Cultural Health Capital and Professional Experiences of Overseas Doctors and Nurses in the UK

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ABSTRACT

This article explores the meanings that overseas doctors and nurses working in the UK assign to their professional experiences. We critically observe that literature on overseas professionals' trajectories draws on psychological acculturation or social capital theories and that an integrated approach is needed. Drawing on autobiographical narratives of a small sample of overseas doctors and nurses working in the UK, we analyse emerging 'subjective theories' of their professional experiences and we explore how these are related to the theoretical framework of cultural health capital, an 'expert theory' on a form of cultural capital which is leveraged in healthcare contexts and may result in more optimal healthcare relationships. Findings of our analysis illustrate that there is a wealth of expertise and experience among overseas health care professionals but these are underutilized due to structural and institutional barriers. Healthcare professionals on temporary migration status faced longer delays in their career progression than those with EU citizenship or on work permits. Also, irrespective of migration status, career aspirations were thwarted by external circumstances with negative consequences upon individuals' well-being with doctors being affected more severely than nurses. Structural and institutional barriers impacting on professionals' ability to progress into the UK healthcare system are discussed. We conclude by considering the potential of cultural health capital as a framework to capture and explain the trajectories of overseas healthcare professionals' experiences.

KEY WORDS: cultural health capital; diverse healthcare workforce; migrants and refugees; subjective theories; professional experiences; psychosocial well-being

INTRODUCTION

The necessity for and usefulness of a diverse healthcare workforce is consistently highlighted in the European context (Bach, 2003). In the UK it is also acknowledged that the healthcare sector relies on staff from migrant backgrounds (Rechel et al., 2006). In fact, recent estimates indicate that more than a third of registered doctors (General Medical Council, 2011) and one in twelve nurses qualified outside of the UK (Royal College of Nursing, 2007). However, in this age of 'super-diversity', making the best use of these people's resources is complex, as the professionals arriving in the UK have difficulties transferring and utilizing their knowledge and skills (Phillimore, 2010).

Indeed, the post-migration experiences of highly skilled migrants and refugees in the UK are neither simple nor straightforward (Author B, 2007). Research with overseas professionals from the healthcare and welfare sectors indicates they struggle to utilize their skills because of interconnected reasons such as complicated conversion systems of educational credentials, processes around recruitment and professional development which are often indirectly discriminatory, racism experienced at the workplace, and inadequate levels of local support and mentoring (Butler and Eversley, 2009; Henry, 2007; Sinclair et al., 2006; Smith et al., 2006). It should also be pointed out that studies exploring these professionals' post-migration experiences find poor psychosocial well-being outcomes such as low self-esteem, frustration, depression, demoralization and disappointment (Alexis et al., 2007; Cohn et al., 2006; Stewart, 2003).

In this article we explore the meanings that overseas doctors and nurses in the UK attach to their professional experiences and look into the processes which impede or facilitate their professional progress and influence their psychosocial well-being. We do so by drawing on an innovative framework on the interactional dynamics taking place in healthcare contexts. We use the theoretical approach of cultural health capital (CHC) (Shim, 2010) while exploring the 'subjective theories' of overseas healthcare professionals in the UK institutions which employ them. The aim is to highlight some of the micro-interactional but also macro-structural mechanisms affecting these groups' development and well-being.

Following a brief literature review in the field of migration of healthcare professionals, we discuss the CHC approach and how it can address the shortcomings in this area. We then employ this approach to analyse the 'subjective theories' conveying the professional experiences of a group of overseas doctors and nurses in the UK.

The components of CHC are defined by Shim (2010: 3) as a "coherent collection of cognitive, behavioural, social and cultural resources theorized to serve as a 'tool kit' for patients… to optimize their relationships with health professionals and the care they receive". We argue that such resources can serve as a 'tool kit' also for overseas healthcare professionals who may activate them for improving relationships with colleagues and service users in the healthcare institutions they work. In our analysis of the 'subjective theories' of a sample of overseas doctors and nurses we examine whether the participants fully utilize the above resources or not. Our proposition is that those who cannot use effectively their CHC, will emerge as the most vulnerable in terms of professional development and/or psychosocial well-being. We conclude with recommendations on which barriers have to be addressed and in what ways in order for these professionals' potential to the delivery of healthcare to be utilized in the best possible way.

POST-MIGRATION EXPERIENCES OF OVERSEAS HEALTHCARE PROFESSIONALS

An increasing shortage of healthcare staff has led to recruitment of these professionals from less developed countries as one of the main responses of developed countries to this challenge (Clark et al., 2006). The main motives for this migratory movement include poor remuneration, bad working conditions, political instability and discrimination, as well as personal ones such as security, threat of violence and better education of children (Pang et al., 2002). Common 'pull' factors are better working conditions, quality of life and greater career opportunities. Migration of healthcare professionals occurs in two ways: through active recruitment by employers or agencies or through passive recruitment by professionals' access of information and work opportunities via new communication technologies (Batnitzky and McDowell, 2012; David and Cherti, 2006; Troy et al. 2007).

In the UK, as far as post-migration experiences are concerned, there is a growing research literature examining either motivations and psychosocial process or socioeconomic outcomes (Batnitzky and McDowell, 2011; Cohn et al., 2006; Jones et al., 2009; Larsen et al., 2005). In the first area looking at psychosocial processes, most studies draw on models of the acculturation process (Ward, 1996) and acculturation strategies (Berry, 1997) for exploring at the micro-level overseas professionals' adaptation to the host society. These classic models have been criticized on several grounds, such as the lack of importance given to how the host majority can shape and be shaped by migrants' acculturation orientations, and have been amended to include a more interactive dimension (Montreuil and Bourhis, 2001).

In the second area, which looks at socioeconomic dimensions, most studies draw on theories such as Loury's (2002) on how racial/ethnic inequalities are structured and often use Bourdieu's (1986, 2001) theory on the forms of cultural capital while exploring highly skilled migrant groups' integration into the receiving society's labour market. According to Bourdieu (1986), migrants' cultural capital refers to non-financial assets, i.e. educational, intellectual and social resources people 'inherit' (e.g. from the family through socialisation) or consciously acquire over time (e.g. through formal education). This would include formal or institutionalised cultural capital i.e. educational credentials, accredited professional training, and recognised work experience but also informal/incorporated cultural capital, i.e. migrants' affiliation to ethnic communities, social and professional networks both in their country of origin and the host country, as well as the values they bring along, their motivations and finally the strategies they use for bringing changes through their work.

Bourdieu's theory on cultural capital has been criticized for not paying attention to people's self-concept because he assumes that professionals seek to maximise their status out of habit (Lamont, 2010). Lamont (2002) conceptualises cultural capital as more than a 'residual category' which sustains social hierarchies but also something stemming from people's self-worth, that is, she assigns to cultural capital a nuance which is both habitual but also purposeful.

Despite being further developed, these two theories of acculturation and cultural capital, when applied to research with overseas professionals can be criticised on various aspects. One the one hand, psychosocial acculturation models focus too much on intra-individual or interpersonal states, thus cannot explain the macro-mechanisms which suppress collective

minority rights and perpetuate socioeconomic inequalities between native-born and foreign populations (Rudmin, 2003). On the other hand, sociological approaches on cultural capital do not explain the psychological processes which are co-constructed in sociocultural contexts (García-Ramírez et al., 2010), and through which people respond to the challenges they face during acculturation.

The need for conceptual frameworks looking beyond the agency- structure dichotomy, and constructively blending the personal with the collective, is widely acknowledged (Flyvbjerg, 2001; Heron and Reason, 2001; Stephenson and Papadopoulos, 2006). In accordance with this view, we highlight the CHC framework with 'its simultaneous focus on biography and social structure' (Lareau, 2003: 311, note 6 in Shim 2010: 4). Such frameworks are rooted in Bourdieu's conception of culture as an emergent set of resources critical to the exercise of professional power and embedded in the habitus of healthcare systems. Moreover, CHC is a specialized form of cultural capital that is leveraged in healthcare contexts to lead to more effective engagements with providers of care.

THE THEORETICAL FRAMEWORK OF CULTURAL HEALTH CAPITAL

Cultural health capital (CHC) is 'the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviours and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal healthcare relationships' (Shim, 2010: 1). These attributes comprising CHC are specific to a given socio-historical moment. Shim (2010) points out that in the current US healthcare system - with its emphasis on patient initiative, self-knowledge, and self-management - certain features tend to be rewarded in healthcare contexts and clinical interactions. Some of these features are: health literacy ('the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions', Ratzan and Parker, 2000: vi); knowledge of what information is relevant to healthcare personnel; an enterprising disposition which presupposes a sense of mastery and self-efficacy; an orientation toward the future and its control through action; and, sensitivity to interpersonal dynamics and the ability to adapt one's interactional styles (Shim, 2010:3).

While drawing parallels with cultural capital, Shim (2010:4) points out that CHC is similarly:

1) purposeful (since patients enact health-related practices such as engaging in self-surveillance and risk-reduction) but also habitual (many patients engage in the above practices because these are rooted in their experiences and long-lasting ways of organising action)
2) empowering for individuals and structurally restricted (since holders of CHC are not entirely free agents who can use resources at will but are also constrained by systematic inequalities)
3) deeply relational (that is, in the interactive clinical encounter, clinicians can encourage patients to be the kinds of actors they would like them to be).

The above description of CHC suggests that this is indeed one of the integrative theoretical frameworks which combine agency and structure. Moreover, similarities between the American and British healthcare systems indicate that this framework can be applied to the current UK healthcare context, where there is also emphasis on: ill health prevention and risk reduction; maximising people's capabilities through lifelong learning and to have control over their lives; citizen participation and community engagement in healthcare decision-making (The Marmot Review, 2011).

Through our analysis in the following sections, we show that the CHC theoretical framework can be valuable for exploring the repertoire of competencies, attitudes and interactional styles that not only patients but also healthcare professionals cultivate. Also its second feature, i.e. that it can highlight social inequalities operating in clinical encounters, renders this theory appropriate for understanding how barriers that overseas healthcare professionals may face at the workplace shape their professional development and well-being.

THE STUDY

Findings presented in this paper are drawn from a project which studied the educational and professional pathways of overseas health and social care professionals before and after migrating to the UK. The project aimed to explore these groups' experiences and the relevance of cultural capital for their professional development. We decided to target medical doctors, nurses and social workers as these professions attract the majority of overseas-

trained professionals in health and social care (Bach, 2003). Therefore, our main inclusion criterion was overseas medical doctors, nurses and social workers, who had obtained qualifications in their home countries and had work experience in the UK health and social care sector. Given that among the overseas healthcare professionals there are a large numbers of EU citizens (GMC, 2011), the sample also included participants from EU countries. We employed purposive sampling to recruit 5 doctors, 5 nurses and 5 social workers via our professional networks in London. For the purposes of this article, we discuss findings referring to the doctors and nurses of our sample.

Ethical approval for recruiting and interviewing the participants was granted by the Research Ethics Committee of the Faculty which the authors are affiliated with. All participants were ensured of confidentiality and anonymity of the accounts they provided. Three interviews were conducted at the participants' homes, two at a public place the participants suggested (coffee shop, community centre) and the remaining interviews were conducted at the participants' workplace, after they has finished work.

The interviewer described in detail the aim of the study and the purpose of the interview and provided each participant with the opportunity to ask further questions and clarifications. Once each interviewee provided written informed consent, the autobiographical narrative interview began with the 'generative narrative question': "I would like to ask you to tell me the story of your educational and professional life before and after you came to the UK. A good way to do this would be to start talking about your education and work experience you gained in your home country, and then about your education and work experience in the UK until today. After that you can also tell me your thoughts about your professional future".

There were also specific narrative inquiries, such as questions regarding experiences with UK institutions ('did you approach an employment agency or job centre?'), psychosocial resources ('how are your relations with other compatriots') and individual coping ('do you think you are in control of things in your life') and psychosocial well-being ('are you satisfied with the way your life is').

All interviews were conducted in English and audio-recorded with the participants' consent. Each interview lasted approximately 1.5 hour. A questionnaire, where participants provided

demographic information and an outline of their educational and professional history, was given after the interview for allowing us to contextualise biographical accounts. Verbatim transcriptions of interview data were analysed with the assistance of a qualitative data analysis software programme, NVivo.

We looked deep in the participants' autobiographical narratives in order to elicit 'subjective theories'. The term "subjective theory" refers to the fact that each interviewee constructs a complex stock of knowledge about the topic under study. This knowledge includes assumptions that are explicit and immediate and which they can express spontaneously in answering an open question - such as the generative narrative question used in this study. These are complemented by implicit assumptions, which can be derived through questions more directed to the research topic- such as the more specific narrative inquiries (Flick, 2002: 80).

By comparing these with 'expert theories', concepts through which scientists, researchers, and policy makers explain the participants' experiences, professional development interventions can be planned along participants' own understandings and therefore can provide them with resources suited to their needs. 'Subjective theories' do not refer to 'objective' stocks of knowledge that people hold; they are shaped by existing social norms and cultural values and are influenced by the others one interacts with. This is because all individuals create meaning from the interaction between their existing beliefs and the new ideas and situations they encounter in social settings (Schwandt, 1998).

Acknowledging the above entails that the meanings overseas doctors and nurses attach to their experiences are being constructed through various interactions in the different social contexts they have found themselves after migrating to the UK. Expert theories on the other hand, such as the CHC framework, make claims that attempt to describe an 'objective' social-psychological reality (Denzin & Lincoln, 1998). In this paper then we open a dialogue between what is 'objective' (namely, expert knowledge) and the 'subjective'; that is, we discuss overseas doctors' and nurses' subjective theories of their professional experiences while exploring how they use the attributes comprising CHC, when constructing these theories.

PARTICIPANTS

Participants originated from a mix of developing and European countries and their ages ranged from 28 to 52 years old. There were two EU citizens, four participants were economic immigrants on work permit, one was on the Highly Skilled Migrant programme, one was a refugee with British citizenship and two were asylum seekers on Limited Leave to Remain (LLR).

The sample of doctors consisted of four men and one woman. Four of these doctors had been residing in the UK for an average of five years, apart from one participant who arrived in the UK in the early 1990s.This participant was the refugee with British citizenship mentioned above and although he had lived in the UK for much longer than the other participants, we consider his experience to be still relevant, as at the time of the study was still actively trying to join the UK medical workforce. All had a university degree in medicine and significant work experience in their home countries but also abroad. In the UK, two participants were working as doctors in public hospitals. One had a managerial post in the NHS, one worked as a health officer in a local authority and one as a project officer in a health and development company.

The sample of nurses consisted of four women and one man who had been residing in the UK for an average of seven years. All participants had nursing qualifications from their home countries and one had also a degree in social work. They had significant work experience in their home countries and other countries as well. In the UK, three participants were employed as NHS nurses, one was working part-time as a carer in a community support agency and one was a staff nurse in a private care home. An overview of the participants with their characteristics is presented in Table 1.

PLEASE INSERT TABLE 1 HERE

ANALYSIS

Thematic network analysis was used to organise the narrative interview material and to interpret the participants' emerging 'subjective theories' (Attride-Stirling, 2001). Thematic

analyses of qualitative data in general attempt to reveal the themes salient in a text at different levels and thematic networks in particular, aim to facilitate the structuring and depiction of these themes (Attride-Stirling, 2001: 387). In what follows, two thematic networks, consisting of basic and organising themes will be presented. The basic and organising themes are first discussed and relevant quotes are integrated, to illustrate how these themes link together into a subjective theory. Along with each quote the gender, occupation, and migration status of the particular interviewee are noted in brackets.

The first step in a thematic network analysis is to code the material; this was carried out by dissecting the text into meaningful text segments which discussed one of the three following themes: a) first work-related experiences in the UK (e.g. the accreditation process of qualifications acquired abroad), b) the psychosocial resources the participants said they used while facing various post-migration challenges (e.g. resilience, optimism, forming solid social networks) and c) psychosocial well-being outcomes (e.g. feeling disappointed, anxious, optimistic). Those sections which we initially coded as 'psychosocial resources' were further coded according to CHC elements such as health literacy; an enterprising disposition presupposing a sense of mastery and self-efficacy; an orientation toward the future and its control through action; and adaptive interactional styles.

Once the text was coded, the themes were abstracted by going through the text segments in each code and by extracting the common or significant themes in them (Miles & Huberman, 1994). Inter-judge reliability was attained by creating codes and themes separately and then cross-checking the codes/themes each of us had found. Where there were discrepancies in the codes we had created and the themes we had generated, we resolved them through discussion and thorough re-examination of the data.

The emerging themes were assembled into groupings, an action made based on content and on theoretical grounds. These groupings became the basic themes and by creating clusters of basic themes centred on larger, shared issues, the organising themes were created. Finally, the main claim the organising themes referred to was summarised and this 'global' claim was the 'subjective theory'. Two different 'subjective theories' emerged from the interviews that contained similar basic themes (e.g. first UK labour market experiences) and organising themes (i.e., resources activated for enhancing professional development) but diverse global

themes (i.e., psychosocial well-being outcomes). As mentioned above, the paper aims to highlight some of the micro-interactional but also macro-structural mechanisms, as described by CHC, affecting these participants' development and well-being. It should be noted that macro- mechanisms (e.g. overregulation within the medical profession affecting minorities' rights) emerged not at the stage of initial coding but as the two 'subjective theories' were taking shape.

FINDINGS

Basic themes

The basic themes were the themes that all participants brought up in their narratives. The generative narrative question prompted the participants to talk about their educational and professional experiences before and after migration. The issues of *accrediting one's* qualifications in the UK, and being recruited and how these were influenced by migration status constituted the basic themes emerging from all interviews.

The process of accrediting qualifications and its dependence on migration status

As expected, having the qualifications acquired abroad recognised in the UK depended largely on participants' migration status. Especially for nurses and doctors who were refugees the above process was far from straightforward. The following quote is from the doctor who held refugee status and later acquired British citizenship; the long delay of the accreditation process of his home country qualifications impacted on his professional development:

> *'...because I had no documents I was not eligible to update my training or continue* my training and follow registration. So I was just waiting for my status to be clarified by the Home Office. After two years, with the help of [X] University, they sent my *diplomas for recognition to the British Council. Then the British Council doesn't* recognise my qualification and they say that because of the [time] *gap'* (male doctor, health officer in local authority, Refugee/British citizen).

For those interviewees who were EU citizens, the accreditation process was more straightforward when compared to those on a UK visa.

> *'...I had my i*nterview before I had my certificate of completion of training and I emigrated [to the UK] very quickly after receiving the certificate. So I worked in my home country for about 6 years and then I came to the UK and I have worked here for about 5 years as well...*'* (female doctor, NHS psychiatrist, EU citizen)

Pace of recruitment based on migration status

Fast and successful recruitment also depended on migration status. Once again, the process was simpler for those on work permit than those with a more temporary status:

> *'I sent in my application July and then in October the agency phoned me....I went for an interview and it is this Trust, so I'm lucky I got the job. I came here in January 2001 so it's very quick. It's a straightforward process, after the i*nterview, in 3 months *I came here'* (female nurse, employed in the NHS, work permit)

Interviewees with a temporary status faced a more complex and slower recruitment process. The delays due to migration status were compounded with the time spent out of the UK workforce. The quote below from a doctor on Limited Leave to Remain is indicative:

> *'I'm afraid if I can't get back into the system, what shall I do? It's shocking, you know. Sometimes I think 'I've been out of job nearly two years, it is really bad',* although I can qualify now for interview. But if I get a job in one year, then there will *be a gap, three years gap, and then more difficult to get back into the system again...'* (male doctor, project officer in private healthcare agency, LLR)

Organising themes

The organising themes refer to the active use of resources the participants initiated in order to progress professionally in the UK. This active use of resources was selected as the main principle linking the basic themes, because it showed what the participants claimed to do in order to surpass difficulties related to their professional development. The resources we identified in their narratives and present here refer mainly to CHC aspects such as health

literacy; sensitivity to interpersonal dynamics and *ability to adapt one's interactional styles*; an enterprising disposition which presupposes self-efficacy; orientation toward the future and its control through action. We selected quotes where interviewees described what they did in order to professionally progress and where the above aspects of CHC are captured.

Enhancing health literacy

One positive experience noted when discussing how one can progress professionally was the opportunity to undertake training and thus improve one's health literacy. In the following example, this NHS nurse highlighted the complexity of the training they were required to undertake. At the same time, she acknowledged it enhanced her health literacy, thus improved her chances of career progression:

> *'We have many skills f*rom back home we can use here but we are not allowed to... *until we do the training. So I've done that and now I am able to do everything I was doing back home, even mentor the students which is very good. It's very good, I have* been always interested in l*earning more and accepting the challenges that's why I'm* trying to do much training...because everybody wants to go higher up the bands and I *love to improve as well'* (female nurse, NHS hospital nurse, work permit)

Sensitivity to interpersonal dynamics/adaptability

The ability to adapt while interacting with others was also noted when discussing one's professional advancement. The next quote captures another relevant aspect of CHC, one's *sensitivity to interpersonal dynamics and the ability to adapt one's* interactional styles, as the interviewee noted discriminatory attitudes at the workplace, yet discussed how to bypass them:

> *'...*You can hear most of the staff has been abused, not physically but verbally *especially if you're a foreigner, although I haven't experienced that or maybe I didn't give attention, but I've heard a lot about racism and it's true with colleagues, especially if they're coloured. But so far when I'm with the patients and the relatives* we always have good feedback ... they will say all *your nurses are good so that's good*

because everywhere you go you find nurses from my country... it's alright, I don't regret being here' (female nurse, employed in NHS rehabilitation ward, work permit).

The doctor in the following quote also raised the issue of adjusting interactions. He narrated how he embraced the interprofessional aspects in his first post in the UK, later on experienced tension within the workplace and finally realised the sacrifices he had to make.

*'*I liked that *I didn't have to rush*, I could see the patient and talk with them. I liked the close interaction with teams, not only medical but palliative care, psychology, counselling, social care. I thought it was very holistic. So I just clicked I could do this for the rest of my life and after that I got this job...There is a problem that you need to be prepared to work more than 12 hours a day... if you say to one of the bosses, this is *out of hours, I'm not going to do this they see that as a sign of weakness. Colleagues* will think you*'re not motivated... And I've come across that competitiveness here a* lot*. I guess I need to make sacrifices in my personal life... now I'm more prepared to* do*'* (male doctor, NHS oncologist, EU citizen)

Orientation toward the future and its control through action

Some interviewees described their long-term professional plan, thus indicating that progress could be attained through another aspect of CHC and in particular, an orientation toward the future and its control through action. In the following quote from a doctor, professional progress was made possible by being clearly future-oriented and taking –radical in her case- actions towards achieving one's goals:

'...in [my country's] system it's very hierarchical...doctors use the power with the patient... *In the UK, it's far more equal and doctors have to consider the cultural background and the patient's belief system and share* the decision making. So the *patient has to be part of the process and that's why I embraced it once I landed...But* the regulator*y bodies they've been really pushing on doctors and there's a lot of discontentment... there's a trend in the UK* psychiatry of people coming to a doctor *with what I call 'life syndrome' and expecting I prescribe a happy pill and they'll be* happy ever after*. I just disagree with that...it's overwhelming and I am preparing my exit from the profession'* (female doctor, NHS psychiatrist, EU citizen).

An enterprising disposition which presupposes self-efficacy

Another element of CHC, an enterprising disposition presupposing self-efficacy, emerged as well in some narratives. In the next quote this doctor discusses the different professional pathways he took, while trying to attain his main professional goal:

> *'...when I was working for the pharmaceutical industry* it was very different... that was not me... because it was a lot of commercial work and was too far away from *what I was doing not so long ago which was dealing with patients. I just didn't feel* comfortable. So coming into the NHS was a personal decision. I wanted to get into the public sector and see how it goes...because pursuing international development, *that's probably the ultimate career goal for me, do a bit of consulting and then get* into the international development sector. I think the public sector would offer more *development opportunities than the private sector. I don't know if that's true but that's my perception of it'* (male doctor, NHS strategy manager, Highly Skilled Migrant)

Since the basic and the organising themes cutting across all narratives, have been pointed out, it is important to describe the 'subjective theories' the two subgroups of participants presented. Two 'subjective theories' emerged from our interpretation of the narrative material. Their differences were not immediately evident but the significant ones rest on the psychosocial well-being outcomes they presented.

First subjective theory

Four participants - all of them nurses- made sense of their professional experiences in the UK through the first subjective theory (see Table 2). Its main point was that all four participants claimed to have activated various resources to cope with the problems they faced and that all discussed having positive psychosocial well-being. This group made sense of their professional experiences by discussing accreditation, recruitment and acculturation problems, resources they activated to cope with these problems and their improved psychosocial well-being.

PLEASE INSERT TABLE 2 HERE

In this subjective theory, the basic themes referred to accreditation of qualifications and recruitment, and in particular how these depended on migration status. Other issues, such as initial problems of acculturation were also raised. With regards to the organising themes, there were several resources the participants said they used, such as adapting one's interactional style at work, and improving health literacy. Finally, this theory contained a positive psychosocial outlook, since this group presented itself as resilient, hopeful for the future and overall satisfied with their post-migration life.

In the next quote, a nurse discussed the difficulties of acquiring a permanent healthcare post (compounded by his temporary status). He confronted this issue by cultivating two CHC elements, that is, by choosing to actively strengthen his knowledge in psychiatry and by being future-oriented:

> *'I am working as a carer but it's part-time, it's not enough. I also do voluntary work,* because I am willing to increase my knowledge of psychiatry. If I go to work in a factory *or something I'll be missing all my education so I want to be inside the* medical field and then get full-*time work... I'll get my goal, because I'm willing...and* patient... They sent me a letter and said they are processing [the asylum claim] so I *can't say* when...Some people get into depression. I know doctors [from my country] that became mentally sick. Like me, they waited for a good document [and did not get it]. But I continue with what I do...*'* (male nurse, carer in support agency, LLR)

In another participant's narrative about the difficulties of securing a post as a hospital nurse, there is an example of cultivating a different CHC element, namely adapting her interactional style at work and eventually emerging as resilient and satisfied in her post:

> *'*When I came here I told myself I am going to work in a care home and then maybe go back into a hospital. After two years I tried applying for the post. I went for interviews four or five times and they would ask do you have the adaptation course. I would say no… *And then also when you're working in a care* home you know, you are not a nurse. This is the thing I noticed and then it took me time to say you know what, *you're* a foreigner and you are not working as a nurse in a hospital, but I am here *and it's* been fine*'* (female, nurse in private care home, work permit)

Second subjective theory

The remaining six participants - all five doctors and one nurse - made sense of their professional experiences in the UK by focussing on difficulties they experienced as they were trying to enter the British labour market, failed efforts to activate resources and subsequent negative psychosocial well-being (see Table 3). This group made sense of their professional experiences by discussing accreditation, recruitment and acculturation problems, failure of activating resources to cope with these problems and declining psychosocial well-being.

PLEASE INSERT TABLE 3 HERE

In this subjective theory, the basic themes evolved again around the issues of accreditation of qualifications and recruitment, and in particular how these depended on migration status. Then the participants discussed the resources they attempted to activate to cope with some of their difficulties, but it was noteworthy that especially for professional development issues, they highlighted how they failed to attain the state they were aiming for.

With regards to psychosocial well-being these interviewees presented themselves as lacking the confidence to overcome difficulties and being dissatisfied with their professional life in the UK.

In these participants' accounts, there is a sense of failure of utilising CHC, despite making concerted efforts to do so. For example, one of the doctors made reference to two CHC elements while narrating how he tried to cope with his problems: an orientation towards the future and its control through action (as he kept trying for different jobs which matched his qualifications) and a clear sensitivity to interpersonal dynamics (as he did not want to insult his friends who had lower skills). However, he expressed shame about his current professional stagnation and anxiety about his future. He revealed his hurt pride and his subsequent depression because despite his credentials and the on-going efforts he could not find a medical post in the NHS:

> 'Then I was applying for jobs here and there, one position with Oxfam, monitoring *evaluation, that's my specialisation, and also with a PCT in London, a position of*

*Public Health Information Officer there. With Oxfam, I didn't even get a*n interview. *With the PCT I got one interview, but I didn't do well,* my English or my presentation skills were still not good...then *friends told me 'Why don't you work in the supermarket?' I was controlling myself not to say anything...They are graduates* but *not in any profession, so they don't understand how we build up our professional pride...Even if I'm not qualified here as a medical doctor, still as a public health* professional, I am qualified to work somewhere and I am still getting interviews...But *it's quite depressing, I feel this is quite difficult'* (male doctor, project officer in private healthcare agency, LLR)

Another doctor made also reference to feeling shame due to professional exclusion. In the next quote, he narrated that despite his efforts to cultivate the CHC element of adaptability, he was not given the opportunity to convey his skills as a medical doctor in the UK:

*'*I am capable of work in my profession. In my home country I was working as a head *of the hospital, but I don't want to be head of the hospital here in London because… they won't give it to us. Because of the age, the race, the status, because there is no racial equality. So we don't expect these things, but this diploma I have, put it in a* pharmacy department, see if I was *capable of work, if not, fine. But they didn't give us* a chance, they should use us in a positive way to help ourselves and to help this country... *So it's a shame for us, a shame for the profession and shame for all those* people who see us like that*'* (male doctor, employed as a consultant in local clinics, refugee status)

Finally, a doctor employed in the NHS discussed his frustration of not being able to advance his career in the current post because, despite his enterprising disposition, his contribution remained unacknowledged due to differential treatment:

'The other thing this organisation doesn't do well is talent management. Clearly I've managed quite a few things and I've actually done well on the change management programmes... every time they nee*d somebody I'm always approached. But when I try to make that as a permanent career I'm always told there isn't a permanent need* so that pushes me back...*because I'm from that country and we're classified in that bracket it's a much tougher road than peop*le from the EU... and the biggest *frustration I have doing this role is it's still not considered a strategic priority, and...*

it doesn't help at all in terms of confidence building' (male doctor, NHS strategy manager, Highly Skilled Migrant)

DISCUSSION

Our study is limited by its small sample and disparate background of participants therefore we need to be cautious not to draw conclusive explanations about the professional experiences of overseas doctors and nurses in the UK. Also, although we attained inter-judge reliability, participants did not validate our interpretations, mainly due to the difficulties of researching mobile populations such as migrants and refugees, who may face added work and childcare restrictions to be able to meet with the researcher more than once. Despite these limitations, our findings add in-depth knowledge to an expanding body of research related to health workforce development and highly skilled migration, and offer an alternative way to conceptualise professional experiences and career development.

Overall, our findings show the crucial role of migration status in overseas nurses' and doctors' professional progression in the UK. Indeed, participants with a 'temporary' migration status experienced barriers and delays as they tried to develop professionally, while those with more permanent status progressed in the most linear and fast way. The finding that migration status largely shapes foreign-born professionals' labour market participation and employment routes in the UK confirms previous research (Bloch, 2004).

Despite the above similarity between doctors and nurses, there was an obvious discordance between them in terms of professional development and psychosocial well-being: doctors appeared to be more negative about their professional prospects, despite the fact that some had 'succeeded' in initiating a career in the UK healthcare sector, and expressed dissatisfaction with life in the UK. Actually two participants discussed how they often felt depressed and two others - one of whom was preparing to leave the UK- emerged as deeply disappointed. On the other hand, nurses emerged as psychosocially adjusted despite the initial difficulties they faced and their admittedly slow professional development. All but one nurse (who appeared psychosocially vulnerable but due to specific family circumstances) discussed being overall satisfied with life in the UK.

This difference between the two professional groups could be attributed to psychosocial factors such as perceived and experienced discrimination. However, these factors have been identified in relation to both doctors (Esmail, 2007) and nurses (Larsen, 2007) so they could not explain differences in the two groups' well-being.

Structural factors could provide another explanation, as identified by sociological discussions of power in caring professions (Hugman, 1991). Such factors are traced back to the historical dominance of medicine which restrained other professions such as nursing from asserting their professional identity and seeking equal treatment to doctors. According to this analysis, nurses were often considered as 'semi-professional' and '*tended to "silence" themselves in* order to maintain the culture of the workplace' (Roberts, 2000: 74). The nurses in our sample could have been sharing this traditional view of their profession – an attitude possibly reinforced in the developing countries where most came from – perhaps therefore not holding high expectations about their career progression in contrast to doctors who were always considered having "a strong and unchallenged position in medical work" (Svennson, 1996). However, through this sociological perspective it is still unclear why doctors with 'unchallenged positions' emerge as psychosocially vulnerable.

Alternatively, doctors' low well-being could be attributed to their inability to utilise effectively their cultural health capital. More specifically, doctors emerge as psychosocially vulnerable as the 'deeply relational' (Shim, 2010: 4) aspect of their CHC has been affected by work relations and environment restrictions. The narratives of doctors who are EU citizens and work in the NHS suggest that the distorted doctor-patient interaction (where patients request prescriptions of 'happy pills'), the tight supervision (where one should work overtime without showing 'signs of weakness') along with competitive relations with colleagues, clearly constrain them. These observations agree with previous findings that overseas-trained doctors are constantly more supervised than UK-trained doctors because they are not trusted to use their discretion and in turn have low morale (Oikelome and Healy, 2007). It is highly possible then that the above interactional difficulties, compounded with the reality of the medical profession becoming more regulated (Case, 2011) lead doctors in our sample to share a strong sense of frustration and disappointment. Such observations allude to Foucault's thesis that 'power is everywhere', diffused and embodied in discourse, knowledge and

'regimes of truth' such as the highly regulated English medical environment (Foucault, 1991). Foucault points to a kind of 'disciplinary power' that can be observed in the administrative systems and welfare services; their systems of surveillance and assessment no longer require force or violence, as people learn to discipline themselves and behave in expected ways.

Our analysis demonstrates that the theoretical framework of CHC is a useful tool to consider the relationship of professional development and psychosocial well-being in participants' narratives and to expose structural and institutional barriers to career aspirations compounded by social inequalities faced by immigrant groups. As our examples from interviews suggest, CHC functions when overseas professionals can communicate cultural skills and attributes in ways that are recognised and usable to the healthcare systems.

CONCLUSION

Overseas healthcare professionals are a significant group of workers in the healthcare sector. Although they represent a great opportunity for diversification and multiculturalism of healthcare provision in the UK, their multi-faceted professional experiences and needs are not fully understood by the application of existing theories of acculturation and cultural capital; therefore, an integrative approach, such as the CHC, more specific to the healthcare context, is needed. Through our analysis we supported an integration of macro and micro perspectives (Larsen et al., 2005) and having established the usefulness and applicability of the CHC framework, we conclude with some recommendations for improving the professional experiences of overseas doctors and nurses.

It has been noted that the work-related experiences of highly skilled labour such as healthcare professionals are more favourable than that of unskilled labour because of their qualifications and bargaining power (Wickramasekara, 2002:3). This distinction is useful but should not divert attention from the vulnerability of overseas professionals trying to integrate in the healthcare sector (Bach, 2003). Indeed our findings highlight the urgency of alleviating barriers (such as the expensive and time-consuming conversion system) which thwart these professionals' entry in the workforce, and ensuring they have a steady career progression. This will benefit not only individual professionals but also contemporary communities who

require now a diverse workforce to attend to localized healthcare needs. In the current UK context, migration is not only greater in number in comparison to previous decades but also more diverse. This diversification of migrant populations' origin countries is beginning to impact on what diversity means and the policies to get the best from it (Kyambi, 2007), therefore progressive policies which will encourage highly skilled migrants' socio-economic inclusion are needed now as never before.

At the same time, it is necessary to attend to the professional advancement of overseas doctors and nurses who are fully employed. We know that maintaining one's professional identity plays a central role for highly skilled migrants in modern Western societies (Liversage, 2009). For healthcare professionals we also know that continuous professional development is crucial for their wellbeing (Dawson et al., 2009). This is especially the case for staff working in the NHS which has been changing not so much in terms of organizational structure but more importantly in terms of managerial - that is, disciplinary, ideological, negotiative and re-allocative - processes which can produce shifts in the balance of power between healthcare staff and managers with the locus of control having clearly shifted towards the latter (Sheaff, 2008: 16). Our findings highlight that maintaining sensitivity to interpersonal dynamics is crucial, in both clinical and interprofessional encounters. Attending to this will again benefit not only individual doctors and nurses but also the organizations and the communities they serve.

Further research drawing on CHC theory and with larger more ethnically diverse samples of overseas healthcare professionals is required to provide deeper understanding of how to use these populations' potential to the delivery of healthcare in the best possible way.

ETHICAL APPROVAL

The authors confirm that the conformed to the Declaration of Helsinki and the study was approved by by the Research Ethics Committee of the Faculty of Health, Social Care and Education which the authors are affiliated with.

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CONFLICTS OF INTEREST

None

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