowski, 2000). Thus for this study, data was collected by face to face, one on one in-depth personal interviews which were focused yet unstructured in order to remain flexible and versatile (Parahoo, 2006). The purpose of interviewing was to assemble the nurse's story, which formed the data or actionable research texts yet the nurses were able to express their own understandings of their actions in their own way (Patton, 2002, Sandelowski, 2004). In this way, the nurses' feelings, perspectives, ideas and thoughts were heard and explored while information was obtained (Beanland, Schneider, LoBiondo-Wood & Haber, 1999; Holloway & Wheeler, 2010)

A conversational strategy within a general interview guide approach, as discussed by Patton (2002), was used to ensure that all relevant topics were covered and to guide the conversation. This involved outlining the topics and issues I wanted to address with each nurse before the actual interview began. In addition each participant was told there was no formal set of questions to be asked; rather I was interested more in the story of their migration journey. By using this unstructured approach it was hoped, in the limited time available, to focus the conversation primarily on the reasons why the nurses migrated yet still allow a great deal of flexibility for other spontaneous topics, interests and concerns that the participants may have had (Patton, 2002, Holloway & Wheeler, 2010). It also ensured the same basic inquiries were made of each participant yet allowed the participants to tell their stories in their own way.

In order to ensure that both I and the participants would be comfortable with this form of information collection, I asked a close friend, also a New Zealand nurse currently working in California, to take part in a 'practice' interview. In this way I was able to ascertain the correct position for the digital recorder where it was unobtrusive. I was also able to conduct an interview with someone I felt comfortable with while developing an interview style that would, I hoped help the interviewee also feel more

relaxed. This friend also provided constructive feedback with regard to the interview conversation and elements raised at the end of the interview. She was able to validate my choice of a conversational general interview guided approach by commenting that the interview had really made her think about her migration choices which she had never done before.

Locations for the interviews were chosen by the participants with some input from me. As information being relayed was not deemed patient sensitive or likely to cause any psychological trauma the majority of the interviews were conducted in public places that still afforded some privacy. This was to ensure safety for all participants as well as for myself and consequently the majority of interviews were conducted in cafes. One interview was conducted at my house. This informal environment seemed to help relax most participants.

A period of time prior to the recording of the interview was spent in introductions and general conversation. This was to ensure both the participants and myself was comfortable in the situation. Some basic background demographic questions were then asked. An open ended question asking the participant to begin by talking about nursing in New Zealand prior to leaving was used to begin the interview process. No set group of questions were used for each interview. Instead a series of open ended questions and topics along with the occasional clarifying question were used in order to gain narratives in the nurses' own words. An aide memoire listing topics to be covered (Appendix C) was employed to assist with this (Holloway & Wheeler, 2010). In this way, as is utilized in narrative inquiry, the nurses had the time to tell their own story in their own voice (Connelly & Clandinin, 1990).

Although a period of two hours was set aside for each interview, it was anticipated each interview would take approximately one hour. This time period seemed to be acceptable for all participants and in most cases while the interviews lasted 45 minutes to one hour, with the addition of some 'getting to know you' time before the interview began and some general conversation after the interview, several hours were spent with the participants. The time spent with participants after the interview was deemed to be important to answer any additional questions they may have had as well as ensuring the nurses felt comfortable with providing the information in the stories they had just told. I wanted to ensure there was as Holloway and Wheeler (2010) discuss, an equal balance of power between me and the participants; a type of collegial

relationship. To this end, after the interview, some of my own personal information related to nursing and my own migration experiences were shared as many of the nurses had questions and were interested in comparing their experiences with mine.

All interviews were taped using a digital tape recorder placed in an unobtrusive place on a table between the participant and myself. The participant was aware of when the recorder was both turned on and turned off. Recording the oral interview was determined to be a critical part of data collection as it was felt that the experiences of the participants would be more clearly captured and heard in their own words (Liamputtong, 2009). In addition, as the interviewer I wanted my interest to be on the participant rather than on writing down information while they spoke. In this way probing clarifying questions could be asked more easily and my attention was firmly focused on the nurse and what he/she was saying.

A short time after the interviews were concluded, I spent some time in reflection and wrote impressions and notes on what I felt were the prevalent topics discussed in the interview along with some basic demographic information not included in the recorded interview. I felt it was important to do this on the day of the interview while the information was still foremost in my mind and on reflection these notes became the first steps towards data analysis.

The recorded interviews were downloaded into a windows media format into my personal laptop computer which was stored in a secure location at my house. The interviews were transcribed within a month of recording and a second copy of both the recording and the transcription was placed on a zip drive and stored in a separate secure location. This was to ensure in the event of a computer malfunction, the data would still be available. No one else had access to the interviews or transcriptions. All data stored on the computer was permanently erased at the end of the research process.

I then transcribed all the tapes. Despite the large amount of time it took to transcribe each interview verbatim, it was felt that by doing this, I could become immersed in the data at an earlier point in the research. Because the interviews were listened to several times during the transcription process and again at the end to check for accuracy I became very familiar with the interview narrative. Several authors have acknowledged that this early immersion in the data is very useful in the analysis process as it enables the researcher to begin analysis at an earlier stage and develop a more

thorough understanding of the data (Braun & Clark, 2006; Liamputtong, 2009; Sandelowski, 2000).

Once each transcription was completed, a copy was emailed to the research participant so they could read and validate the narrative as well as make comments or corrections. It was important that the participants had this opportunity to study and reflect upon the interview content to ensure the accuracy of each story told. It was also imperative that the nurses felt comfortable making their stories available for research purposes and this final step in data collection was to ensure this happened. Without exception, each participant allowed the research to continue verbatim as told and several added additional comments on their interview and their stories in their responses.

Ethical considerations

Although many factors considering ethical concerns have been alluded to in the previous sections, some clarification may be needed with regard to the specific steps taken to ensure the importance of respecting ethical concerns in the research process. Ethical considerations for the study were taken into account throughout the entire research process under the overlying principle of non-maleficence (Grbich, 1999; Liamputtong, 2010). This concept of 'doing no harm' guided many of the decisions made throughout the participant selection and data collection steps, and guided the dissemination of the results of data analysis as well as the discussion sections of the study.

Prior to beginning the research, an assessment for the potential for risks to any potential participants was conducted (Creswell, 2009). It was decided, upon discussion with my faculty supervisor, that this study could be considered a low risk study and as such a low risk notification was sent to the Massey University Human Ethics Committee prior to commencement of the study. This decision was made based on a determination that the risk to participants was minimal. The potential participants would be totally in charge of relaying whatever information they wanted to give about their travel from New Zealand to the US. In addition there was no patient or client information sought and the nurses were free to explore or not explore any avenues related to the study topic. A

letter was sent from the Massey University Ethics Committee confirming the recording of the study on the Low Risk Database at the university (Appendix D).

The need to protect research participants, to gain their trust and to ensure the integrity of the research was maintained was essential (Creswell, 2009). Informed consent was considered to be a fundamental element of this study as it is in any reputable research (Creswell, 2009; Liamputtong, 2010; Munhill, 2012). To ensure that respondents were fully informed about the nature of the study, potential participants were sent an information sheet (Appendix A) detailing the aims of the research along with the research process. They were given several opportunities to ask questions and discuss any concerns they had related to the study prior to agreeing to be involved.

An informed consent form (Appendix E) was signed by all participants prior to their interviews, signifying their acceptance into the study as well as acknowledging their rights would be protected (Creswell, 2009). All participants were free at any point to withdraw from the study without consequences and to answer or not answer any questions as they saw fit. In order to ensure full disclosure continued to be part of the research process after the interviews were completed, participants were also sent transcripts of their interviews so they could review them for accuracy and also to be able to take out any information they did not want to used. By seeking clarification from the research participants in this way, participants were able to check and validate the interview narratives (Liamputtong, 2010).

The privacy of participants was protected at all times by the use of pseudonyms. Only I knew the real names and locations of the participants in the study. My faculty supervisor knew only the pseudonyms used by the participants during the research. Any personal details that could potential identify the nurses were not included in the data analysis and discussion chapters of the study. All audiotapes and transcripts were kept in a secure location at my private residence where no one else had access to them. In this way the confidentiality and anonymity of participants could be safeguarded.

Data analysis

As multiple authors suggest, data analysis is an ongoing process that begins and occurs concurrently with data collection (Creswell, 2009; Gillis & Jackson, 2002;

Sandelowski, 2000; Thorne, Reimer Kirkham & O'Flynn-Magee, 2004). It is also a process that is difficult to categorise and name until the data has been read and reread multiple times. As Sandelowski (2010) comments, methods in the hands of different researchers are recreated and adapted every time they are used and methods overlap each other. As such it was problematic initially to predict the method of data analysis to be used in the study until the study was in process, although it was always the intention to undergo a form of thematic analysis. Qualitative content analysis after all, always aims to summarise the informational content of the data and produce some kind of descriptive summary of the event (Sandelowski, 2000). It is always an inductive method where the researcher stays close to the data, building from particulars to general themes while interpreting the meaning of data (Bisit, 2003; Conrad, 2004; Creswell, 2009).

A three step process as described by Grbich (1999) was eventually used as part of an iterative data analysis technique where data was collected, reflected upon and emerging themes were identified. The first step, as Grbich explains, is an ongoing preliminary analysis where as interviews were conducted some preliminary themes and concepts began to emerge. The data was critiqued as it came in. During and immediately after the interviews were conducted, some themes began to emerge, both reinforcing ideas already supported by the literature available along with new issues that came to light. At the end of each interview, these initial topics were noted in my comments and formed the introductory part of the analysis process.

The second and third steps of this process involved coding and thematic analysis (Grbich, 1999). After receiving the reviewed transcripts from participants, reviewing comments and rereading them multiple times, as well as considering interview notes made at the time, the data was loosely coded to organise and make sense of the data. Creswell (2009) explains coding as the process of organising material into small pieces of text. There was no provisional start list to begin coding as it was felt data in this study must come from the transcripts by, as Bisit (2003) suggests, looking for commonalities, patterns, differences and structures.

A thematic analysis as described by Boyatzis (1988) was employed initially in order to look for further patterns in the information and to organise them. Boyatzis describes thematic analysis as a type of bridge that can be built between the varying philosophies, viewpoints, orientations and field's that different researchers bring to research. It is very useful in the initial stages of analysis as it is systematic and can be

used inductively to make sense of material that seem to be unrelated by finding common themes and patterns within data across research participants (Boyatzis, 1988; Braun & Clarke, 2006; Riessman, 1993).

Coding and thematic analysis was done in two stages; firstly after reading, rereading several times, and immersing myself in the raw data generated by the transcripts. This gave me a general sense of the information provided by the participants and allowed me to reflect on the overall meanings portrayed (Creswell, 2009). I was able to extract significant sections of text from each transcript and from those segments a list was made of several topics. From the list several themes emerged easily and were readily identified. I then chose to set the data aside for a period of three to four weeks and revisited it, again reading the transcripts several times. By doing this, I was able to come back to the data with a fresh perspective and several further themes began to emerge.

Some elements of narrative analysis were also used to interpret and make sense of the data. Polkinghorne (1995) describes several components inherent in the analysis of narratives. While paradigmatic processes will result in themes holding across the narratives or stories of the participants in the study, much like thematic analysis; there is a historical developmental dimension also studied so that the sequential relationship of events is understood (Polkinghorne, 1995). In other words, by looking at the data describing when events took place and the subsequent effects these events had on the ensuing decisions and experiences of the participants, more information can be obtained. This is best done by trying to stand in the shoes of the storyteller by analysing how people, events, values, histories and possible futures are made sense of and interpreted by the storyteller participants who in turn shape the narrative (Bury, 2001; Riley & Hawe, 2005).

Considering these narrative analysis components I returned to the data again and began to consider each participant's story in its entirety. This time I focused on the chronological and historical nature of the events and attempted to begin to understand what other factors may have influenced the decisions they made at certain points in their lives. The order in which they told their story was addressed in some detail and I was surprised to find significant differences in the story telling process which led to several further themes being identified. Once I felt that I had exhausted the coding process and

the subsequent development of themes, I decided to explore the connections between the themes to identify any overlapping topics.

By looking at the data in these different ways, I felt I was better able to immerse myself in the data and consider the meanings behind the data; a necessary component. It would have been straightforward to identify a few topics, however, understanding what is not written or spoken aloud yet drives decision making in the migration choices and in the experiences of these nurses, was paramount for this study. Therefore interpreting the data and describing it anew was always at the forefront of my mind when reading and analysing the transcripts. At the end of this analysis process, I found that by considering the data from a chronological perspective as many of the participants had, three distinct overarching themes easily emerged which form the basis for the following three chapters. Under each of these subjects I initially identified six to eight sub-themes but was later able to integrate some of these themes together to confirm three or four distinct sub-themes for each major topic.

Trustworthiness

The question of how a researcher can “persuade his or her audience that the findings of an inquiry are worth paying attention to” (Lincoln & Guba, 1995, p. 290), needs to be considered. There are many terms used in qualitative research to discuss this concept and certainly authors tend to use these terms interchangeably. For the purpose of this study, the term trustworthiness is used. Under this ‘umbrella’ term, three sub topics are briefly discussed to demonstrate this constantly evolving and ongoing process.

Rigour

Rigour is generally explained by multiple authors as validating the thoroughness, quality, and appropriateness of the research methods used (Holloway & Wheeler, 2010; Kitto, Chesters & Grbich, 2008; Liamputtong, 2010). In other words, a researcher should be able to justify the choice of data collection and analysis, verify the data as authentic and show that what comes out of the research can be traced to the collected data (Grbich, 1999; Sandelowski, 2008).

In this study, theoretical and procedural rigour demonstrating the aim and choice of data collection and analysis techniques along with full transparency of the way the research was conducted has been clearly and fully articulated in previous sections of this chapter. By using an audiotape to record the data, any variation in observation was reduced by the use of a constant source of the information (Boyatzis, 1988). Every effort was made to verify data by checking transcripts for errors and comparing them several times with the tape recordings and by sending the transcripts to participants so they could confirm the data. In the analysis and discussion of data, rich thick description and verbatim quotes were used to convey findings, the identification of any contrary and discrepant information was conveyed to the reader and scanning for the adoption of erroneous findings was a constant throughout the study (Creswell, 2009; Holloway & Wheeler, 2010; Liamputtong, 2010; Lincoln & Guba, 1985). In order to ensure findings were consistently corroborated, themes were established from the perspectives of several participants and data was constantly checked with identified codes (Creswell, 2009; Holloway & Wheeler, 2010; Liamputtong, 2010).

The early engagement of reflexivity on behalf of the researcher was also utilized to clarify any bias in the data collection and analysis (Creswell, 2009; Golafshani, 2003; Holloway & Wheeler, 2010; Liamputtong, 2010). This cognitive process is used by researchers to distinguish what the researcher believes, in an attempt to separate out his/her personal beliefs and biases from the data collected from participants (Holloway & Wheeler, 2010; Kitto, Chesters & Grbich, 2008). By identifying myself as a New Zealand migrant and acknowledging my role, I recognized there could be both positive and potential negative consequences related to the research. I also appreciate while it is impossible to completely separate from my own background, history and prior understandings; while I stand in the researcher role it is important to acknowledge this and consciously take steps to mitigate personal bias as much as possible.

I naturally come into this research with my own perspectives on what I feel contributes to migrant decisions related to leaving New Zealand and staying in the US. My own personal decision to migrate was influenced by the desire to travel and coincided with my husband's decision to leave the New Zealand military and do something different. The decision to stay in the US for a protracted period of time is due to a number of factors influenced by my husband's reticence to return to New Zealand to live at this time. Certainly taking an introspective look at my own reasons for migration

was necessary to recognize any potential bias in the results particularly in the analysis stage. Therefore, any themes and codes that emerged during analysis that aligned with my own thoughts were carefully examined to ensure there was adequate support in the raw data to justify inclusion in the results.

Because I was myself a nurse migrant in the same position as the participants in the study, I felt the nurses were able to open up and be honest in their narratives as they felt a type of kinship with me which was reflected in some of their transcripts where they acknowledged I may have shared their experiences. To ensure I did not influence their responses or direct answers, I did not share any of my experiences with the participants till after the interviews were conducted and only then if it came up in conversation. As previously mentioned, some of the participants were curious about my background and my own migration journey. The use of an open ended questioning strategy along with a broad 'aide memoire' certainly contributed to ensuring the participant's thoughts on the subject of migration were foremost in the narrative and not my own.

Credibility/Dependability

Credibility refers to how well the complex findings are presented in a meaningful and plausible way and how well they are articulated (Kitto, Chesters & Grbich, 2008; Thorne, Reimer, Kirkham & O'Flynn-Magee, 2004). In other words is the research genuine and reliable? (Liamputtong, 2010). Golafshani (2003) suggests that this is achieved when the research steps are authenticated by the examination of raw data and the process of data reduction producing information. The research is also considered dependable when the findings can be seen to come out of the data and the research process is logical, traceable and documented (Liamputtong, 2010). As described in the discussion chapter later in this study, many of the findings from this research are supported by information gained from the limited number of previous studies on migration from one developed country to another.

Throughout the research process in this study, there have been clear reasons given for the choices made in the study design. From the selection of a qualitative study design, to the snowball sampling technique to ensure credible research participants, to the choice of interview methods and analysis; these decisions have been clearly articulated in proceeding sections of this chapter. In addition there are coherent links between the data and the findings. The use of many of the participants own words to

support the findings as conveyed in the following analysis chapters of the study show a clear traceable path from data to the source, so that even the participants should be able to recognise their own meanings (Holloway & Wheeler, 2010).

Relevance/Transferability

If the findings of a study can be conveyed to similar situations and participants then it is considered to be transferable, another important aspect of trustworthiness (Golafshani, 2003; Kitto, Chesters & Grbich, 2008; Liamputtong, 2010). Despite limiting the participant inclusion to a certain geographical area yet allowing the only criteria to be New Zealand nurses working in California, the characteristics of the research participants ended up being quite diverse. And although there were similarities in many of their stories there were significant differences also. Certainly by allowing the participants in the study to speak to the subject of migration themselves, there has been every attempt to remain as close to the everyday reality of the participants as possible so that others can estimate the importance and relevance of the study findings for themselves (Beanland, Schneider, LoBiondo-Wood & Haber, 1999).

Relevance considers the utility of a study's findings; that is, how useful the findings are to the topic studied (Kitto, Chesters & Grbich, 2008). The aim of this study was to identify reasons why New Zealand nurses migrate to the United States and what keeps them from returning to NZ. Certainly with the lack of previous information and studies available, the data that emerged from this study provided some new information and supported other findings related to nurse migration. This is debated in some length in the discussion chapter of this study.

Summary

This study asks the question of what makes New Zealand nurses migrate and what keeps them from returning home. Because the study was concerned with the subjective information provided by the participants an interpretive descriptive qualitative research design with narrative components was chosen. Elements describing the theoretical underpinnings of this type of research along with the rationale for choice of design have been discussed in this chapter. Methods used in the study related to participant selection, data collection and ethical considerations are mentioned along

with the steps for data analysis including immersion in the data along with coding and thematic analysis along with elements of narrative analysis. Finally the trustworthiness of the study including rigour, credibility and relevance are considered and reflexivity is discussed in several sections of the chapter.

The following chapters present the data and introduce findings from the study.

CHAPTER 4. LURE OF OPPORTUNITY

“Now bring me that horizon” (Johnny Depp)

Introduction

The purpose of this study was to explore the migration experiences of New Zealand [NZ] nurses who migrated to the United States [US] to work. In particular, the study was focused on the reasons why these nurses chose to migrate and the subsequent circumstances and decisions they made that kept them in the US. From analysis of the data collected from interviews conducted with NZ nurses working in the US, several distinct main areas of focus emerged related to the topic. These themes; lure of opportunity, putting down roots, and where is home now, are discussed in the following three chapters along with the various subthemes identified. A general overview of the characteristics of the nurses participating in the study begins this chapter and is followed by an introduction to the complexity of the migration decision making process.

Introduction to the study participants

Of the six participants in the study five were female and one was male. They were all aged in their forties and fifties. All had received their nursing education and registration in NZ and all but one of them had worked as NZ staff nurses prior to coming to the United States. The time spent nursing in NZ prior to emigrating ranged from 0 to 14 years. Prior to this current emigration period, four of the six nurses had either previously worked in another country or in the US. Three of them had returned at some point to live and work in NZ for a period of time before travelling to the US. The length of time spent living and working overseas ranged from six to thirty years. All of the nurses interviewed are currently working in a hospital setting; the majority of them in critical or specialised care areas. Three of the nurses interviewed were single. Only two of the nurses had children.

The complexity of the migration decision

People travel abroad to live for a diverse number of reasons and for varied periods of time. As Conradson and Latham (2005) comment, time spent overseas is becoming common place and almost considered to be a normal part of an individual's life. It is not unreasonable to expect an individual or family to travel abroad and as such to even work while doing so but "such mobility emerges from a complex set of personal motivators" (Conradson & Latham, 2005, p. 288).

This chapter examines the motivating factors precipitating the departure of the nurses in the study from NZ. It also examines what influenced their decision to migrate specifically to the US. Subthemes in the chapter are related to the big overseas experience, the travel bug and opportunistic recruitment. Migration decisions are rarely simple and thus while specific subthemes are identified and discussed independently in this chapter, it is important to realize that these themes intersect and are interconnected on many levels. For all of the participants interviewed there were several often complex and multifaceted factors that contributed to each of their decisions to leave NZ to travel to the US and work.

'The big O.E.'

The opportunity to travel abroad and to work while doing so was one of the strongest motivating factors influencing the nurses' migration decision. For many New Zealanders, travelling overseas for several years is almost a rite of passage and this overseas experience commonly called the 'big O.E.' is a large part of a young New Zealanders life (Wilson, 2006; Wilson, Fisher & Moore, 2009b). While there were several factors that influenced the decision to migrate abroad, for all of the NZ nurses in this study, travelling overseas to see a different part of the world was certainly a primary reason for them to leave the country. This emphasis on a 'working holiday' is articulated well by Gina in the following quote.

Well, I wanted to travel; you know every New Zealander wants to travel, right, don't we?... you know you like go to school, you get your degree and then you travelI guess it was just instilled- New Zealanders have the travel bug. It's just – it is your part of passage. (Gina)

Traditionally the majority of New Zealanders travel to the United Kingdom and to Australia to work and travel (Health workforce information programme team, 2009). This choice of destination is influenced by several factors. Historically the UK has been one of the most popular working destinations for New Zealanders and thus there are many like minded New Zealanders on their O.E's over there (Wilson, Fisher & Moore, 2009b). Its close proximity to Europe as a holiday destination also holds an allure for the overseas bound traveller. Australia is close to New Zealand both geographically and in some cultural aspects. Both countries offer an easier immigration entrance process to work with minimal bureaucratic procedures to navigate. The nurses in this study however chose to travel and work specifically in the United States.

Several factors influenced the nurses' choice of destination. For three of the nurses, previous vacations to the US had solidified the idea of going back on a working holiday whenever the opportunity arose. For Kate the experience of a six month vacation travelling and camping across the US encouraged her to apply for work there so she could return to see and experience more of the country.

(travel) to see the States properly; well I'd seen most of the States; it was to go back to places I liked (Kate)

For Sarah the memory of a trip to Hawaii coupled with an advertisement in a newspaper for nurses encouraged her to return to the States.

we jokingly said oh this would be a nice place to live, it'll never happen and then a year and I came home from work after doing an evening shift and there sitting on the table was an ad that my husband had cut out of the paper that there was a hospital in Hawaii in Honolulu that was looking for nurses (Sarah)

Beth, while visiting a friend was offered a job. While she didn't immediately take the job, the offer made her think about the potential of going back to work in the States at a later time.

I'd come for a two and a half month trip to States; saw a nursing friend ...and met her supervisor who said to me you're a nurse do you want a job? I said no but I thought, this is interesting (Beth)

Megan, Jason and Gina also wanted to come specifically to the US to travel. Jason explained his decision to come to the US based on wanting different experiences as he had never been out of NZ while Megan had family in the US which encouraged her to choose it as her destination. For Gina, going to the US was something she had always wanted to do from childhood.

It was always about the travel but I think my focus was USA; I would end up here and I don't know why. Maybe cause I saw it on the TV and it was you know brought up and it looked really fun and it was big and they had all these fancy cars which are nothing now you know the thing is when you look at it America has everything; you look at all the landscape. It's right there (Gina).

The idea of travelling and exploring new locations was a theme echoed throughout all the nurses' interviews. For them, leaving New Zealand was about experiencing something different and being able to go out in the world with a job that would enable them to see different places and have diverse experiences they couldn't have at home. They felt, their training as a nurse gave them an occupation that would ensure they would be able to find skilled work to support themselves. Megan articulates this well in the following statement.

Nursing it really gave me my lifestyle like it came from New Zealand cause that's where I trained so it really did give me my lifestyle and it's afforded me some amazing luxuries....nursing's given me a lot of opportunities and I still feel it's from New Zealand (Megan)

The final push to travel abroad

While the desire to travel was present amongst all the study participants, the motivation and timing for leaving on their O.E's varied. Several factors have been

identified as contributing to an individual or family's decision to leave NZ on a working holiday. These include relationships with friends and/or family members, work attitudes and job placements, and a need for a change and stimulation (Inkson & Myers, 2003).

Family considerations contributed to several of the nurses' decisions to begin their big O.E. For Beth, the motivating factor that persuaded her it was time to travel overseas was connected to family and relationship events in her life.

it just ticked around there and there was some other things happening not just with family but with my relationship and I thought I need some distance here so I took it
(Beth)

For Jason, while the original impetus to look at travelling to the States was related to seeking additional medical care for a family member, when the care was no longer needed, he at that point in his and his family's life thought, why not?

we decided since we'd gone down the process of talking to the people from the recruitment company we would see if we could go to the States anyway just for the experience cause I'd never been out of the country (Jason)

For others the migration decision was influenced by their job and career. For Gina it was all about the need for a change, to experience something different at that point in her life.

I got to this phase where I was like ... I think it's time, I'm bored (Gina)

For Megan, it was the frustration in not being able to get a job in New Zealand that led her overseas not just initially but several times in her life.

I got sick of the rejection letters like I got rejected from every hospital from Auckland down to Christchurch and I graduated top of my class they wouldn't recognize my overseas experience as any experienc (Megan)

The search for further educational opportunities to advance her career while being able to travel provided the motivation for Kate to leave New Zealand initially.

I felt like I had already done as much as I could go in New Zealand so I wanted to do a proper Intensive Care course and get a qualification... you're only young and you wanted to travel but I wanted to learn something at the same time (Kate)

For all of the nurses, while the impetus to leave New Zealand may have varied, the underlying drive to travel abroad and work was firmly rooted in the desire to explore the world and discover new experiences.

The 'travel bug'

For the majority of O.E participants, the time spent away from NZ is initially not supposed to be permanent or even long term. It is instead considered to involve extended residence overseas (Wilson, Fisher & Moore, 2009b). Most young New Zealanders travelling and working expect to be away from home for a time ranging from several months to several years (Inkson, Arthur, Pringle & Barry, 1997; Wilson, Fisher & Moore, 2009a). This is true for many of the nurses in the study. When they first left NZ for their O.E. their initial plans included being away from New Zealand for only a short period of time.

We were going for a year cause that was all they required was a year (Sarah)

I was pretty excited about coming here and so you know and after that my goal was to stay a year here and then go home (Megan)

For all of the nurses in the study, the time spent away from home ultimately ended up being significantly longer than several years. For those who did return after a year or two, they eventually travelled abroad again to work and have since spent a much longer period of time away from NZ. The positive memories of their previous travel abroad seemed to contribute to these nurses making the decision to migrate for a second time.

For Megan the ease of work availability in the States with positive previous work experiences along with the opportunity to travel while working was a strong motivator to return to the States several times.

came straight back, back to travelling again....I just said I want to come back, they said fine and did you want to work in Florida again and I said sure, they'd love to have you back and off I went I was a very valuable employee so I got my job back
(Megan)

Jason and his family returned to NZ because of disillusionment and frustrations with some aspects of US healthcare and also because of the poor health of a close family member in NZ. He spent several years working back in NZ but memories of a better lifestyle lured him back to the US.

we loved the opportunities; the things to do; we had a young family....so there were things to do with the family....we had more opportunities; we could go for weekend trips away (Jason)

Comparing life abroad with life back in New Zealand supported the decision to return overseas. While the positive experiences during previous working travel holidays abroad contributed to the decision to repeat the experience, for the nurses that did return to NZ after a year or more, it seemed that difficulties adjusting to life in New Zealand and feelings of restlessness were even stronger incentives to return overseas.

I had always been busy while I was away and it just seemed quiet and cause I was younger then you know you're in your late 20'sThe first year, 18 months I didn't really settle down, I was a bit restless, found it hard to adjust so I came up with this bright idea I'd come over to the States (Kate)

I was so used to the semi city lifestyle like I would try to go to the store on a Sunday and they were closed and you know and I'm so used to everything available to me 24 hours a day here (Megan)

For Megan the continual frustration of trying to find work in NZ while her overseas experience was not considered, was a driving force sending her back abroad.

I kind of feel like they sent me away ; it wasn't my fault I couldn't get a job so you know I don't really believed I should be punished for you know having my overseas experience because that's all I could get (Megan)

While financial considerations did not play a large part in the initial decision making process for leaving New Zealand, for some of those nurses that returned to New Zealand after their time abroad, the decision to return overseas to work was influenced by economic concerns.

When we left NZ and we were going back to NZ it was going to be the best thing to go back; going back home would be the best thing and it turned out for us not to be.... it came down to if we wanted to do anything like the lifestyle we'd had in the States we couldn't replicate. We didn't have the ability to just go for a weekend trip away because we couldn't afford it. Our income had halved with both of us working fulltime; we were able to tread water but we weren't able to get anywhere (Jason)

These findings are consistent with results from other studies conducted on NZ migrants. In their study on NZ return migrants from Europe, Chaban, Williams, Holland, Boyce, and Warner (2011) found many returnees had difficulties adjusting to life back in NZ. They cited NZ's isolation contributed to a lack of future travel opportunities, smaller communities than what they were used to in Europe seemed to lead to a much tamer lifestyle with a lack of adventure and the cost of living was much higher than was expected. Lidgard and Gilson (2002) researched all NZ citizens returning home during the month of November 2000 who had been abroad for a period of time greater than one year. They found that one quarter of those who replied to their survey had plans to return overseas for an extended period of time and one third were considering it.

Opportunistic recruitment

In a study looking at the international recruitment of nurses to the US, it was found that many nurses travelling to the US to work were recruited by either hospital based recruiters, commercial recruiters or staffing agencies (Pittman, Folsom, Bass & Leonhardy, 2007). While it is difficult to ascertain just how many of these recruiters were assisting the migration of nurses from New Zealand it is known that for example in the years 2001- 2005 there were in fact 11 US based active recruiter companies in New Zealand (Pittman et al, 2007). It is unknown how many other companies, agencies and hospitals were also recruiting.

Certainly opportunities for working overseas were easy to find for all of the nurses in the study. The availability of these opportunities coupled with the ease of recruitment and financial incentives offered, contributed in part to their decision to leave New Zealand to work abroad. Prominent advertisements in newspapers and nursing journals that presented the prospect of nursing overseas with the aid of various agencies and recruiting companies, were very prevalent around the time that the majority of the nurses' were thinking about travelling.

found an ad in the newspaper for nurses to go to the States, have a holiday, go to Disneyland and sit the exam. If you don't pass you get a free holiday (Megan)

someone approached me, I thought they approached a lot of NZ nurses ...he was recruiting....I went to sit the CGFNS exam in Wellington and the recruiters were outside the door like a bunch of vultures (Beth)

we went to the information evening...they interviewed us and then they offered to send me over here to the States to sit my NCLEX and to sat my boards and all that. It was a 10 day trip they paid for (Sarah)

For all of the nurses in the study, the ready availability of agencies and recruiters willing and able to assist them with their travel and career plans, significantly contributed to their US migration decision.

Most recruiting agencies will offset the costs of required testing, visas and credentialing as well as paying for flights, while some also offer bonus sign-ons and housing and relocation costs (Pittman, Folsom, Bass & Leonhardy, 2007). This was true for many of the nurses in the study.

With some of the costs involved in travelling to the States and in obtaining the necessary credentials for working there, paid or subsidized in part by recruitment agencies and US hospitals, for some of the nurses this economic incentive was a factor in the travel decision. In addition, in order to be able to work in the US, the nurses had to sit one or two exams, some of them in the US, before being approved by the US government for working visas. This was usually a 6 to 18 month process and for some of the nurses, the costs involved in doing so were allayed by the various recruiting parties.

As part of the recruitment process, there were other financial inducements that encouraged some of the nurses to travel abroad. Assistance with housing and travel were often part of the employment package.

*they paid for us to go out; they paid for our tickets to go home twice a year
subsidized accommodation (Megan)*

that was at the company's cost; they sent me to Hawaii to sit the exam (Jason)

While Jason and his family returned to New Zealand after several years in the US, his second trip abroad was also subsidized by the recruiting hospital.

*I had a job offer at more than double my current pay rate and all the money I
needed to relocate our entire family so they were obviously keen and it seemed like
everything was falling in place for us (Jason)*

Despite the lengthy time period it took to gain nurse registration and work visas for the US, this was not generally considered by most of the nurses to be of significance. Most of the nurses seemed to consider it to be just part of the process. This may have been in part because for many of them the recruiting agencies actually expedited and took care of a lot of the paperwork involved in obtaining the necessary documentation for not only the nurses but family members as well.

they got us visas, work visas they were H1 work visas for me and then my husband he was on a H2 non working visa...all paid for by the hospital (Sarah)

Summary

For all of the nurses in the study, the decision to leave NZ to work as a nurse in the US was made based on a variety of individual considerations and circumstances at the time. For all of them, however, the desire to travel abroad while financing their travel experiences by working was a major reason for leaving NZ. The drive to experience the NZ 'big O.E.' seemed to be of major significance in the decision making process. The choice of when to go overseas seemed to be precipitated by either family considerations or career choices. Previous positive travel and overseas work experiences were also important factors in choosing whether to work abroad. In addition adjustment difficulties and feelings of restlessness upon returning to New Zealand to live also contributed to some of the nurses preferring to return overseas to work again. Opportunistic recruitment seemed to be a factor in the migration decision process. The ready availability of recruiters and agencies coupled with the financial assistance they offered served to assist the nurses in their US migration decision.

With the decision to migrate made and with travel visas and professional documentation in order, the nurses left NZ. The next chapter discusses the experiences they had upon arrival in the US.

CHAPTER 5. PUTTING DOWN ROOTS

It's not the destination that matters; it's the change of scene (Brian Eno)

Introduction

Adjusting to life in the United States [US], both working and socially, was a meaningful part of the migration experience by all of the nurses in the study. A significant portion of the interviews with the nurses was concerned with this period of time. For many of them this transition period from new arrival to established US resident seemed to influence any later decisions related to returning to New Zealand [NZ] or continuing to work abroad. For this reason the experiences the nurses had while settling in a new country was considered to be an important topic to explore.

Deciding how to move, adapt and adjust within a different society from one's own is a decision migrants make upon arriving in a new country (Tabor & Milfont 2011). During this process Tabor and Milfont (2011) call acculturation, migrants move between maintaining their own culture and identity while involving themselves in the new culture and environment. How and to what degree they become accustomed to their new situation is part of the acclimatization process in this transition period.

A variety of factors contributed to the nurses' becoming habituated and settled into their work and social life upon arrival in the US. Subthemes related to this 'settling in time' that will be explored in this chapter are home is all around, fitting in, and venturing out.

Home is all around

For many of the nurses, one of the key features that helped them to feel more comfortable in a different country was the close proximity of other foreign nurses. These other nurses who were mostly from NZ, Australia and the United Kingdom shared a similar background, both nursing and culturally, and seemed to make the transition and adjustment to life in the US easier for the study participants. Having other nurses around them who they could share work and social experiences with and who would

understand what they were going through was an important component of adjusting to their life abroad.

Kate, Megan and Sarah had large numbers of foreign nurses around them both in their work environment and in their home and social lives.

wherever you were there was like a hundred of us travelling nurses.... the first year there was probably a couple of hundred of us so we were very friendly and we were travelling in packs ...it was good because you didn't really have to make friends because they would be your friend when you first got there so it was nice, a nice environment so it was fun....we had our own little compound...we were like just a big group and everyone was very young....we were pretty solidly tied, I'm still very good friends with a whole lot of them (Megan)

Although not in social isolation from American society, by living in apartment buildings surrounded by other foreigners, the nurses appeared to gain comfort and a sense of security. This seemed to allow a gradual indoctrination into US society with a support network where they were able to come home after work to be around others of very similar cultural and social circumstances. For those nurses who had partners travelling with them from NZ, the opportunity for these partners to be able to socialise with others in similar circumstances also seemed to help the family unit as a whole adjust to the different environment.

we were always working with at least one other New Zealander so in that respect was really good; it made it easy; you could bounce things off each other.... we all lived in the same building, we socialized together; there were about 25 husbands so they all hung out together cause they couldn't work...it was a really good thing (Sarah)

Gina and Beth also travelled to US areas where there were other NZ nurses working in the same hospital and in the surrounding areas although in fewer numbers. Still, the connection with other NZ nurses contributed to the settling in process with a sense of familiarity and encouragement. Upon arrival in the US, Gina lived with another NZ nurse in several locations before buying her own place. For Beth, the close proximity

of other nurses from NZ not only made her feel supported upon arrival but knowing they were here and working prior to her departure, also contributed to her decision to travel to her specific destination.

I listened very carefully to what she (NZ nurse speaking at recruitment meeting) said and what she didn't say and I thought hmm plenty of Kiwi and Aussie nurses over in this general area. It can't be all bad so that was what decided me (Beth)

Jason travelled initially to an area where there were few other nurses from a similar background. But for Jason, having his wife, also a NZ nurse, travelling and working with him, seemed to provide a strong sense of familiarity and support.

This preference to be around other people from similar backgrounds is not unique to either the nursing profession or the US. In a study looking at the experiences of NZ return migrants who had been living and working in Europe, Chaban, Williams, Holland, Boyce and Warner (2011) found that upon arrival abroad, NZ migrants tended to be drawn towards local networks of fellow NZ migrants. In addition to emotional support, these informal systems seemed to provide practical assistance with accommodation, job opportunities and general advice for navigating a new city or country (Conradson & Latham, 2005).

Fitting in

Despite some differences and small hurdles to overcome, for the most part the nurses seemed to acclimatize to the US hospital working system relatively easily although several of them had difficulties with some of the policies and practices they observed. Several features related to the US work environment were identified and are discussed in the following section. These features include day to day work life in the clinical environment and financial and immigration assistance.

Day to day work life

Transitioning from working in the NZ health system to the US system of healthcare had its challenges for the nurses. While the nurses didn't seem to struggle with the actual provision of nursing care to their patients, there were some obstacles

they had to overcome. Communication was identified as one of the primary barriers. Some of the language used in everyday colloquial conversation was quite different and the difference in accents of speech was often commented on by staff and patients.

when you come to America they speak a different English.... I didn't know what they were talking about because the words they were using were not words I was familiar with (Megan)

In addition procedures, tools and drugs often had different names and initially these had to be learned quickly while on the job, along with different policies and protocols for care provision.

you just had to figure out, you had to know the protocols and things and figure out what you could and couldn't do and try and do that before you get into trouble for not doing something properly (Beth)

Having to adjust to the different roles and responsibilities that numerous ancillary staff members have in the US was also part of a learning curve for the nurses newly arrived to the US. Many of the tasks they performed for their patients in NZ were not considered part of the nursing job in the US and instead were performed by various therapists and technicians in expert positions. Learning to navigate around these specialized roles to incorporate their responsibilities with the care of a patient was another skill to be learned by the nurses in the early transition period.

You had to learn the different roles cause in America there's techs for everything like respiratory, ortho techs; everywhere you work there's a different department and they really are very protective of their department roles (Megan)

In the States the nurse is nurse, the respiratory therapist is the respiratory therapist, the dietician is the dietician and each of those roles is very clearly defined and demarcated (Jason)

Adjusting to this system with clearly segregated roles and responsibilities was obviously frustrating for several of the nurses. Having been trained in NZ to provide almost total care for their patients, it was difficult for them to almost step back and allow someone else to do a certain aspect of care they had always done themselves.

I mean there's all sorts of stupid things that don't make sense when you've done it all for you. You've done all the care for your patient then to have someone else say 'no, that's my job, you can't do that anymore' (Jason)

For several nurses, there were other aspects of US critical care nursing that they were not happy with. For some it seemed that their autonomy as a nurse taking care of a patient was much less in the US and they weren't able to utilize their nursing judgement. Disillusionment with the overall standard of the care in Jason's highly specialized field of nursing at the time was certainly one of the factors that took him back to NZ at one point.

it was almost assumed that you would see what was up and coming healthcare where ... it was the opposite.... you weren't really given much credit for any nursing judgment or that's the way it seemed (Jason)

For Kate specific aspects of nursing care in the critical care field bothers her still yet she also acknowledges she has learned a lot and gained a lot of experience in the various hospitals she has worked.

For all of the nurses though, there were few additional nursing skills that had to be acquired before they felt comfortable on the job. Many of them looking back felt that the nursing training and work experience they had in NZ served them well in this transitional time in the US. Generally most of them felt the work of an RN was comparable between countries and this made the change in working environments easier.

I knew that I could work anywhere... Changing over from their system to our system in nursing wasn't too much different....the communication probably was the biggest thing but everything else was pretty much the same(Gina)

I think the nursing is slightly different all over the world but the basic principles are the same. You know the job descriptions are slightly different but still you know the fundamentals are the same (Megan)

Financial and immigration assistance

The US immigration process is not an easy one. While entering the country on a working visa enabled the nurses to begin working there, continuing to work abroad for a longer period of time often required additional visas and interactions with immigration officials. For some of the nurses, these often complicated processes were augmented by assistance offered by the agencies and hospitals they worked for.

I think they helped us. We had to pay for it but they helped us with the paperwork and knowing what to do and when to do it and all that stuff (Sarah)

But the hospital helped you a lot with that? (Interviewer)

They did, yeah they did, I still appreciate it because I know what's involved. They even had to get a couple of congressmen to get involved because they couldn't find the application for my visa (Gina)

As mentioned in the previous chapter, financial incentives offered by recruitment and travel agencies as well as several of the hospitals contributed in some small part in a number of the nurses' decisions to come to the US. Assorted incentives offered by agencies and hospitals continued to be presented to the nurses during the initial years of their journey abroad. These enticements ranged from help gaining more permanent working visas such as 'green cards' to subsidised accommodation and travel.

we arrived; they had bought an apartment building; we each got our own individual furnished apartments within walking distance to the hospital. There was a shuttle for when it was dark at night that would run us back to and fro from at the end of our shift and it was great, it was like they did everything possible that they could to make it good for us (Sarah)

they paid for our tickets to go home twice a year... in the end (of the first year) you got a 5000 dollar bonus (Megan)

Initially at least, the nurses seemed to feel supported by the agencies and/or hospitals that hired them and were appreciative of the assistance they provided in this transitional time period. But for several of them, once settled in as time went by and feeling more comfortable in their new positions, there seemed to be a growing awareness of distinct differences between themselves as a migrant employee and US nurses. These differences were mostly financial. Surprisingly, looking back the nurses did not feel exploited or upset. They merely noted the disparities and seemed to chalk it all up to experience.

that was considerably less than what other nurses you were working with were making (Researcher)

Yeah but I didn't actually know it. I never actually asked what they were making; I didn't really care at the time and so.... I had enough money...I never really felt like I was hard done by (Megan)

This inequality and exploitation of foreign nurses is supported in current literature, notably Bach (2003) and Kingma (2008) who write about the financial discrimination of foreign workers compared to those of the home country.

Venturing out

The ability to travel around much of the country during the first few years abroad seemed to contribute to the positive feelings the nurses had about their move to the US. While all the nurses seemed to comment on the fact that they worked hard when they first arrived in the country, there appeared to be ample time for exploring their local areas and for travelling further afield. Initially several of them were employed by nurse travel companies and thus had flexibility in choosing assignments around the country which allowed them even more free time to travel between jobs.

I was young. I was having fun in another country. I was travelling all over the place (Megan)

We used to spend all of our time on our days off going out of the States or driving; you know how we do at home, you go for a drive see the countryside (Kate)

This flexibility in their work assignments also extended to allowing the nurses time to travel back to New Zealand to visit family and friends

I decided there was travelling nursing, lots of options and I kind of just stayed....travel nursing actually was the best option for me other than a job here because it allowed me to go home for three months a year at Christmas time (Kate)

This ability to travel extensively whilst still working fulltime was a prime motivator in the nurses' decisions to continue to stay on in the US past the initial point in time they had originally planned on returning to NZ. Financially and career wise, the opportunities to venture further afield seemed to be easily available and taken advantage of.

Summary

The transitional period in the nurses' lives when they became accustomed to the US way of working and living was of significance to the nurses in this study. With mostly positive experiences during this time, the nurses were able to adapt and adjust to their new environment with limited difficulties. This ability to settle into the US lifestyle so well seemed to influence their decision to remain in the US for an extended period of time. The close proximity of other expatriate nurses from similar backgrounds and culture that supported them in the early time period after arrival had a significant positive influence. In addition despite some initial minor adjustment difficulties at work related to communication, role identification and policy and procedure differences, the nurses seemed to ease into their new nursing jobs well. Even with some financial disparities the nurses did not appear to feel exploited. Financial and immigration

assistance provided by employers along with increased travel opportunities related to work contributed to the positive transitional experience.

Once they had progressed through this intermediary period between new arrival and established US resident, the majority of the nurses felt secure in their working and social lives and were not ready to go back home. The following chapter examines the reasons why the nurses remain in the US now after an extended period of time.

CHAPTER 6. WHERE IS HOME NOW?

"You can't go home again" (Thomas Wolfe)

Introduction

The decision whether to stay abroad or to return to New Zealand [NZ] to live is one faced by many migrants at various times in their lives. The move from the United States [US] back to NZ was a choice many of the nurses in the study considered at one point in time or another. Half of them had in the past worked abroad and then returned to NZ to live and were now 'second time migrants'. All of them are now firmly ensconced in the US and all but one have no plans to return to NZ in the immediate future.

This chapter explores the reasons why the nurses have chosen to remain in the US for a prolonged period of time and attempts to ask what it might take for them to return to NZ to work. The four subthemes discussed in this chapter are living the California dream, the work ladder, it's a small world' and 'it's been a long time'.

Living the California dream

Living in California seems to suit all of the nurses in the study. While two of the nurses have never worked anywhere else abroad, the other nurses have worked in other countries and/or other states in the US. They all have been living in California for several years now and appear to be enjoying their time there. The Californian lifestyle appears to be a major reason for the nurses staying put and not returning to NZ. They seemed to find an ease in the lifestyle with ready accessibility to many resources both material and geographical.

For most of the nurses, it is the cost of living in the US coupled with better wages that has contributed to the significant length of time they have spent in California. They seem to feel they have the ability to live 'easier' in the US and are able to do more than they would if they returned to NZ. Certainly it seems having the financial means affords them the opportunities to do more of the things they like to do in their leisure time including travel.

We have two good paying jobs....the lifestyle that comes with the working hard and the pay that we get enables us to do that....when you are used to making what you make, the thought of going back and making so much less without really that big a drop in cost of living now just makes it impossible you know. (Sarah)

we loved the opportunities, the things to do....there were things to do with the family. We could go places we could never have the opportunity to go to because for one thing we couldn't afford it...with two of us earning more money that we were earning in New Zealand we had more finance so we had more opportunities, we could go for weekend trips away without having to worry about the cost of it (Jason)

While there was some recognition of the high cost of some aspects of life in California, for the majority of the nurses there seemed to be a feeling that overall, on balance, financially they were far better off staying in California than returning to NZ

For several of the nurses, an element of the California lifestyle that seemed to rank highly was the weather. For these nurses, the sunny climate and warm temperatures contributed to their perceptions of a better lifestyle in California.

We love the weather and I hate the rain and I can't go back ... because it rains too much (Sarah)

There's nowhere else I'd rather live in the States. I've seen all of it. I don't like the cold; I could never live in the northern states. I don't like hurricanes, I don't like tornadoes. I'm quite happy with earthquakes; they don't bother me in the slightest (Kate)

For the majority of the nurses, though, it was something intrinsic in the life they are living in California that was difficult to narrow down and put into words. Financial and climate reasons aside, they just liked where they lived. As Kate commented,

It's got a vibe, California....I like being able to do a variety of things and I was always off doing something; there's a lot here (Kate)

The nurses seemed to be for the most part happy with where they were in their lives and what they were doing. Certainly, all of the nurses have at least at some or many points in their time away considered whether they would move back to NZ. Comparisons to the lifestyle they had back in New Zealand or to what they perceive they would have if they moved back to NZ, inherently came out in favour on the side of California. With no specific reason for this viewpoint, even when asked, the nurses would just sum it up as, 'I like it here'.

I've essentially got my life pretty much the way I want it.... It's about balance in your life and I feel I could get a better balance in my life over here surprisingly enough than what I could in NZ....I was meant to be here, that's all I know for sure (Beth)

You've never wanted to go back to live? (Interviewer)

No, and I never will ...maybe it's the lifestyle, maybe it's cause I have everything here. I don't even want to be a nurse back there....there's a whole world out here in America so I don't know, I like it here (Gina)

The best of both worlds

For several of the nurses, there are thoughts of 'having the best of both worlds'. Reluctant to give up the good lifestyle they enjoy in California yet still attached to NZ, they expressed a compromise to returning fulltime to NZ where if it was possible they would entertain the idea of living in both countries each year. In essence, they talked about a type of circular migration where they could travel between the two countries living a portion of each year in both.

I mean the US, the nursing is getting so short that I reckon I could live in NZ for six months of the year and work here six months of the year and earn enough money to live on (Megan)

Ideally I guess we would like to spend part of our time in both places....It's kind of nice in some ways to have the best of both worlds and to be able to pick and choose which part you want to take advantage of, so to speak (Sarah)

This sentiment of preferring circular migration over permanent migration is echoed in the limited research on return migration and supported by statements from the International Center for Migration (Kingma, 2006).

Of significance, when talking of the potential of living in two countries and travelling between them, it is worth noting the nurses spoke primarily of working in the US with their time in NZ spent more on leisure with family and friends. They didn't appear to be entertaining thoughts of working in both countries. Instead, the focus was more on being able to have the opportunity to work whenever and wherever they wanted in the US in order to support themselves while travelling again, albeit to back home.

The work ladder

The nurses in the study have been working in California now for several years. Many of them are in positions of seniority in their chosen fields, some of them in quite specialized positions. With a stable career and with further opportunities for further education, advancement or reciprocity with work changes, for the most part the nurses seemed to feel that their nursing careers at this point in their lives were best served in the US. They felt a wider more varied array of nursing positions were available along with some flexibility and choice of working hours and conditions.

I've had more opportunities in my professional life working here ...opportunities that would never have come up in the hospital I was working at in New Zealand. In fact I know people who have, who are still working in exactly the same position that they were in when I left there... it's been very good for me from my career perspective (Jason)

Once I got over here I enjoyed the responsibility, I enjoyed what I learnt, the level of autonomy in certain things I had...you can in this country you can do anything you

want, you can be anything you want if you're prepared to work hard enough, the classes are there, everything's here.... I've done a heap of things and it's cool. I would have never had the time or the opportunity to have done it at home (Beth)

As some of them had spent considerable time abroad working, there appeared also to be a reluctance to return to NZ to nurse based on the length of time spent away from the NZ health system. They seemed to anticipate difficulties adjusting back to nursing in NZ with many of them articulating they really had no idea what nursing in NZ was like anymore. In addition, as they 'rose through the ranks' in the US they felt should they return to NZ, finding a comparable position there would not be easy if at all possible.

It would be incredibly hard to change from to New Zealand now and just where I am in seniority in job status. It's like I couldn't move laterally back there to that position I have now so once you get that high it becomes not really an option anymore (Megan)

"It's a small world"

A strong attachment to one's birthplace is part of the universal nature of just being human (Lidgard, 2001). Certainly, staying close to family and maintaining ties to NZ appeared to be important for all of the nurses in the study. While firmly ensconced within US society, the importance of the connection to their roots in NZ was very evident in all of the interviews. For most of the nurses, though they choose to live in the US, NZ is still considered 'home'. While this strong connection may have been seen as a strong 'pull' factor to bring the nurses back to NZ, the ready availability of modern technology and communication devices along with relatively inexpensive and numerous flights home to NZ, ensures the nurses feel never far from loved ones and only a phone call or plane ride away. Thus, the nurses on a day to day basis don't feel too removed from their families and their lives in NZ. This has enabled them to continue living abroad while maintaining frequent contact back home.

The ability to use technology to stay in frequent contact with family was an important component in allowing the nurses in the study to remain in the US while

feeling involved in their NZ families lives. The nurses seemed to feel closely connected with loved ones left behind because of the capability to have this almost constant connection with them through computer and phone. Because of this, there seemed to be few thoughts of isolation from family and friends left behind.

We have family in New Zealand and we talk to them regularly. We use skype a lot
(Jason)

I felt like I was missing out on their (family in NZ) life a little bit but now Skype, you know they call like every other day to see what I'm doing or show me something or chat about something and so I feel like I'm a very big part of their life and they don't actually want to talk on the phone now, they want to talk on skype. They want to see me....I really don't feel like I'm missing out on anything anymore. Technology's changed the world (Megan)

Cheaper and more frequent flights to countries around the globe contribute to a much more mobile international population. Thus migration is no longer a one way journey but rather a series of two way journeys between countries (Larsen, Axhausen & Urry, 2006). For many of the nurses in the study the ability to be able to travel home to New Zealand frequently to visit family and friends contributed to their decision to remain in the States for an extended period of time. They were able to maintain these close ties to their homeland yet still continue to work and live in the US.

I don't think we would feel as connected to New Zealand as we still do if we didn't go back so often. I think that connection is there because we are constantly there visiting our families and I think it will change too as our families change ... (Sarah)

I go home twice a year; three months a year....home and family's important to me
(Kate)

I used to go back every year but now my nieces and nephews are older and they actually like to come here so I go every two years....It's nice for them and it's easier for me too, it's neat that they want to come see me here (Megan)

For several of the nurses it was the close proximity of California to NZ that encouraged them to stay in this state rather than perhaps going further east to live and work in other states in the US.

I came back out to California; decided it's easier to be on the west coast close to home (Kate)

We decided we would try and find work on the west coast rather than the east coast because it's a little easier to get back to New Zealand from somewhere in California than it is from Florida (Jason)

'It might pull us home'

The nurses in the study were reluctant to think of any reason for returning home to live at this point in their lives. However, despite the ability to have close contact with family while abroad, many of the nurses did discuss moving back to New Zealand if family circumstances determined it would be necessary. As the nurses are aging, so too are their parents and although currently happily living in the States these nurses stated if their parents needed them in their old age or sickness, then they would probably move back to NZ to assist in their care.

if there was serious illness requiring my consistent presence at home I would certainly consider it (moving back to NZ) then (Beth)

my parents are 70 now so something, if something happened to them I'd feel obliged to go home (Megan)

For Sarah and Kate, having already experienced being far away from home when a close family member became ill, the distance between countries was more strongly felt. The inability to get home in a timely manner to be with family during difficult times is something that resonated with many of the nurses.

that to me is one of the biggest problems with the distance, I'm over here and they're over here and I couldn't be that on the spot advocate (Sarah)

Kate was the only nurse in the study with definite plans to return to NZ in the very near future and as she gets closer to retirement age, feels she would like to return home to spend time with elderly parents.

I'd always known I'd move home to retiremy mum's 85 this year and I want to spend some time with her yeah it's time....it got to the stage as I got older like that since my parents got sick that I dreaded coming back (to the US) and that's when I started to think, it's time, my mind's telling me it's time to move home and family's important to me. And I thought, I just don't want to be over here if something happens to my mum. (Kate)

For her, the draw of family back home was the definitive push towards getting her to move back to NZ. In the limited studies on the return migration of nurses, this need to return because of family dynamics and change is one of the primary reasons that nurses and other migrants go back home (Gmelch, 1980; Haour-Knipe & Davies, 2008; Lidgard & Gilson, 2002).

'It's been a long time'

Most of the nurses in this study had spent more time working in the US than they had in NZ. They had at one or more periods within this time considered a permanent move back home. Some did move, only to return back overseas. It was difficult for them to ascertain just how much longer they will remain in the States. For some of them the move to the US may be permanent; for others they may return home at some future point in time. Certainly, the longer the nurses have stayed away from NZ the harder it seems for them to make a permanent move back home. A review of studies related to return migration conducted by the International Center for Nurse Migration (2008) supports this finding.

Although still strongly tied to New Zealand, because of the length of time spent away the nurses seemed to feel almost a product of both the US and NZ.

New Zealand seems like a holiday place, it doesn't, it's not my home anymore. It's somewhere I go for a holiday....I don't miss the same things that I used to after all these years (Megan).

We're all of us living over here a long time; we're hybrids now (Beth)

Considering a move back to NZ after so long abroad brings mixed feelings for the nurses. The old adage 'home is where the heart is' certainly rings true, but for many of the nurses their heart lies in both places. They all anticipate some difficulty assimilating back into the NZ lifestyle after so long away should they return.

We have this ideal view of what living in NZ would be like but it would be very mundane, like it is living here only here's so good....people have gotten on with their lives and there's so much of their lives we've missed too. You know that you would think that you would be able to slip back in there but there's so much you've missed of their life in 20 years....live goes on and no matter where you are I guess (Sarah)

Summary

Settled in the US for some years now, the nurses in the study profess to be essentially content with their life at this point in time working in California. Though one of them prepares to leave to return home to NZ, the others expressed no desire at this point to return permanently. The Californian lifestyle which offers economic advantages, better weather and opportunities to experience more in their leisure time keeps them firmly on US shores. Opportunities at work have enabled them to be in positions they are comfortable in with some seniority along with the prospects of advancing their careers as they choose. In addition the ability to remain in close contact with loved ones back in NZ through technology and frequent trips home ensures that the nurses still feel a part of families and friends lives. For most of them the pull to return home at this time is not strong. Changes in family circumstances particularly as parents age and may need assistance seems to be a potential factor that may bring the nurses back to NZ. The continual strong ties with NZ also may contribute to the possibility of some of the nurses

becoming circular migrants spending some of their time in the US and some in NZ, financial circumstances permitting.

CHAPTER 7. DISCUSSION

Introduction

The purpose of this study was to investigate the reasons why nurses leave New Zealand [NZ] to live and work overseas and what keeps them from returning home. The study was initiated because of an identified deficiency in current research exploring the migration decisions of nurses travelling from one developed country to another. In NZ while literature acknowledges a strong pattern of nurses migrating both in and out of the country, there was no research on the lived experiences and motivations of the nurse travelling abroad.

The previous three chapters have examined and explored the data gained from interviewing six migrant NZ nurses currently living and working in California. Several subthemes were developed under three main themes related to lure of opportunity, putting down roots and where is home now. In this chapter the findings and themes identified from the data analysis are further examined using comparisons to current literature and research and study limitations are addressed. Additionally implications as well as opportunities for both future research in NZ nurse migration and health policy and workplace planning are discussed in the concluding sections of this chapter and study.

Leaving New Zealand

Towards the end of her interview, Kate tells of reading an article in a NZ newspaper that talked about NZ nurses leaving and coming to the States. She was upset because the paper seemed to portray nurses as leaving NZ only because of better pay and opportunities without an understanding of comparable costs in each country and negating any other reasons behind the nurses' decisions. As she felt compelled to write to the paper with a response, it was clear that even years after this event happened Kate still felt strongly about the message the paper appeared to portray about nurses leaving NZ.

With the current disparity in nursing wages between NZ and the United States [US] it would be easy to assume that nurses are travelling to the US for financial reasons. Certainly anecdotal stories and some media reports perhaps perpetuate this myth. The inference that NZ nurses are 'economic migrants' leaving home in search of better money may be reflective of discussions and views held by some in NZ and abroad but is only very partially supported by the results of this study. For all of the nurses interviewed the foremost reason for deciding to work in the US was not financially motivated. Instead, findings seem to be similar to several other studies that indicated the migration decision is a more complex and multifaceted process usually involving a variety of reasons, coupled with environmental and the personal circumstances of the individual and family at the time. Just as Hardill and MacDonald (2000), Larson, Allen, Bryan and Smith (2005), and Sidebotham and Ahern (2000) found after interviewing nurses in the UK and Australia, there were a variety of reasons contributing to the emigration of the nurses from their countries of origin.

New Zealand has a large geographically mobile population (Conradson & Latham, 2005; Lidgard, 2001). It has been estimated as many as 45,000 NZ citizens a year leave on a permanent or long term basis (Statistics New Zealand, 2013). The geographical isolation of NZ along with the expense of travelling has resulted in New Zealanders spending a sustained period of time journeying to various places in the world and working to support themselves to ensure that long term travel plans remain viable (Wilson, Fisher & Moore, 2009). As several authors articulate, this tradition of a working holiday where travel, exploration and cultural experiences are considered more important aspects of the journey rather than career development is a cultural practice in NZ that dates back more than 50 years (Inkson, Arthur, Pringle & Baring, 1997; Inkson & Myers, 2003; Wilson, Fisher & Moore, 2009b).

Like many other New Zealanders who travel abroad for work, for the nurses in this study, the lure and pursuit of overseas travel was found to be the primary motivating factor to leave NZ. While family considerations and work limitations contributed to the timing of the decision to leave the country, it was the opportunity to travel and work in another part of the world that seemed to have the greatest bearing on the decision to leave. While studies on nurses who migrate from one developed country to another are few, there is some data that supports this finding. Haour-Knipe and Davies (2008) found that some nurses travel for adventure and to see the world. This

was especially true, they claimed, for those who came from isolated countries. Larsen, Allen, Bryan and Smith (2005) also found that the opportunity to travel was a strong motivator for the nurses in their study to migrate to the UK.

While migration theory discusses both 'push' and 'pull' factors that play a role in migration decisions; it has been shown that for the NZ nurses in this study 'pull' factors had by far the greater influence. Only one of the nurses spoke strongly on the need to leave NZ based on their work conditions or lifestyles. Limitations in the number and type of jobs available for the nurses along with a lack of specialised training opportunities were perhaps the only factors that 'pushed' these nurses to leave the country initially. Instead the sentiment that it was 'time for a change' seemed to feature prominently in their interviews.

Several overseas studies have identified other 'pull' factors that will contribute to the decision for nurses to migrate. Free travel, licensure and accommodation along with extensive learning and practice opportunities are strong incentives for a nurse considering overseas work (Brush, Sochalski & Berger, 2004; Ross, Polsky & Sochalski, 2005). This was certainly the case for many of the nurses in this study as shown in the previous chapters. While considering travelling abroad, enticements from recruiting hospitals and agencies contributed significantly in helping the nurses make the decision to leave NZ.

NZ cannot mitigate the 'pull' factors. It has already been shown that New Zealanders travel a lot and will continue to do so, often for long periods at a time. By recognizing and accepting that this is the situation and it probably will not change in the perceivable future, NZ then has to look at ways to ensure these migrants return at some point to be welcomed back as experienced and valued nurses.

The 'push' factors that serve to drive NZ nurses out of the country can however be addressed by studying the work environments and the day to day concerns of the NZ working nurse. By acknowledging the value of nursing and attempting to understand what nurses need to flourish in their working environment (Thupayagke-Yshureneagae (2007) provisions can then be put in place to either keep nurses at home or encourage an early return from an overseas excursion or assignment. As the International Council of Nurses (2007) discusses, nurses will stay where they are fairly paid and can advance professionally while participating in the healthcare decision making process.

It is worth noting for the nurses in this study, the settling in period after arrival in the US was for the most part a positive experience. Supported by both fellow migrants and the companies or hospitals they worked for, there was a consensus that overall it was not that difficult to adjust to the US lifestyle and work environment.

Travelling to areas where there were other migrant workers from similar backgrounds provided the nurses with the support they needed to assimilate into their new environments. This finding is supported by several authors studying New Zealanders living abroad who comment upon this tendency of New Zealanders to gather together in one place (Conradson & Latham, 2007; Wilson, Fisher, & Moore, 2009). They found that the new migrant's need to socialize with others of similar backgrounds who offer social support served to provide emotional security and self esteem to the new migrant along with a sense of community and belonging (Wilson, Fisher, & Moore, 2009). This was certainly the case for most of the nurses in this study. Just having others around them who they could relate to and discuss similar experiences seemed to help provide a strong support network. The nurses identified few barriers to assimilating into their new roles and as they looked back and reflected upon this time, it certainly seemed that this positive 'settling in' period had broader implications related to the length of time they had remained overseas.

For those nurses who had returned to NZ after several years abroad, recollections of the largely positive experiences they had had while working overseas served to resonate with them. They had no difficulty making a decision to once again become a nurse migrant, leaving NZ for further nursing opportunities. For these nurses a combination of 'push' and 'pull' factors seemed to be at play. Comparing conditions in NZ related to both the workplace and lifestyle including financial considerations, with previous experiences overseas in another developed country seemed to have as strong an impact on their decision as did the opportunity to travel again. If New Zealand is to hold on to future NZ nurses returning, these 'push' factors most certainly should be investigated and mitigated.

The reasons why NZ nurses travel abroad may also vary dependent upon their destination. This small study focused on one US geographical location where NZ nurses had travelled to. It has been found however that nurses travel predominantly to Australia and to Europe, primarily England (Health workforce information programme team, 2009). While we can speculate that similar to the participants in this study, other

nurses are travelling to England, along with large numbers of other NZ professionals, to be close to Europe and other travel destinations (Wilson, Fisher & Moore, 2009b), it is perhaps less apparent why some make the decision to only travel as far as Australia. Like many New Zealanders it is assumed nurses make the short trip because of better opportunities including financial considerations but solid data is not readily apparent. Until it is, we can speculate that the motivation for becoming a migrant nurse may be dependent upon the choice of destination or vice versa.

Coming home

While the majority of nurses in this study had no current plans to return to NZ, they all had either considered or had returned home for a period of time. What keeps them established in the US appears to be a combination of factors. This study was conducted in California and the lifestyle factors related to climate, proximity to a wide variety of activities and the financial means to pursue these activities seemed to be strong incentives to remain abroad. Certainly when weighing up the advantages and disadvantages of returning home to NZ to work against continuing to stay in California, the nurses for the most part seemed to feel that staying where they are currently was more advantageous to them, both professionally and personally.

All had strong family ties to New Zealand which they sustained with the use of technology. As several authors have stated, advances in informational and communication technology have contributed to allowing migrants to maintain close connections to family and old community ties (Hamel, 2009; Oiarzabel & Ulf-Dietrich, 2012). Geographically they may be thousands of miles apart yet they are only an email, skype or phone call away allowing for almost instantaneous contact with loved ones when care and support is needed (Larsen, Axhausen & Urry, 2006). In a study which examined Australians living in the US, Parker (2012) showed that the high use of technology connecting these migrants with friends and family back home enables each party to feel involved in each other's lives thus overcoming distance between them. In effect as Hamel (2009) articulates, "information and communication technologies are bringing the migrant home and bringing home to the migrant (p.24)....blurring the distinction between absence and presence" (p.28). As the nurses describe in their interviews, they rarely feel too far from home.

However, the actual geographical distance was more profoundly felt when loved ones back home became ill or needed to be supported. Supporting family members during illness, aging or difficult times seemed to be the only factor that would bring the nurses back to New Zealand at this point in their lives. Few studies have explored return migration but of the few that have, non economic reasons primarily related to family issues are cited for nurses who choose to return to their country of origin (Gmelch, 1980; Haour-Knife & Davies, 2008). This is certainly the case for the nurses in this study.

Concerns about finding a reciprocal job in NZ that was comparable to one they had currently in the US along with the financial security the job affords, was another consideration the nurses expressed with regard to returning home. For them, the longer they spent away and the higher the 'career ladder' they climbed, the harder they felt it would be for them to go home to work. The adjustments they would need to make coupled with learning about new aspects within the healthcare systems in New Zealand were obvious concerns for some of the nurses.

Enticing these nurses back home would almost certainly involve helping these nurses adjust to a different system of healthcare practice in NZ. Supporting and encouraging them as they navigate back into the NZ workplace is crucial along with the understanding that this process of adjustment back into the NZ way of life could take several years. Recognising these nurses bring a wealth of information, experience and skills back to New Zealand is key.

Study limitations

Initially, there were concerns that the small number of participants in this study would not yield sufficient data for analysis. However, as Thorne, Kirkham and O'Flynn-Magee (2004) have written, a small sample can provide rich data for analysis. While it would have been preferable to have eight participants in the study, interviews with the six participants yielded a significant amount of robust data. It was felt that the results from the study provided important information that could contribute to the dialogue on NZ nurse migration.

The small number of nurses in the study may also have been reflective of the geographical area where the participants were recruited. Limiting the location of the

nurses to one state in the US unquestionably made it more difficult to find potential participants. Limited time for travel and financial constraints on the researcher were primary reasons for this decision as face to face interviews were the preferred data collection strategy for the study. Additionally restricting the participant's current location to California is reflected in the data as features of the geographical location, such as climate and lifestyle, were part of the reason the nurses chose to travel and work in California as well as contributing significantly to their reasons for staying.

While face to face interviews were regarded as the best source for data, there are also limitations associated with this choice of data collection. Information given by participants in interviews is always filtered by them and the choice of what to disclose to the researcher is tempered by the quality of rapport and level of trust between interviewer and interviewee (Creswell, 2009; Grbich, 1999). Also not all people are as able to express their thoughts as clearly as others and there are differences in how insightful one participant may be over another (Creswell, 2009). As Bury (2001) writes, "narratives are always edited versions of reality, not objective and impartial descriptions of it...and interviewees make choices about what to divulge" (p. 282).

The choice of using snowball sampling to identify participants in the study may also have had the potential to limit participation to those who share similar demographic characteristics. As Parahoo (2006) has noted, participants who are utilizing snowball sampling tend to refer others with a similar background to themselves. While this may have been a possibility in this study, it was felt that despite the relatively small number of nurses, there was significant diversity at least for the first part of the study concentrating on the reasons for leaving NZ. This was probably because there was a small pool of potential nurses who could be part of the study and participants tended to refer any NZ nurse they knew who was currently working in California.

The participants in the study were generally long term migrants who had either travelled extensively and lived and worked in several countries or had been in California for a number of years. In this respect there was a great deal of similarity between the participants particularly when considering the reasons why they had stayed as long as they have in California. While it would have been advantageous to have some participants in the study who were recent migrants, none of the nurses interviewed appeared to know of any other NZ nurses who had recently arrived in California.

Whether this is indicative of recent tougher immigration policies in the US or can be contributed to other factors is unclear.

Participants who enter a research study would have some expectation of how an interview would proceed and what sort of information the researcher is looking for particularly if they are well informed of the aims of the study. The nurses interviewed were interested in the research I was conducting and appeared to want to please me, the interviewer. Several of them commented prior to the beginning of the interview, "I hope I can give you what you want" and others asked at the end if what was said was alright and "did I get what I wanted?" There was certainly the potential for information to be provided in the interviews that would put a more positive slant on the migration experience. The lack of a list of set questions to be answered appeared to be surprising to many of the nurses. Upon explanation that I wanted the stories of their migration journey rather than answers to questions, the nurses appeared to be more relaxed especially as the interviews proceeded. They seemed to be more contemplative and reflective of the choices they had made. While the potential for a predisposition to put a more positive slant on their experiences was still present, on studying the transcripts of the interviews and based on the comments the nurses returned on review of their interviews sent to them, I feel that the information provided by the nurses was truly indicative of their journeys and how they felt about their migration experiences. Comments such as "it made you think" and "I hadn't thought about these things in a while" reflected the post interview thoughts of the participants.

Implications for the NZ workforce

More than a decade ago, concerns were being raised about the loss of skilled workers from NZ. As the demand for proficient experienced workers throughout the world increases, so too does the competition between international labour markets to obtain and keep these trained individuals (Bedford, Ho & Lidgard, 2000; Lidgard, 2001). In a study looking at international migration of New Zealanders, Bedford et al. expressed concern about the corresponding shrinking in the working age group in NZ because of this competition. They felt that more and more people would develop transnational careers in multiple locations and because of this, in response; NZ needed a greater acceptance of an almost repetitious cycle of net gains and losses in its population.

Nursing is one population group that has always had large number of migrant workers both exiting and entering the country. Supplementing NZ trained nurses with overseas trained nurses has for many years been a strategy NZ has relied on to ensure adequate numbers of trained nurses for its population (New Zealand Department of Labour, 2006; North, 2010). But retaining these overseas workers is difficult (Caliister, Badkar & Didham, 2011; Hawthorne, 2011). As the District Health Boards of NZ and the Ministry of Health (2006) estimates, only about a quarter of foreign trained nurses will stay in NZ until retirement.

There is the potential for a surge of NZ citizens to return home at any time (Lidgard, 2001). Skilled returnees bring back additional ideas, skills and experience that can improve and enhance the workforce environment (Gmelch, 1980, Inkson, Arthur, Pringle & Barry, 1997; Lidgard & Gilson, 2002, Lowell & Findlay, 2005). Embracing these returnees and encouraging them to both return home and stay may be the challenge NZ has. Certainly for nursing, this seems to be a concern as from the limited data available, it appears even when nurses return home they either do not stay in the nursing profession for many years or they return abroad (Health workforce information programme team, 2009; New Zealand Department of Labour, 2005). This is supported by the comments made by the nurses in this study. Half of the nurses had returned to New Zealand to work for varied lengths of times in their careers and all had returned overseas again. While reasons for returning abroad varied amongst the nurses, there seemed to be an agreement that working abroad was better than working in NZ at least at that stage in their lives and careers. For Megan in particular, the aggravation of navigating through the bureaucracy of trying to get her overseas experience counted whilst looking for a job was a continual frustration for her.

Haour-Knipe and Davies (2008) have identified several factors to facilitate the return migration of nurses. Because returnees often have considerable ambivalence and expectations that are unrealistic (International Center of Nurse Migration, 2008), Haour-Knipe and Davies believe assuring returnees are adequately prepared with realistic expectations is essential. They explain that reducing bureaucratic hurdles while acknowledging professional accomplishments with appropriate salaries, promotions and pensions is important along with policies that have the capacity to adjust to long term leaves of absence.

“When nurses have been able to increase their skills, knowledge and experience

by working abroad; when these bits of knowledge, skills and experience are relevant to the needs of the home country; when nurses are willing and able to return home and to use them, then they can be at the origin of the ‘return of innovation’” (International Center of Nurse Migration, 2008, p. 2).

As shown in this study, the nurses were not totally averse to returning to New Zealand particularly after just several years abroad. Adjustment difficulties aside, feelings of not being recognized for their overseas experience and accomplishments with corresponding salary adjustments seemed to play some part in their decisions to return abroad. After being abroad for a prolonged period of time as many of these nurses had been, it seemed that it was more difficult for the nurses to make plans to return to NZ. This sentiment is supported by the International Center of Nurse Migration (2008) which acknowledges that the longer migrant nurses stay away from their country of origin the harder it is for them to return. In addition, it must be considered that as they rise higher through the ‘ranks’ in the US, equivalent positions may not yet be available in NZ especially in the more highly specialised areas. Mitigating the adjustment difficulties the nurses and their families have on arrival in New Zealand is also an area yet to be explored.

Looking to the future

Looking forward

The recruitment and retention of qualified nurses to meet the needs of health care consumers is an essential part of health workforce planning. The World Health Organization (2010) has stated that countries should create a health workforce that can be maintained and as such, strategies that are focused towards education, training and retention of health care workers should be employed along with bilateral and multilateral agreements between countries to facilitate and compensate nurses travelling. With increasing health care costs and resources that are becoming more restrictive the challenge is to continue to provide good care (Kingma, 2001) while nursing numbers decrease and health care needs increase.

As mentioned in this and several of the preceding chapters, like many countries NZ imports a large percentage of foreign educated nurses to its shores to fill nursing

vacancies. But, as the Ministry of Health (2006) reports, relying on immigrants to meet NZ health care needs will no longer be a sustainable approach. The Ministry predicts there will be increasing competition for labour both within New Zealand and throughout the world. By their estimation, by 2021 there will be an excess of health care worker labour demand over supply by between 28 and 42 percent of the 2001 NZ workforce numbers. This is concerning when you consider that changing demographics and labour market conditions across OECD countries will still continue to entice New Zealanders abroad as international competition for nurses' increases (Ministry of Health, NZ, 2006; Nursing and midwifery workforce strategy group, 2006).

As NZ continues to look abroad to recruit nurses, perhaps some of the focus should be on their own trained overseas population. Recruiting nurses that have been trained within the NZ system would ensure much less time and money would need to be utilized upon these nurses re-entry into the NZ health workforce in comparison to other nurses brought in from abroad. Bach (2003) and Haour-Knipe and Davies (2008) suggest acknowledging the accomplishments of these nurses whilst finding jobs to meet their skills is necessary in order to retain their services. Certainly, supporting these nurses upon returning home to work by assisting them not only in the workplace but in adjusting back into the NZ lifestyle may also ensure they stay within the profession longer.

Further research

Further research is required before countries are able to implement policies to assist with retaining a viable nursing workforce that is able to meet the needs of their populations. Strategies to retain nurses in the workplace should include the study of nurses' work patterns as being essential to understanding what nurses want and need in their careers. Examining the migration of nurses to gain insight into both their reasons for travel and the experiences they have is necessary so that insightful approaches to both retaining and recruiting nurses can be then put into practice.

Accurate data on the numbers of nurse migrants and their impact on the labour market is crucial (Kingma, 2006; McElmurry et al., 2006). The International Council of Nurses (2007) has called for research that looks at how migration of nurses will affect various aspects of health care related to quality, demand for nurses and educational preparation. The World Health Organization (2010) also has identified the need for

better documentation on migration numbers and studies to show the influence of nurse migration on health care systems.

Several nurse researchers have identified a need for further migration research. Along with the recognition of the need for more data on nurses' career plans, histories and job satisfaction, Buchan and Sochalski (2004) assert studies on why nurses both leave to go abroad and return home are also necessary. Larsen, Allan, Bryan and Smith (2005) recognize further investigation on nurse migration is required stating: "social constraints and financial opportunities cannot stand alone in providing explanation for decisions to seek work overseas; individual motivations have to be investigated through the dialogical explorations of individuals' life perspectives; their values, expectations, hopes, and plans" (p. 364). This need for qualitative data studying the personal accounts of the migrants is echoed by other researchers (Bach, 2003; Buchan & Sochalski, 2004; Kingma, 2006; Mambo, 2009; North, 2010; Zurn & Dumont, 2008).

In Conclusion: The focus for New Zealand

There have been several NZ researchers and government organizations calling for further study on the movements of NZ nurses. The Nursing and Midwifery Workforce Strategy Group (2006) recommends focusing on retention of nurses along with improving information on workforce flows and encouraging those nurses overseas to return home. Researchers also claim more analysis is required focusing on the migrant NZ workforce (Zurn & Dumont, 2008) and the dynamics of nurse migration (North, 2010).

This study, while small, provides a starting point for further discussion on NZ nurse migration. While giving a glimpse of the motivations and thoughts of NZ nurse migrants the study also provides numerous opportunities for further exploration and research. Larger studies on nurses abroad in varying geographical locations could yield further data for analysis on the motivations and experiences of these nurses. In-depth qualitative studies focused around nurses who have returned to NZ after some time working overseas would also provide valuable information on not only the impetuses for leaving the country but also the experiences they had assimilating back into NZ society on their return. Specifically, information regarding the motivations behind the nurses' return to NZ is an avenue worth exploring as is the question of what can be done to help these nurses feel more settled back into their NZ lives.

As acknowledged previously in this and previous chapters, NZ cannot stop nurses from travelling abroad for extended periods of time and it could be argued that NZ shouldn't. While some may advocate strategies focused on each country training and retaining an adequate number of nurses while mitigating the factors that drive nurses from their shores (Aiken, Buchan, Sochalski, Nichols & Powell, 2004; International Council of Nurses, 2007; Walker, 2009), it is clear that while these 'push' factors should be managed, nurses will still continue to migrate. As shown, many NZ citizens love to travel and historically will be overseas for several years. While retaining NZ nurses in the country is certainly important, perhaps NZ also needs to examine and explore other options for the nurses who want to travel and work abroad. As Rosenkoetter and Nardi (2007) write: "the challenge to all countries is to develop mechanisms that support a nurse's free choice to work anywhere the nurse wishes to work and to encourage funding bodies to assist with the repatriation of nurses in their own countries" (p. 309). How does NZ nursing accommodate the nurses' desire to travel whilst encouraging a timely return to NZ? What can be done to ensure on return, that these nurses will stay both in NZ and in the nursing profession long term whilst enriching nursing with their experience and skills? Should NZ then be exploring various options for the nursing population such as short term reciprocal overseas placements or circular migration? These are all questions worth investigating in future research on nurse migrants as NZ looks towards the future in an international race to ensure there are enough qualified nurses to meet its growing health care needs.

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APPENDIX A

NEW ZEALAND NURSE MIGRATION TO THE UNITED STATES: WHAT MAKES THEM GO? WHAT WILL BRING THEM BACK

INFORMATION SHEET

Thank you for considering being part of this study. The following pages will provide you with information to help with your decision to participate.

Researcher information:

My name is Lynette Whittaker and I am a New Zealander currently working as a Registered Nurse in a hospital in California. I am currently undertaking this research to partially fulfil a Master of Arts (Nursing) degree at Massey University, New Zealand. As this is part of my University study all costs for the study will be incurred by myself and I will receive no financial remuneration for the research done.

Study information:

The purpose of this study is to examine the reasons why New Zealand nurses leave New Zealand to work abroad. In addition the research hopes to explore what nurses gain from the overseas experience and what might facilitate the return of nurses to New Zealand. The study will be focused on a small group of New Zealand nurses currently working in California, USA.

Participant eligibility:

Participation in the study is voluntary. It is anticipated that 8-10 participants will be involved due to the in-depth interviews required and my time restraints to complete my study. Any nurse who received their education and graduated as a New Zealand registered nurse and is currently nursing in California is eligible to contribute to the study.

Participant requirements:

Research participants will be asked to share their experiences in an interview with the researcher. The interviews, which should last approximately 60-90 minutes, will take place at a location of your choice. In order to ensure that no information is lost, the interview will be audio recorded with your permission. At the conclusion of the study

the tapes will either be destroyed or returned to you at your request. All participants will have the opportunity to review transcripts of their interviews and make any further comments.

If further clarification of data is needed, there may also be the opportunity to participate in a focus group interview but you are under no obligation to participate in a group interview. The choice of participation in any part of the study is entirely voluntary.

Confidentiality:

Every effort to maintain your privacy will be observed. Only the researcher and her supervisor will have access to your personal information. Any personal details that could identify you including your name, age, and place of work will not be included in the study. You will have the opportunity to choose a pseudonym to be used throughout the study. The audiotape of your interview and any notes made by the researcher will be stored at a secure location before being disposed of.

Risks inherent in the study:

It is expected that participation in this study will have no physical ill effects upon you. However when talking about personal experiences there is always the slight risk of some emotional disquiet. If this occurs you are under no obligation to continue the interview.

Participant rights:

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time.
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher.
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any point in the interview

Contact information:

Please feel free to contact either myself or my supervisor if you have any further questions or need clarification on any items mentioned above.

RESEARCHER: Lynette Whittaker
1113 Sonoma Avenue,
Modesto; California 95355
U.S.A.
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SUPERVISOR : Professor Annette Huntington, PhD, RN
School of Health and Social Services,
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This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director, Research Ethics, telephone 06 350 5249, email: humanethics@massey.ac.nz".

APPENDIX B

Sample introductory paragraph sent to potential participants:

----- kindly gave me your email address and suggested you might be available and willing to be interviewed as part of a study I am doing for my Master's thesis at Massey University, New Zealand. I am a New Zealand nurse working in California and am interested in talking with other New Zealand nurses about their decisions to go abroad to nurse and the experiences they have had. I have attached an information sheet about the study for you to look at. If you are interested in being part of the study and willing to be interviewed, I would be grateful for the help. You can contact me at any time by email or by phone at 209-566-3869. Thank you for your consideration.

APPENDIX C

Aide Memoire

What were they doing before they left New Zealand?

What precipitated the decision to emigrate?

What was the process for emigration like?

The road to the States; did they go directly or via other countries

Have they returned to New Zealand or not?

What stops them going back to New Zealand permanently?

What is it about the US that keeps them in the country?

Educational opportunities?

Career opportunities?

What do they think about nurse migration?

Have they or do they have much contact with other New Zealanders and how does this affect their decisions to stay/go?

APPENDIX D



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

13 July 2012

Lynette Whittaker
1113 Sonoma Avenue
Modesto
California 95355
USA

Dear Lynette

Re: New Zealand Nurse Migration to the United States: What Makes Them Go? What Will Bring Them Back?

Thank you for your Low Risk Notification which was received on 11 July 2012.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research."

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz."

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

John G O'Neill (Professor)
**Chair, Human Ethics Chairs' Committee and
Director (Research Ethics)**

cc Assoc Prof Annette Huntington
School of Health and Social Services
Wellington

Prof Steve LaGrow, HoS
School of Health and Social Services
PN371

APPENDIX E

NEW ZEALAND NURSE MIGRATION TO THE UNITED STATES: WHAT MAKES THEM GO? WHAT WILL BRING THEM BACK

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered by Lynette to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded

I wish/do not wish to have my recordings returned to me.

I agree/do not agree to participate in a focus group interview if one is set up

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name Printed: _____