

Les compétences culturelles du personnel infirmier formé à l'étranger : étude des problèmes et recherche de solutions

Elena Neiterman, Ivy Lynn Bourgeault

Les compétences nécessaires pour exercer la profession infirmière sont généralement évaluées par des organismes de réglementation professionnels, lesquels évaluent les normes d'éducation, les titres de compétences et l'expérience. Toutefois, la compatibilité *bureaucratique* fondée sur la vérification de documents et l'identification de l'expérience *clinique* ne coïncident pas toujours avec la compatibilité *culturelle* et la capacité d'agir en tant que professionnel de la santé selon les normes en vigueur dans un pays. Les auteures examinent les défis que peut entraîner l'absence de compatibilité culturelle dans l'intégration d'un personnel infirmier formé à l'étranger (internationally educated nurses [IEN]) et en transition vers un nouveau système de santé. Des entrevues semi-structurées menées auprès de 71 IEN et 70 interlocuteurs clés au Canada ont révélé que la question de la compatibilité culturelle du personnel infirmier immigrant comporte des défis particuliers pour les organismes de réglementation, le personnel infirmier immigrant et les employeurs. Des constats indiquent que les programmes de transition visant à accroître les compétences des IEN offrent une voie pour préparer ceux-ci à travailler dans un contexte culturel canadien.

Mots clés : personnel infirmier formé à l'étranger, compétences culturelles, compatibilité culturelle, expérience clinique, intégration du personnel infirmier

Cultural Competence of Internationally Educated Nurses: Assessing Problems and Finding Solutions

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Competency to practise nursing is typically assessed by professional regulators who examine educational standards, credentials, and experience. But *bureaucratic* fit based on verification of documents and determination of *clinical* competence does not always coincide with *cultural* fit and ability to fulfil the role of health professional according to a country's standards. The authors examine the challenges that lack of cultural fit can pose to the integration of internationally educated nurses (IENs) transitioning to a new health-care system. Semi-structured interviews with 71 IENs and 70 key stakeholders in Canada revealed that the cultural fitness of immigrant nurses presents a unique set of challenges for regulatory bodies, immigrant nurses, and employers. Bridging programs for IENs to upgrade their skills were found to be a means of preparing IENs to practise in the Canadian cultural context.

Keywords: internationally educated nurses, professional integration, cultural competency, Canada

What some people have said to me is that there's this kind of international . . . "a nurse is a nurse is a nurse" thing. Kind of an . . . imagined community of nurses . . . "We are nurses!" Almost like the international boy scout movement. [laughing] (from interview with a key informant)

Examining the cross-cultural transition of health professionals who migrate reveals an interesting paradox: Whereas the clinical management of health problems is considered universal, the skills and qualifications of the health professionals responsible for delivering health services are not. The assumption that the processes of diagnosis, treatment, and management of illness across different countries are similar is evident in the development of international practice guidelines. Yet the growing movement of health-care workers across the globe illustrates the diversity of the cultural and educational backgrounds of internationally educated health-care providers (IEHPs).

The assumption that "a nurse is a nurse is a nurse" has received its share of criticisms from scholars and nursing professionals (Acord, 2000;

Carpenito, 1995; Wieck, Dols, & Landrum, 2010). When health-service delivery rests on the belief that any nurse can be substituted for another, without regard for the utilization of their unique skills or the impact of substitution on health outcomes, the practice of nursing is devalued and specialty-specific nursing qualifications are disregarded. We argue that this assumption, which is embedded in the practice of recruiting internationally educated nurses (IENs), has come to be seen as problematic by both professional regulators and practising nurses. The profession of nursing is not situated in a social vacuum, and cultural differences often become manifest in the way that nursing is practised.

Competency to practise nursing or another health profession is typically assessed by professional regulators on the basis of educational standards, credentials, and experience. But *bureaucratic* fit based on verification of documents and determination of *clinical* competence does not always coincide with *cultural* fit and the ability to fill the role of health professional according to the standards and expectations of every country. In this article we examine the challenges that lack of cultural fit may pose to the integration of IENs into a new health-care system. Specifically, we explore (1) the ways in which international models of nursing differ from Canadian ones and the challenges that arise from cultural differences, and (2) policy solutions aimed at preparing IENs to work in Canada. We begin with a review of the literature on the migration and professional integration of nurses. After briefly describing our methodological framework, we present our findings. Summarizing the data from interviews with IENs and a range of policy stakeholders, we demonstrate that the issue of cultural fit among IENs presents a unique set of challenges for professional regulators, immigrant nurses, and employers. In conclusion, we reflect on the role of cultural competence in the integration of IENs and propose some practices for facilitating the successful adaptation of IENs to Canadian health care.

Literature Review

The increased mobility of nurses has received growing attention in both the academic and the policy literature. One research topic is the reasons for and motives behind nurses' migration. Much of this research explores the relationship between "push and pull" factors — the various difficulties experienced in the country of origin (e.g., poor working conditions, political or economic instability) and the attractive features of the destination country (e.g., higher living standards, higher salaries, political or economic stability) (Buchan, 2006; Khaliq, Broyles, & Mwachofi, 2008; Klein, Hofmeister, Lockyear, Crutcher, & Fidler, 2009; Rasool, Botha, & Bisschoff, 2012). Although this approach is often described in the migra-

tion literature, the relationship between push and pull factors and the dominance of some factors over others remain relatively unexplored. It has been noted, for instance, that pull factors alone do not account for the mass exodus of nurses from low-resource countries and that push factors are often the reason why nurses migrate (Kingma, 2006). Therefore, a country concerned about nurses migrating might do best to focus on improving working conditions for nurses, including remuneration and the safety and security of their work environment.

The impact of nurses' migration on a country's economy and overall development is often discussed in the context of the ethical aspects of migration or the "brain drain" from low-resource countries and the "brain gain" to high-income countries (Ahmad, Amuah, Mehta, Nkala, & Singh, 2003; Likupe, 2013; Ogilvie, Mill, Astle, Fanning, & Opare, 2007). Researchers and political activists raise ethical questions related to recruitment of nurses from the developing world, which already faces significant shortages of nurses and physicians (Hawkes, Kolenko, Shockness, & Diwaker, 2009; Mackey & Liang, 2012). Low-income countries cannot compete with rich states in terms of the conditions offered to nurses. Researchers have documented the mass emigration of nurses from developing countries through the recruitment practices of high-income countries (Ahmad et al., 2003), while others have traced this movement to the culture of migration fostered through colonization by the imperial West (Hagopian et al., 2005). Finally, while some states look for ways to retain their nursing and medical workforce, others promote emigration since migrant workers often contribute considerably to private households in their country of origin through remittances. According to the International Council of Nurses, IENs regularly send remittances to their home country, which helps to explain why the Philippines, India, and China produce nurses for international export (International Centre on Nurse Migration, 2007).

Along with research on the reasons for and patterns of nurse migration, there is growing interest in the experiences of IENs in the destination country. IENs can face racial discrimination in the host country (Alexis, 2012; Diccico-Bloom, 2004; Higginbottom, 2011; Newton, Pillay, & Higginbottom, 2012). For example, Diccico-Bloom (2004) explores the racialization and discrimination experienced by Indian nurses in health-care facilities in the United States. IENs of colour in the United Kingdom also report discrimination (Allan, Larsen, Bryan, & Smith, 2004). In Canada, nurses from African countries working in the provinces of Quebec and Ontario have similarly been subjected to racism and discrimination (Calliste, 1996).

Although the research cited above touches upon issues related to nurse migration, it deals mainly with nurses who are planning to emi-

grate or are already integrated into the health sector of the host country. The role played by culture in hindering or facilitating integration of IENs into the health-care workforce remains relatively unexplored, although a few studies have concluded that culture can be a challenge to integration (Baumann, Blythe, Rheaume, & McIntosh, 2006; Kingma, 2006). Baumann et al. (2006) explored the experiences of IENs in Ontario. They report that failure to pass Canadian regulatory nursing examinations, a necessary step in obtaining a licence, can result from IENs' lack of familiarity with Canadian nursing culture.

Although the literature does acknowledge that culture may become a barrier to successful integration (Baumann et al., 2006; Kingma, 2006), the issue of cultural "fit" has not been sufficiently problematized. Cultural differences between IENs and domestically trained nurses can stem from a number of factors. First, IENs, like other immigrants to Canada, come from a diverse array of countries. While some of these countries adhere to Western ideals, others have different sets of beliefs and ideologies. For instance, not all countries promote gender or ethnic equality, gay rights, or religious freedom. Such personal beliefs and attitudes have been found to impact nursing practice (Harling & Turner, 2012) and thus can become a challenge for the professional integration of IENs whose cultural ideologies vary from those of the host country.

In addition to the cultural influences of IENs' country of origin, there are cultural differences in the models of nursing education and practice. Depending on the jurisdiction, nursing credentials can take the form of either a diploma or a degree, and even within these categories there is considerable variability in nursing qualifications across the world (Kingma, 2006). In some countries the role that nurses play within the health-care system is very different from the role they play in Canada. Adapting to not only the culture but also the model of nursing practice in Canada is therefore a challenge for some IENs.

Even those IENs whose cultural values are similar to those of Canadian nurses and whose education and training are consistent with Canadian nursing standards may experience challenges during professional integration. Nursing practices can differ from one workplace to another and especially from one country to another (Bourgeault, Neiterman, LeBrun, Viers, & Winkup, 2010). For instance, IENs from the United States may share cultural values and nursing practice models with nurses in Canada yet still need time to adjust due to differences in the health-care system, which is publicly funded in Canada and predominately privately run in the United States.

Exposure to different cultural ideologies, variability in nursing education and training, and diversity in nursing practice styles can affect the integration process. The purpose of this study was to examine the role of

cultural fit during the process of professional integration. The concept of “cultural competence” is gaining ground in nursing education, reflecting the importance of showing cultural sensitivity and respect when providing nursing care to diverse communities of patients (Betancourt, 2007; Boyle, 2007). The discussion on cultural competence, or “the ability to provide effective care for clients who come from different cultures” (Anderson, 2001, p. 1), is usually concerned with the relationship between nurses and their patients (Betancourt, 2007). Nurses are encouraged to acknowledge the cultural diversity of their patients and to be sensitive to different customs and traditions. Cultural education is often seen as inseparable from nursing curricula (Harrowing, Gregory, O’Sullivan, Lee, & Doolittle, 2012). In applying the concept of cultural competence to the analysis of professional integration of IENs, we ask how and why cultural competence of internationally trained nurses becomes a challenge in their professional integration.

Methodology

Semi-structured, qualitative interviews centred on the experiences of professional integration in Canada were conducted in 2007–08 with 71 IENs residing in British Columbia, Manitoba, Ontario, and Quebec. The IENs were recruited through professional associations, immigration communities, advertisements in professional publications, and snowball sampling. Approximately two thirds were practising at the time of the interview and the remainder were in the process of obtaining a professional licence. The majority of the IENs had arrived in Canada between 2000 and 2005 ($n = 60$), while 11 had arrived between 1992 and 1999. They were born and trained in 29 different countries, including Australia, New Zealand, the United States, and countries in Africa, Asia, the Caribbean, Eastern and Western Europe, the former Soviet Bloc, and the Middle East. The three most common regions of birth and training were the United Kingdom and other countries in Western Europe (Belgium, Finland, France, Switzerland) and Eastern Europe (Bosnia, Moldova, Poland, Romania, Russia, Ukraine). Twelve IENs either were not trained in their country of birth or practised nursing in more than one country prior to arriving in Canada. The majority of IENs entered Canada as skilled workers or with a partner, and only a few had refugee status. Some were recruited abroad to work in Canada and some arrived through an independent immigration process. Approximately one third ($n = 23$) began to work as an IEN within 2 years after arriving. Roughly one third self-identified as a member of a visible minority. The vast majority were between the ages 30 and 49 and most ($n = 59$) were women. The interview included a set of demographic questions about age, sex,

country of origin, country of training, year of entry to Canada and immigration category, type of licence obtained (if any), family status, and, where relevant, ages of children. The remainder of the questions were open-ended and focused on the participants' experiences of immigration and integration, from the decision to leave their country of origin to their arrival in Canada and the licensing process. The interviews, which lasted from 60 to 90 minutes, were conducted in person or by phone and were recorded and transcribed verbatim.

The protocol for the study was approved by a research ethics board. The participants were informed that the information was being collected for academic research purposes, that all records would be kept confidential, and that participation in the study would have no implications for the interviewee's licensing or practice. Although participants were very forthcoming during the interviews, it is possible that some did not fully share their negative experiences in Canada for fear of endangering their professional integration.

In addition, 70 short, semi-structured interviews were conducted with federal and provincial stakeholders purposively sampled to include members of professional associations, provincial regulators, government officials from immigration and health offices, and other key figures involved in the process of IEHP integration. These participants were recruited from federal organizations (e.g., Citizenship and Immigration Canada, Human Resources and Skills Development Canada) and provincial regulatory bodies, professional associations, and educational institutions where IENs were updating their training. The provincial key informants were recruited from British Columbia, Manitoba, Ontario, and Quebec. These interviews were conducted exclusively by phone. They lasted from 30 to 60 minutes and were recorded and transcribed verbatim.

The two data sets were analyzed separately using NUD*IST 6, a computer program for managing qualitative data. The analysis of interviews with key informants was based on unstructured, "free" coding, which was later modified into structured coding and reflected the relationship between different thematic categories. The theme of cultural competence as a challenge to professional integration emerged from the analysis in this fashion — that is, it was not an a priori code.

The interviews with IENs were analyzed using NUD*IST 6 as well and the data were approached as a new data set. The interviews were read and coded using unstructured, free coding and later reorganized into structured coding reflecting the relationship between analytical categories. The two data sets differed in content, reflecting the differences between the interviews describing the personal experiences of IEHPs and the more structured interviews with key informants describing the

roles of their organizations in the integration process. We compared the accounts of IENs and those of stakeholders related to the issue of cultural competence and found that both groups perceived it to be a crucial factor for successful professional integration. We identified two inter-related themes: (1) cultural differences as a challenge to professional integration, and (2) policy solutions to address the challenges posed by cultural differences in nursing. In the following two sections we describe the findings as they relate to these two overarching themes.

Cultural Differences as a Challenge to Professional Integration

Lack of Fit

The first step in becoming a practising nurse in Canada is passing the credential assessment by provincial regulatory bodies. The registration process in the different provinces/territories is generally similar: Every nurse wishing to practise in Canada must provide nursing credentials, be qualified to practise nursing in her country of origin, have practical experience and language proficiency, and pass the Canadian Registered Nurse Examination (CRNE) (College of Nurses of Ontario, 2012) or, in Quebec, l'Examen professionnel de l'Ordre des infirmières et infirmiers du Québec.¹ When applying for registration, often nurses must have their level of nursing qualification determined before submitting the application to the regulatory body. The different educational models used in different systems and the different nursing qualifications pose the first barrier for IENs wishing to work in Canada. They make it difficult for nurses and professional regulators to determine the skills and qualifications of IENs:

[The College of Nurses said,] "We're not going to accept your education. You have an associate degree in nursing and that's not equivalent to anything here" . . . So I said, "Well, I have 15 years of nursing practice . . ." I had the associate degree in nursing . . . and it didn't fit the normal mould . . . they just didn't know how to assess my education. They didn't know what to make of me. (IEN practising in Ontario)

The nurse quoted above, who was an immigrant from the United States and knew the regulatory system well enough to navigate it, managed to have her credentials approved. However, many IENs, especially those who had been recruited abroad and were not familiar with the local educational requirements, did not realize that the licence

¹ While some nurses may be required to pass the Canadian Practice Nurse Registration Examination, none of the nurses among our respondents were writing this exam.

assigned to them by the regulatory bodies was below their qualifications until they began to practise in Canada.

Language Proficiency

Another key barrier to the integration of IENs is the language proficiency requirement. Fluency in English or French is a crucial factor for successful professional integration. There are a number of language proficiency tests approved by provincial nursing regulatory bodies. Some of our key informants, however, pointed out that the majority of these do not assess for ability to work in health care:

English-language deficit is a primary problem for people [seeking] licensure. So a number of our applicants had their credentials assessed, but what they lacked was the ability to pass English-language assessments . . . And [often even if] they have passed their English assessment they are not seen as meeting the . . . level of functioning that the employer wants. And there's a differential between what an academic test tells you about competency and what the employer demand is. (stakeholder from provincial regulatory body)

Thus a general knowledge of English or French does not necessarily mean that an IEN is familiar with nursing terminology, which can include acronyms and culturally specific terms. This concern was often reflected in IENs' own assessment of their language competency. As pointed out by a nurse from the United Kingdom, even native English speakers can be confused by Canadian nursing language:

We [in the United Kingdom] don't abbreviate stuff. So . . . you'll hear a lot of people in the workforce talking about certain abbreviations and you're kind of, like, well, what does that mean? . . . Different names for the same drugs . . . or the same thing but completely different words. (IEN practising in Manitoba)

Because general language tests do not assess the individual's knowledge of nursing language, many IENs are forced to learn nursing language "on the go," which can pose problems not only for professional integration but also for clinical care.

Nursing Licensure Examinations

A major hurdle for IENs on the way to professional integration is passing the licensure exam. The pass rates for IENs are considerably lower than those for Canadian-trained nurses (Baumann et al., 2006). Some scholars argue that IENs have lower pass rates because they are at a disadvantage due to language deficits, unfamiliarity with the nursing culture and ter-

minology, and unfamiliarity with the multiple-choice exam format (Baumann et al., 2006; Bourgeault et al., 2010).

The interviews with IENs revealed that indeed language posed a challenge when it came time to write the exam. Because of one's reading speed in English and wording nuances, clues to the correct response (e.g., the nurse *advises* the physician or *informs* the physician) could be missed in the stressful exam environment. However, most of the difficulties reported by our interviewees had to do with the culturally specific questions on the exam. For many IENs who expected to be tested on their knowledge of practical skills and medical knowledge, the cultural questions were a stumbling block:

It's very hard to choose the right answer because they're all right and you have to choose the most right answer, and it's, like, oh, my god! . . . I had a question on exam, they're saying that your patient passed away and [the relative is] crying . . . she's looking down and crying and you come to her and what is your response? The first option is to put your hand on her shoulder, another is to hold her hand, and another one I can't remember. But it all sounds, like, right . . . it all sounds logical . . . I expected . . . too many questions about some pharmacology and about the calculations and about . . . some diseases, but it wasn't that hard. The big part is the cultural. (IEN practising in Manitoba)

Our respondents found the cultural component of the exam to be more challenging than the clinical aspects. They felt sufficiently prepared for questions related to pharmacology or anatomy but not for questions about nurses' interactions with other health professionals or with patients. This may have stemmed from their unfamiliarity with the culture. For instance, one IEN recalled a question about the most appropriate toy for an autistic child and not knowing how to respond because she did not know what a Jack-in-the-Box was.

Local Model of Nursing Practice

The cultural model of nursing practice was identified by both IENs and key informants as posing a challenge to integration:

What people perceive as a nurse in some countries is not what a nurse is in Canada . . . [We have] different roles that people play in nursing, different roles in terms of advocacy, specifically. Other countries don't play an advocacy role on behalf of their patients and that's an expectation here . . . Maybe in their country nursing is, dare I say, a little bit of a subservient role, and it's much more autonomous here and there's some struggle in that. (stakeholder from regulatory body)

Nurses' degree of autonomy varies widely from one health-care jurisdiction to another. While in some health-care systems nurses are not free to question a physician's authority, the orientation of Canadian nursing is to strongly advocate for autonomy:

[In Canada] nurses have authority and scope to function at an independent level on a collaborative team, and the individuals that come to us from other countries for the most part do not do that. They're not an equal player on the health-care team. And so . . . they don't necessarily have the skills to . . . challenge a physician if they know something is wrong. (stakeholder from provincial educational body)

Some of those things . . . from my home nursing . . . were, like, off-limits . . . In Nigeria you don't advise the physician. You just inform . . . You inform the physician of patients' results. You inform and not advise. Advise is like you being the authority. (IEN practising in Manitoba)

Coming from a variety of nursing cultures, the IENs often found that procedures, the use of technology, and communication between nurses, other health professionals, and patients did not reflect their own experience:

In the Philippines you have more power [over] the patients . . . you can tell what is the best for them. But here the patient is the one who is going to decide what is the best . . . you are here only . . . to explain what is available that you can offer, and then if they don't agree you cannot force no matter what, because it is their own life. (IEN practising in Manitoba)

The main differences, as identified by our respondents, between the Canadian model of nursing practice and the models imported by the IENs revolved around nurses' communication with physicians and patients. Whereas for some IENs the role of patient advocate was familiar, for others it was a new role they had to learn upon entering practice. This was a challenge for IENs who had been trained in a health-care system with different relationship structures with regard to physicians, nurses, and patients.

We have demonstrated that many of our key informants and IENs viewed the model of nursing practice, familiarity with the Canadian nursing landscape, and language skills as playing a large part in professional integration. Next we describe a number of policy initiatives that address the issue of cultural competency of IENs and these challenges.

Policy Solutions: Facilitating Integration of IENs

In recent years health and immigration policy-makers and the Canadian public have become increasingly concerned about the issue of “brain waste,” which reflects the lack of professional integration of internationally educated health professionals (IEHPs) (Bourgeault, Neiterman, & LeBrun, 2011). Federal and provincial ministries, regulatory bodies, and professional associations have invested in developing strategies to better accommodate IEHPs in Canada. In 2005–06, for example, Health Canada established the Internationally Educated Health Professionals Initiative to facilitate the process of integrating IEHPs through collaboration with provincial bodies and professional associations (Health Canada, 2010). The Foreign Credentials Recognition program, an initiative of several federal departments, helped streamline the process of credentials verification. Finally, the Canadian Nurses Association’s LeARN program offers preparation and a study guide for the licensing exam, the CRNE Readiness Test, and links to Web-based courses on language and nursing practice (Barry, Sweatman, Little, & Davies, 2003).

Not all policy solutions that have sprung up in the past decade address the issue of cultural integration of IENs, but some do provide useful tools. For instance, by collecting as much information as possible about the registration process in Canada via the Web sites of professional associations and regulatory bodies, IENs can become informed about cultural aspects of Canadian nursing practice. Some of our respondents revealed that they studied diligently for the registration exam while still in their country of origin. Our respondents found that language courses specifically designed for IENs and offered in some provinces were a useful tool for upgrading their language skills.

Our interviewees found that the best way to learn about Canadian culture was to enrol in a bridging program. Bridging programs address the gaps in the skills of IENs and prepare them for practice in Canada. They include language and cultural training, exam-preparation courses, and measures to fill gaps in clinical and academic knowledge (see Table 1). We will now describe the specific role of cultural education in some of the bridging programs developed for IENs.

Cultural Competence

Knowledge about Canadian nursing practice is what our key informants referred to as “cultural competence.” Our findings indicate that lack of cultural competence is increasingly being viewed by Canadian stakeholders as a challenge to the integration of IENs and that bridging programs have become a key tool for addressing not only clinical gaps but also cultural gaps among IENs.

Table 1 <i>Bridging Programs, by Province/Territory</i>					
Province / Territory	Services Offered				
	Language Courses	Academic Courses	Clinical Experience	Exam Preparation	Counselling
<i>British Columbia</i>					
International School of Nursing and Health Studies	✓	✓	✓	✓	✓
Kwantlen University	✓		✓	✓	✓
Vancouver Community College	✓	✓	✓	✓	✓
Open University	✓		✓	✓	✓
Omni College	✓			✓	
<i>Alberta</i>					
International School of Nursing and Health Studies (Psychiatric Nursing)		✓	✓	✓	✓
Norquest College (in development)					
Grant McEwan College	✓	✓	✓	✓	✓
Mount Royal University (research project)	✓	✓	✓	✓	✓
<i>Saskatchewan</i>					
No programs identified					
<i>Manitoba</i>					
Canadian Nursing Tutorial Services	✓			✓	
Red River College	✓				

Ontario					
Care for Nurses	✓	✓	✓	✓	✓
Algonquin College	✓	✓	✓	✓	✓
Quebec					
No programs identified					
New Brunswick					
6 to 8 weeks' supervised clinical experience required			✓	✓	
Nova Scotia					
CRNNS program in development					
Prince Edward Island					
No programs identified					
Newfoundland and Labrador					
No programs identified					
Northwest Territories					
No initial licensure					
Yukon					
No initial licensure					
National					
LeaRN CRNE Readiness Test				✓	
Canadian Practical Nurse Registration Examination Predictor Test				✓	
<i>Source: Association Strategy Group (2005).</i>					

The inclusion of cultural education in the curriculum of bridging programs was supported by all of our participants. Many of these IENs were grateful to have had an opportunity to enrol in bridging programs and were confident that these helped them to obtain their licence:

There's just so much information . . . I'm glad I did it [enrol in the bridging program] because if I [hadn't I wouldn't have been able to] pass the [licensing] exam for sure. In my opinion everybody should take these courses. (IEN seeking professional integration in Ontario)

Upon completion of nursing bridging programs, which can range from several weeks to 6 to 12 months in length, IENs are generally prepared for the licensing exam. While in some situations bridging programs are compulsory (when assessment reveals lack of a specific set of competencies), in other cases nurses take the courses voluntarily. The nurse quoted above, for instance, decided to remain in the program, even after she passed the licensing exam, in order to learn more about Canadian nursing culture prior to applying for a position. However, bridging programs operate on limited funding, which often is renegotiated yearly with local governments and funding agencies. Therefore, prioritizing the focus of bridging programs is unavoidable. Not surprisingly, cultural education is not always given priority and made accessible to IENs:

We're finding that even individuals that do get licensed . . . tend to have some stumbling blocks when it comes to integrating well into the workplace . . . Even after internationally trained nurses graduate [from] the programs and become registered with the College . . . they still have a difficult time in the workplace . . . I've heard this from a number of bridging programs — they're focused on the exams . . . that's their primary focus. And the other issue is . . . well, you have to understand the [cultural] difference . . . I'm being broad here, but those types of issue are really sort of secondary. (stakeholder from provincial government)

As Table 1 suggests, there is no common curriculum among the different bridging programs. While some programs emphasize cultural competence, most concentrate on clinical skills or language proficiency. Also, regional differences in program availability and accessibility make it hard for IENs to attend and inconsistency in funding makes it difficult to recruit and retain educators and participants.

Recently the Canadian Nurses Association announced that the Canadian Association of Schools of Nursing (CASN) would create a Pan-Canadian Framework of Guiding Principles and Essential Components for IEN Bridging Programs (“Bridging the gaps,” 2012). This project is intended to streamline bridging education, and currently a number of bridging programs are testing an assessment tool developed

by CASN to streamline the bridging curriculum. If implemented within the next 2 years, as planned, this could become a useful tool for developing bridging education that addresses the cultural needs of IENs and that provides some consistency in bridging programs offered to IENs.

Finally, a considerable number of IENs are recruited abroad to work in Canadian hospitals. Having signed a contract with the hospital, these nurses are generally expected to begin work within weeks or even days of their arrival. They usually receive orientation in the hospital that employs them. The length and content of the orientation vary from one health-care setting to another.

In summary, evidently many IENs receive cultural orientation in the Canadian health-care system before they begin their professional practice, but the content and structure differ widely among provinces/territories, bridging programs, and local hospital settings.

Discussion and Conclusion

Our study of how the cultural differences in nursing practice impact the process of professional integration for IENs in Canada reveals that many nurses have difficulty adjusting to the Canadian practice model. When navigating the registration process, some IENs find it difficult to understand the different levels of nursing in Canada, which often delays the integration process. Language proficiency remains a central challenge for many IENs, including nurses who are native speakers of one of Canada's official languages (English and French) but are unfamiliar with Canadian nursing terminology. Finally, one of the biggest impediments to IENs passing their exams and becoming successfully integrated into the Canadian health-care system is the differences in the model of Canadian nursing practice compared to models prevalent abroad.

Bridging programs are an important means of introducing nurses to the Canadian health-care system and helping IENs to overcome the challenges they face in the process of professional integration. Due to financial constraints, however, these programs are not always available and accessible to IENs wishing to upgrade their skills. Moreover, duration and content differ greatly from one program to another, and therefore quality and comprehensiveness — particularly vis-à-vis cultural context — are not guaranteed. It is possible that CASN's new initiative to streamline bridging education will mitigate this challenge, but there is still considerable variability in the curricula of bridging programs.

Bridging programs are not mandatory for IENs entering practice in Canada. Some nurses, including those recruited abroad, receive orientation (of varying duration) in the workplace before commencing work. These nurses are essentially left to learn Canadian nursing practice on the

job, which can prove difficult. Due to the nature of our sample, we were unable to explore the different ways in which cultural fit acts as a barrier for IENs who were recruited abroad and those who arrived in Canada without pre-arranged employment. Future research could address this question.

Policy Recommendations

Our findings suggest a number of policy recommendations for addressing cultural gaps and better preparing IENs for Canadian practice.

First, accessibility needs to be increased and more opportunities need to be provided for IENs to enrol in a bridging program. Also, the content of bridging programs should be augmented to meet both clinical and cultural competency needs. As noted above, the CASN initiative is promising in this regard. Given that the need to develop bridging education for IENs is not unique to Canada, it would be beneficial to learn from integrative initiatives in other countries. In the United Kingdom, for instance, IENs must complete a 20-day Overseas Nursing Program and can also, occasionally, be required to undergo a period of supervised practice that can last anywhere from 3 to 12 months.² In the United States, the Transitioning Internationally Educated Nurses for Success program developed at the University of Pennsylvania has been suggested as a model for national bridging programs (Adeniran et al., 2008).

National bridging programs may not be feasible or practical in Canada, where health-care delivery and professional regulation fall under provincial jurisdiction. Nevertheless, a pan-Canadian collaborative effort to streamline bridging education could benefit all parties, especially in smaller provinces with more limited resources and a smaller pool of IENs.

While streamlining of bridging programs seems to be on the policy agenda, the orientation provided by employers also needs streamlining. Although orientation is usually offered in the workplace, creating dialogue between employers and learning lessons from each other could be fruitful ways to begin developing an orientation process that better prepares IENs for practice.

We do believe that collaboration between all parties involved can facilitate the integration process for IENs. Admittedly, the assumption that “a nurse is a nurse is a nurse” can simplify and speed up the process of integrating IENs into the health-care system. But this assumption is also known to cause problems: Unfamiliar with local practice culture, IENs

²Due to standardization of nursing education in European Union countries, nurses from EU and EEA countries are exempt from this requirement.

often find it difficult to navigate the system, which can create problems at the managerial level, complicate inter- and intra-professional interaction, pose challenges to communication with patients, and raise numerous safety issues.

Finally, the cultural diversity of IENs should not be seen only as a disadvantage:

Right now, the emphasis is on how the internationally educated professional must change. And it disturbs me no end that we are not looking at that as a partnership with [immigrants]. Transition and integration is only going to happen effectively if it is seen as a sharing and a gaining and an expanding of the system's capability, not just [as] how can we make these people turn into our cookie-cutter nurses? (stakeholder from nursing regulatory body)

Once the concept of cultural competence is applied to the assessment of IENs' readiness to practise, it can be used in two ways. The first is to define what is lacking in the education, qualifications, and experience of IENs. Bridging programs and other policy initiatives could target these gaps when developing curricula. The second is to ask what is lacking in *our own* education, qualifications, and experience. We rarely ask this question, and the answers might help us to not only integrate IENs more successfully but also improve our health-care systems.

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