Internationally trained pharmacists: their contribution to, and experiences of, working in the Great Britain labour market

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Abstract

Background – In Great Britain (GB), international recruitment has been one of the methods used to tackle the shortage of healthcare professionals. Although research has been conducted on internationally trained nurses and doctors, studies on internationally trained pharmacists (ITPs) is limited. In the first stage of this programme of work, reasons for migration, experiences of work and future intentions of ITPs in GB were explored. Communicative proficiency of ITPs was then explored in the subsequent stages from the perspective of ITPs themselves, as well as that of pharmacy employers to see whether and how this has negative implications for patient safety.

Methodology – For stage one 29 semi-structured interviews were conducted with a purposive sample of 11 adjudication, 14 EU and four reciprocal pharmacists in Manchester and London. For stage two eight focus groups and two semi-structured interviews were conducted with 31 EU and 11 adjudication pharmacists in London, Manchester, Liverpool and Glasgow. For stage three, nine semi-structured interviews were conducted with seven community and two hospital ITPs' employers.

Findings - The findings confirmed that reasons for migration of ITPs are multifactorial. Motives were often, but not exclusively, economic or professional. In general, adjudication pharmacists are happy with the Overseas Pharmacists' Assessment Programme and the pre-registration training that they had received, while the EU pharmacists tended to be more critical of their adaptation programmes. While overall the reciprocal pharmacists were happy with their work experience in GB, EU and adjudication pharmacists' narratives included some dissatisfactory experiences. Communication was described as a daunting challenge, especially during the initial period after their arrival. ITPs experienced communication difficulties through new dialects, use of idioms, abbreviations and colloquial language. Most, however, were adamant that communication problems did not compromise patient safety. ITPs' employers described the importance of having processes in place to assure EU pharmacists' overall language proficiency in the workplace. However, strategies used varied in type and rigorousness.

Conclusion - This novel research provides a foundation for future work on ITPs in GB, and could assist employers to better target their efforts in development of standards to support the recruitment and the working experiences of ITPs in GB.

Declaration

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Last and not least I am grateful to my husband, Saeid. Your patience and endless support has encouraged me to keep going. Thank you for always being there.

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پایان سخن شنو که ما را چه رسید   از خاک برامیدیم و بر باد شدیم

Abbreviations

BME	Black and minority ethnic
CCLB	Centre for Canadian Language Benchmarks
CELBAN	Canadian English Language Benchmark Assessment for Nurses
CLB	Canadian Language Benchmarks
CPD	Continuing professional development
EEA	European Economic Area
ESP	English for Specific Purposes
EU	European Union
GB	Great Britain
GMC	General Medical Council
GP	General Practitioner
GPhC	General Pharmaceutical Council
HCA	Healthcare assistant
IELTS	International English Language Testing System
IPG	International Pharmacy Graduate
IRN	Internationally recruited nurse
ITD	Internationally trained doctor
ITP	Internationally trained pharmacist
LREC	Local Research Ethics Committee
MPharm	Master of Pharmacy
MUR	Medicine use review
NHS	National Health Service
NI	Northern Ireland
MCP	Model of Communicative Proficiency
NMC	Nursing & Midwifery Council
OCP	Ontario College of Pharmacists
OET	Occupational English Test
OSPAP	Overseas Pharmacists' Assessment Programme
PJ	Pharmaceutical Journal
RCN	Royal College of Nursing
RPS	Royal Pharmaceutical Society
RPSGB	Royal Pharmaceutical Society of Great Britain
SOP	Standard operating procedure
SPSS	Statistical Package for the Social Sciences
TOFEL	Test of English as a Foreign Language
UBELT	University of Bath English Language Test
UK	United Kingdom
US	United States
WRS	Work Registration Scheme

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Chapter 1

Introduction to the study

1.1 Rationale for the study

With 50,664 registered pharmacists, pharmacy is the third largest health profession in the Great Britain (GB), behind nurses/midwives with 562,071 and physicians with 214,534.[1-3] One of the main necessities of providing the best healthcare is the accessibility of enthusiastic and qualified professionals.[4] At the moment pharmacists are one of the most accessible of all healthcare professionals and they play a key role in the delivery of healthcare services.[5] This is due to the convenient location of many community pharmacies on busy high streets, which allows the public to simply walk in and seek advice from a pharmacist without the need for an appointment.

There has been a growing shortage of pharmacists in Australia, the United States (US), Canada, Norway and Ireland and this is no different in GB.[6-11] Expressed as the number of pharmacists per 100,000 populations, the pharmacy workforce in GB is not the highest compared with many other European countries; it has an average of 66 per 100,000 compared with, for example, 117 in France.[12] A scan of the vacancies advertised in the Pharmaceutical Journal (PJ) gives some indication of the number of unfilled posts that currently exist.

The growth in the over-the-counter market, prescription volumes and the elderly population, the extended roles of pharmacists, the new pharmacy contract and longer opening hours are some of the contributing factors to an increase in demand for pharmacists.[13;14] Shortages, in part, also reflect issues to do with emigration, the feminisation of the workforce, the aging workforce and the degree to which part-time working is undertaken.[7;15-18]

Some of the factors that affect the supply and demand of pharmacists, for example the growing number of elderly in the population, are issues that are unchangeable, so the shortage needs to be tackled in a different way. One of the obvious steps taken has been the dramatic increase in the number of Schools of Pharmacy in the United Kingdom (UK), as well as increasing enrolment in the schools originally offering the Master of Pharmacy (MPharm) programme.[19-21] Other steps have also been taken, for instance, using the skills of other pharmacy team members, such as pharmacy technicians to increase efficiency and free up more of the pharmacists' time.[22]

Another way to increase the number of pharmacists in GB is through increasing the number of internationally trained pharmacists (ITPs) who enter the GB and register with the regulatory body. ITPs are pharmacists who did not obtain their original pharmacy qualification or training in GB and increasing their number on the Register could boost the number of pharmacists available to the pharmacy workforce. When the Overseas Labour Office officially classified pharmacy as a shortage occupation in 1998 the process of employing overseas nationals became much easier, as work permit applications were simplified.[7;23] As a result of pharmacy's presence on the shortage occupation list, the proportion of ITPs on the Register has been rising: 10.1%, 10.3%, 11.1%, 11.3% and 12.1% in 2004, 2005, 2006, 2007 and 2008, until 2009 [a] when there was a slight decrease (11.2%) before the proportion went back up again in 2010 (12.1%).[2;7;27-29]

In 2009, Schafheutle and Hassell[27] published the first peer-reviewed study on ITPs in GB by conducting secondary research. Other than socio-demographic information from this work, little else is known about ITPs in GB. As far as can be established no empirical primary research has ever been conducted on this group of pharmacists in GB. There is no data available on, for example, why ITPs migrate to GB, how they are recruited, the permanence of their movement and the quality of care they provide to patients. Little is also known about the physical, psychological and social adjustments they have to make to integrate into, what is for them, a new culture and society. In addition, up until now, no research has been conducted to look at how employers recruit and train ITPs or whether they have had to deal with poor performance of an employed ITP and its consequences. Gaps in existing data limit our ability to fully understand the dynamics of pharmacists' migration, the country's reliance on this process and its broader impact on the workforce. A study into migration of pharmacists into GB is, therefore, novel and would contribute to the profession's knowledge of its workforce.

Although no previous primary research has been conducted into migration of pharmacists into GB, the topic has long been explored in medicine and nursing. Most of

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[a] On 15th June 2009 a decision was made to remove community pharmacists from the shortage occupation list leaving only hospital pharmacists (including hospital pre-registration pharmacists) on the list.[24] This decision was criticised by various pharmacy bodies.[24;25] On 16th March 2011, the community pharmacy was reinstated on the shortage occupation list.[26]

the literature from these two professions explores the reasons for migration and the work experience of these healthcare professionals in GB. Although lessons could be learnt from these professions, the differences between the medical/nursing and pharmacy profession (for example, internationally trained doctors and nurses are mainly employed by the National Health Service (NHS), unlike ITPs who mainly work in the private sector) could mean that their findings may not be applied in their entirety to pharmacy. Nevertheless, their findings can be used as a useful framework when researching the phenomena of pharmacist migration into GB.

The remainder of this chapter presents the background literature that informed this study. Section 1.2 describes the history of pharmacy in GB and the current policy context. Sections 1.3 and 1.4 describe the different routes that exist to enter the Pharmacy Register and the sectors pharmacists can practise in once registered. Section 1.5 provides data on the number of pharmacists on the Pharmacy Register. Section 1.6 describes the approach taken and methods used in searching the literature. Sections 1.7, 1.8, 1.9, 1.10 and 1.11 review and critique the empirical evidence that exists on migration of internationally trained doctors and nurses. The key concepts from each of these sections are then used to set the background on the overall object of enquiry of this study – migration of ITPs – and this is explained in sections 1.12, 1.13 and 1.14.

1.2 Pharmacy in Great Britain

Lately the pharmacy profession in GB has undergone a profound change. Until recently the Royal Pharmaceutical Society of Great Britain (RPSGB) was responsible for both regulatory and professional leadership functions in GB. However, on 27th September 2010 a new body, known as the General Pharmaceutical Council (GPhC), took over responsibility for regulating the pharmacy profession, leaving the Royal Pharmaceutical Society (RPS) as the professional body for pharmacists in GB.[30]

The GPhC has responsibility for a broad range of regulatory functions that merge to assure the capability and fitness to practise of pharmacists.[30] The Pharmacy Register lies at the heart of the Council's regulatory role and, in addition to other information, it lists

all the members of the pharmacy profession.[31] [b] No person may practise as a pharmacist in GB unless registered with the GPhC as a pharmacist.[31;32] To register or renew registration, it is necessary for pharmacists to pay a requisite fee which could vary from year to year.[33] The Register contains information on individual pharmacists':[14;34]

- Date of Birth
- Gender
- Ethnic origin
- Name, home address and postcode
- Date and route of registration

Prior to the split, pharmacists were registered by the RPSGB and, from 2005 up to the establishment of the new regulatory body in 2010, could register either as practising or non-practising.[27;35] A pharmacist was deemed to be practising if s/he: "(undertook) *any works or (*gave*) any advice in relation to the dispensing or use of medicines, the science of medicines, the practice of pharmacy or the provision of healthcare*."[36] However, the GPhC does not have a non-practising Register. Legislation requires the GPhC to register only those pharmacists who are appropriately qualified and fit to practise, who meet continuing professional development (CPD) requirements and who intend to practise in GB, the Channel Islands or the Isle of Man.[35]

There are different routes to register as a pharmacist in GB and these are described in the following section.

1.3 Registration routes

At the time when this programme of work was being conducted the RPSGB acted as the pharmacy regulatory and professional body and held the list of all members of the pharmacy profession - the Register of Pharmacists - in GB. The RPSGB used the official Interpretation Act 1978 (appendix 1) to define what constitutes GB. Great Britain was defined as England, Scotland and Wales, but not Northern Ireland (which is part of the United Kingdom) or the Isle of Man and the Channel Islands (part of the

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[b] The GPhC maintains a comprehensive Pharmacy Register. As part of this, they register pharmacy premises, training premises, pharmacy technician and pharmacists.[32]

British Isles). The RPSGB accredited MPharm degree courses in GB as well as Northern Ireland (NI), but registration with either the RPSGB or the Pharmaceutical Society of Northern Ireland depended on where the pre-registration year was undertaken and passed.[27]Although there is now a new regulatory body (GPhC) in place, the described definition and the different routes on to the Pharmacy Register have remained the same. Therefore, to explain these different routes, the most up-to-date data were obtained from the GPhC and are described here.

Pharmacists can register with the GPhC via different routes.[37] One of the main routes of entry is for UK-recognised pharmacists.[38] This route applies to two groups of pharmacists. The first group are the GB-trained pharmacists who have studied pharmacy at a UK school of pharmacy (England, Scotland, Wales or Northern Ireland) and successfully completed 52 weeks of pre-registration training in GB (England, Scotland or Wales) and passed the pre-registration exam.[27;38] The second group are Northern Ireland qualified pharmacists. These pharmacists hold a UK accredited 4 year MPharm degree and have successfully completed 52 weeks of pre-registration training in Northern Ireland and have passed the Pharmaceutical Society of Northern Ireland's registration examination.[27;38] Based on the reciprocal arrangements that exist, pharmacists from Northern Ireland can register with the GPhC once they fill in and submit the relevant application form, with the following documents, to the Council: certified copies of birth certificate, marriage certificate (if applicable), degree certificate and passport, letter of good standing, completed health declaration form and a recent passport-sized photograph (certified by a solicitor or the like).[39]

There are also a number of other possible routes to register with the GPhC. These apply to pharmacists who (a) have completed a pharmacy degree that is comparable to those offered in UK and (b) are registered, or are eligible to register, with the competent authority in their country of qualification.[27;40;41] These pharmacists can register in GB via two routes: (1) the European route, for the European Economic Area (EEA) pharmacists and (2) the adjudication route, for pharmacists from non-EEA countries.[40;41] In the past a reciprocal route existed between the RPSGB and the pharmacy regulator in Australia and New Zealand, but this route was decommissioned on 30th June 2006 and now only exists for Northern Ireland pharmacists.

1.3.1 European route

This route is straightforward because of mutual recognition of qualifications for pharmacists from member states of the EEA.[27] To be eligible to register as a pharmacist in GB with a European status, a pharmacist must be a national of a member state of the EEA (that is, European Union (EU) member state, or Iceland, Liechtenstein, Norway and Switzerland), be entitled to practise as a pharmacist in the EEA and also be in good standing with the professional authority in that member state.[27,40] This route is further divided into two categories. The two possible categories, routes A and B which are described below:

Route A

Candidates are eligible to apply through this route if they either:

1. *"Hold a qualification in pharmacy from a member state of the EEA which is listed in Annex V, section 5.6.2 of Directive 2005/36/EC [c] (appendix 2) (or if not listed is regarded as comparable to the qualification listed in the Annex) and which complies with all the Minimum Training Requirements described in Article 44 of Directive 2005/36/EC."* (p.11) [40]

Or

2. *"Have a pharmacy qualification from a member state of the EEA which was started before the reference date specified in the Annex V, EU Directive 2005/36/EC for that member state and have worked in a member state in an activity referred to in Article 45 of Directive 2005/36/EC[42] (which is also an activity regulated by that member state) for at least three consecutive years during the five years preceding the award of the certificate."* (p.11)[40]

Route B

Candidates are eligible to apply through this route if:

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[c] EU directive 2005/36/EC on pharmacists refers to the movement of pharmacists within the EU. It states the training requirements that pharmacists have to undertake, so that recognition can be facilitated. [42]

1. "(Their) *pharmacy qualification from a member state was started before the reference date in the Directive for that member state and* (they) *have not worked for three consecutive years in the last five years as a pharmacist.*" (p.12)[40]

2. "(Their) *pharmacy qualification from a member state was started after the reference date but the Competent Authority has confirmed that* (their) *qualification does not comply with the minimum training requirements of Article 44 of Directive 2005/36/EC.*" (p.12)[40]

3. "(Their) *pharmacy qualification was obtained outside the EEA or Switzerland but it has been recognised by a member state and* (they) *have been permitted to practise as a pharmacist in that state."* (p.12)[40]

This procedure enables the Council to make a comparative assessment of the candidate's pharmacy qualifications and work experience as a pharmacist against the national requirements for registration, that is, the UK MPharm (4 year degree), twelve months pre-registration training and the pre-registration exam.[40] Should any significant differences exist between the qualifications and experience and the national requirements for registration the candidate may be required to complete a period of additional education, training or experience before registration.[40]

Documentation must be provided to support the application. Applicants must provide the certified degree certificate, birth certificate, passport, the Licence to Practice certificate and marriage certificate (if applicable), completed health declaration form and a recent passport-sized photograph (certified by a solicitor or the like). A letter confirming registration and good standing should be sent directly to the Council from the professional authority. [40]

1.3.2 Adjudication route

This route is for non-EEA qualified pharmacists or a non-EEA national with an EEA pharmacist's qualification (other than a UK pharmacy qualification).[41] Those joining through this route will need to apply to the Adjudication Committee at the GPhC who will make a decision on the equivalence of their pharmacy qualification. If passed, to be eligible to practice these pharmacists will have to undertake further education, that is, they must complete a 12 months Overseas Pharmacists Assessment Programme

(OSPAP) at one of the following universities: Aston, Brighton, Sunderland, Kingston or Robert Gordon and then complete 52 weeks pre-registration training and pass the pre-registration exam.[41]

Documentation must be provided to support the application.[41] The original degree certificate, certified copies of their passport, birth certificate and marriage certificate (if applicable) are required. Other documentation includes full details and evidence of training and work experience set out in curriculum vitae, two recent passport-sized photographs (certified by a solicitor or the like) and a completed questionnaire. Academic transcripts, a letter confirming registration and good standing and two references should be sent directly to the Council from the issuing body (university, pharmacy council, and referees).[41] An International English Language Testing System (IELTS) result with a minimum score of seven out of nine in every category, at the same sitting, must also be sent directly from the IELTS test centre to the Council.[41]

Alternatively, if the Adjudication Committee decides that the candidate's degree is not comparable to a UK MPharm degree, or if the candidate has provided his/her own transcript and/or letter confirming registration and good standing, s/he may be required to attend a formal interview with the Committee. In the interview, the candidate's pharmaceutical knowledge, knowledge of the practice, law and ethics of pharmacy in GB and their proficiency in English language will be verified. Following the interview, the committee will decide whether or not the candidate is eligible to undertake an OSPAP programme.[41]

1.3.3 Reciprocal route

As mentioned previously a reciprocal route existed between the RPSGB and the pharmacy regulator in Australia and New Zealand. This mutual recognition allowed pharmacists trained in GB to practise in these countries, provided they undertook a period of supervised training, the length of which varied between countries. Pharmacists from these countries could also join the GB Register provided they supplied the relevant paperwork, attended a reciprocity meeting at the RPSGB and completed at least four weeks pharmacy experience in GB.[27;43] This route ended on 30th June 2006, after it was decided by the Society that all non-EEA applications would be considered by the

Adjudicating Committee process, hence increasing transparency and fairness. Currently, this route exists only for pharmacists who studied at a school of pharmacy in the UK, but following the 52 weeks pre-registration training in Northern Ireland, registered with the Pharmaceutical Society of Northern Ireland.[27;38]

1.4 Pharmacy sectors

Once registered in GB, pharmacists can practise in different sectors. The two main sectors are the community and the hospital pharmacy.

1.4.1 Community pharmacy

The job of a community pharmacist involves helping the public, assessing their conditions, dispensing medicines and counselling patients on healthy living. Community pharmacists manage the use of medicines, for instance by ensuring that dispensed medicines are clinically appropriate for patients to take, and advising patients on the correct use of the medicine. Recently, community pharmacists have been taking on more of the clinical roles, such as blood pressure testing.[44]

1.4.2 Hospital pharmacy

Hospital pharmacists, working in either NHS or private hospitals, are involved in selecting treatments for patients. Pharmacists in hospital usually address more complex clinical medication management issues compared with community pharmacists. Because of the complexity of medications, including specific indications, efficacy of treatment regimens and safety of medications, many pharmacists practising in hospitals undergo further education and training and may specialise in a specific area. Aside from regularly attending ward rounds, hospital pharmacists may get involved with sterile manufacturing of medicines, working in the dispensary and providing information on medicines.[45]

There are other sectors in pharmacy, aside from the main ones in the community and hospitals, where a qualified pharmacist could practise. Some of these include the pharmaceutical industry, primary care and academia.[46]

1.5 The pharmacy profession

In August 2002, the first ever census of pharmacists' work patterns was commissioned by the RPSGB to provide comprehensive labour market data about all registered pharmacists.[47] A second census was commissioned in 2003 and a further two in 2005 and 2008.[48-50] Current sector(s) of work, job and hours worked in job and plans to change sector or to leave the profession were some of the information collected in the censuses. An annual review of the Register has also been conducted since 2004, so the profession has regular updates on numbers of pharmacists and trends in employment patterns.[50]

In August 2010 there were 50,664 registered pharmacists.[2] Of these, 6,128 (12.1%) had qualified overseas and entered the Register via one of the routes explained above. Based on data drawn from the 2008 Census and extrapolated to the 2008 Register, it was estimated that 70.1% of practising pharmacists worked in the community pharmacy sector and 21.7% in hospital pharmacy. More than half (55%) of pharmacists working in the community sector were employed in multiple (chain) pharmacies.[50] [d]

In terms of employment tenancy, pharmacists work as business owners or salaried employees within the community sector. In hospitals, pharmacists are generally salaried NHS employees and in each sector pharmacists can also work as self-employed locums. According to the 2008 Pharmacy Workforce Census, more than a quarter (27.4%) of actively employed pharmacists were self-employed locums.[50]

There were 10,691 community pharmacies in England at 31st March 2010.[51] Traditionally, the majority of community pharmacies functioned as independent pharmacies but there has been an inclination towards increased ownership by multiple contractors. As of March 2010, 61% of pharmacies in England were owned by multiple contractors.[51]

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[d] The figures by sector were obtained from data from the 2008 Census which was then extrapolated to the Register, therefore the percentages do not match the 50,664 given as the overall figure. These were the most recent figures available.[2]

Following this description of pharmacists' proportions and the different routes that exist to enter the Register, the subsequent sections describe a review of the literature existing on pharmacists' migration and also that of other healthcare professionals, such as doctors and nurses. Before presenting the findings, the following section details the approach and the search terms used in searching the literature.

1.6 Literature review strategy

A broad question, 'what do we know about reasons for migration of ITPs into GB and their experiences in the British labour market', was posed as the initial basis for exploring the explicit issues addressed in this thesis. The quest to answer this question evolved into three key cycles of literature searching: (a) the aim of the initial literature search was to identify specific literature on immigration of ITPs into GB. However, due to the scarcity of literature on this topic, literature on immigration of other healthcare professionals, such as doctors and nurses was also obtained; (b) the preliminary findings in this study identified communication difficulty as a source of anxiety for ITPs when they initially started to practise in GB therefore the search was extended further to explore the communicative proficiency of ITPs and, (c) the employers' perceptions of ITPs' communicative proficiency and its potential impact on patient safety. The researcher will describe each of these cycles now:

1.6.1 The initial literature search

In order to be aware of the extent of literature on immigration of ITPs into GB, to identify the gaps, to establish specific research question/s and to provide a contextual background, a literature search was conducted using various electronic databases. Pharmaceutical, medical and sociological databases were searched. These are listed in table 1.

The individual keywords used to identify studies included: "pharmc*", "migration", "overseas", "supply", "demand", "brain drain", "shortage", "Great Britain", "globalisation", "motivation", "foreign", "recruit*", "satisfaction", "retention", "registration", "United Kingdom". These search terms were applied in various combinations. Some key websites were also searched: the General Pharmaceutical Council (GPhC), the Royal Pharmaceutical Society of Great Britain (RPSGB), the

General Medical Council (GMC), the Nursing & Midwifery Council (NMC) and the Royal College of Nursing (RCN).

From the literature search conducted it was clear that most of the pharmacy related articles on migration of pharmacists into GB were letters, opinion pieces and comments in professional press such as the PJ. These are best decribed as 'gray' literature.

Electronic Databases	Date
OVID- MEDLINE	1950-2011
EMBASE	1980-2011
CINAHL PLUS	1937-2011
PSYCH-INFO	1806-2011
SOCIAL SCIENCE INDEX	1983-2011
SCOPUS	1966-2011

Table 1– Electronic databases searched

As mentioned previously, the only peer-reviewed study on immigration of ITPs into GB had been conducted by Schafheutle and Hassell.[27] The review was also able to identify a study conducted by Hassell *et al*.[7] into emigration of British-trained pharmacists, in addition to five other studies, conducted in different countries, into pharmacists' migration. Due to the scarcity of literature on migration of ITPs into GB, these studies are described (see section 1.12) to establish context, demonstrate key themes and the methodologies used to obtain the data.

In the presence of very little empirical research on this topic, another literature search was conducted on migration of other healthcare professionals, such as doctors and nurses. This search was conducted with two main purposes: (1) to provide an overview of the common results, and (2) consider the use and potential applicability of methodologies to the pharmacy setting. Keywords from previous search (excluding "pharmc*"), in addition to new terms such as "doctors", "nurses", "internationally trained doctors", "internationally recruited nurses", "internationally trained healthcare professionals" were used in various combinations to identify relevant studies. Primary emphasis was placed on more recent studies and, where possible, studies conducted in GB were selected. Nevertheless, non-GB studies were also read when it was felt

additional understanding could be gained into the migration phenomena. The key themes identified in these studies, such as, reasons for migration, migrants' adaptation to the British healthcare system, internationally trained nurses' and doctors' experiences of working in the NHS and the private sector, are described in section 1.7 to 1.11.

1.6.2 Literature search on communicative proficiency

The preliminary findings in this study identified communication difficulty as a source of anxiety for ITPs when they initially started to practise in the GB healthcare setting. In order to be fully aware of the extent of literature on communicative proficiency of ITPs and its potential impact on patient safety, another literature search was conducted using the previous electronic databases. Some keywords from previous search, in addition to new terms, such as "communication", "proficiency", "language", "patient safety", "education", "regulation", "competency", "culture", "test", "linguistic", "dialect", "accent", "idiom", "colloquial", "medical language" were used in various combinations to identify relevant studies. Apart from one study on communicative proficiency of ITPs in Canada, no other empirical research existed on this topic. Nevertheless, further studies on this topic into other internationally trained healthcare professionals, such as doctors and nurses, were identified. The key themes identified in these studies, are described in section 1.13.

1.6.3 Literature search on employers of internationally trained pharmacists

Following the preliminary findings, which identified communication difficulty as a source of anxiety for ITPs, it was also decided to conduct a literature search to identify studies on employers' perceptions of ITPs' communicative proficiency, its potential impact on patient safety and to see if, and how, employers provide language support to assist their recruited ITPs. A number of key words from previous searches, in addition to new terms, such as, "employers", "regulation", "English for specific purpose", "assessment", "training", "language support", "pharmacy education", "adaptation", "quality" were used in various combinations and applied to the previous electronic databases. No empirical study was found on employers' perspectives of their recruited ITPs in GB. However, eight studies were identified from the perspective of the ITPs' regulator in Canada. These studies are described in section 1.14.

In the three described cycles, there were no strict inclusion and exclusion criteria for selection of papers. The researcher selected studies she felt were most relevant to the topic based on the abstract. Bibliographies of the read articles were scanned to identify further useful articles and books. Overall, using a range of search techniques resulted in this study being informed by a wide range of literature, including articles in academic and professional journals, 'grey' literature and books.

The literature review was treated as an ongoing process, although, as expected, during the early stages, the researcher spent most of her time reading a wide range of material. However, as time went on, the literature was gradually narrowed and was used to establish the specific aims and objectives and the research design for this programme of work. The researcher kept up to date with relevant literature throughout the course of undertaking this study. This was done through different mechanisms, for example, subscribing to email alerts from relevant publishers.

Whilst this section has described the search strategies used to explore the topic under investigation, the following sections (1.7 to 1.14) will present the findings and insights gained from these searches, starting with an explanation of the terms selected and used to describe internationally trained healthcare professionals.

1.7 Terms used to describe internationally trained healthcare professionals

In the migration literature, different terms such as "foreign trained", "overseas" and "internationally recruited" were used to refer to internationally trained healthcare professionals. In the migration literature on doctors and nurses, "overseas" commonly refers to those healthcare professionals trained outside Europe. Other terms such as "foreign trained" have been criticized, for example, by pharmacists who took part in Austin's study in Canada.[6] These pharmacists perceived "foreign" means not liked or someone who does not belong. The term internationally recruited nurses (IRNs) and internationally trained doctors (ITDs) were unanimously used in the GB migration literature of nurses and doctors. On the other hand, the term "internationally trained pharmacist" was first used by Schafheutle and Hassell[27] to refer to all pharmacists who did not obtain their original pharmacy qualification or registration in GB. Consequently,

the researcher adopted these terminologies (ITPs, IRNs and ITDs) and has used it throughout her thesis.

1.8 Reasons for migration

The underlying causes for doctors' and nurses' migration are well documented in the literature.[52-74] Many scholars refer to the 'push and pull' theory to explain the uni-directional flow of doctors and nurses. 'Push' factors are described as unsatisfactory living or working conditions in the country of origin, which push migrants out of their home countries. 'Pull' factors are appealing working and/or living circumstances in the country of destination, which pull migrants towards host countries.[59-61;63-65] The literature on the reasons for migration of healthcare professionals, is discussed under the following subheadings:

1.8.1 Intention to migrate

Some studies investigated 'reasons for migration' by asking the students and trained professionals still living and working in their home country about their decision to migrate.[53;58;61;67] Nguyen *et al*.[61] conducted a study looking at intent to migrate among nursing students in Uganda. Questionnaires were disseminated to 139 nursing students at two schools of nursing. Two focus groups were also conducted at one of the schools consisting of eight and twelve volunteers respectively. Most (70%) of the students stated their interest in working outside Uganda and said it was likely that they would be working in the US (59%) or the UK (49%) within the next five years. Poor financial remuneration caused more dissatisfaction than any other factor in pushing the respondents towards emigration.

One might think that economic gains are the sole driving force for migration from developing countries. However, recent studies highlighted a more complex interplay of motives. For example, Vujicic *et al*.[68] found a small correlation between the supply of healthcare migrants and the size of the wage differential, suggesting that, beside financial gain, other factors also play a significant role in the decision to migrate. In this study, South African professionals, who earned five to six times more than Ghanaians, showed almost the same level of intention to migrate. In another study in six African countries, a survey was conducted of healthcare workers who intended to leave their

home country.[67] The result demonstrated that, although reasons for migration vary amongst individuals, common patterns within countries could be obtained. For example, in Cameroon, poor living standards, lack of promotion and the desire to gain further experience ranked above financial motives as a reason why the professionals intended to migrate.[67]

Hagopian *et al.*[58] used focus groups and interviews to find out the views of African doctors on the 'flight of physicians from West Africa'. The authors conducted focus groups and interviews with 71 students and postgraduate residents, the faculty and administrators in six medical schools in Ghana and Nigeria. The majority of the students and residents stated a strong aspiration to leave Africa, at least to gain further training, but more likely to permanently migrate. A number of reasons were identified as to why these physicians were drawn abroad. Push factors, such as political corruption, poor infrastructure and low standards of living, as well as pull factors, such as job security, prestige and high salaries in developed countries, were identified.

Akl *et al.*[53] set out to find the factors underlying the intentions to migrate of graduating Lebanese medical students. The study participants consisted of pre-final year and final year medical students from five medical schools in Lebanese. Tow focus groups with pre-final year and final year students were conducted in the summer of 2005. Akl *et al.*[53] then conducted semi-structured interviews with students who had not participated in the focus groups. Seven and 16 students participated in semi-structured interviews and focus groups respectively. The main reasons identified by the study were better training opportunities, better job opportunities, better residency working conditions, financial factors and civil stability.

Although all these studies provided valuable insights into factors that could affect the migration process, the use of students in some of the studies does not give a definitive picture.[53;58;61] This is because students' perceptions are perhaps more likely to change during their employment as fully qualified professionals in the healthcare system of their home country.

1.8.2 Actual migration

A number of studies investigated 'reasons for migration,' by asking the healthcare professionals who had already migrated, about their decision to migrate.[55;57;62;70] George *et al.*[57] developed an on-line survey using a pre-validated questionnaire, asking non-EU doctors in the NHS to report their main and other reasons for migration to the UK. Invitations were sent to various organisations of overseas doctors via email. Respondents were asked to suggest the survey to other non-EU doctors. They received 1619 completed questionnaires from doctors of 26 different nationalities. This represented 2.96% of all non-EU doctors registered with the GMC. Over three-quarters of the doctors migrated to the UK mainly for 'training'. Other reasons specified were 'better pay' (7.2%), 'better work environment' (7.1%) and 'having family and friends in the UK' (2.8%). Reasons such as: 'better human rights', 'spouse working in the UK' and 'a step to the US' were also mentioned. The authors acknowledged two main shortcomings of their study. Firstly, doctors from India were over-represented (90.1% of the respondents were from India). Secondly, using an online method of data collection may have restricted the type and number of doctors who responded to the survey.

In a mix-method study, 120 questionnaires were distributed among Filipino nurses in the Oxford Radcliffe Hospitals NHS Trust.[70] Data were collected from 45 of the completed questionnaires and eight semi-structured interviews. The opportunity for professional development, together with earning more money and being able to send part of it back to Philippines, were the main reasons for migration.[70] These were consistent with the findings from a similar study undertaken by Daniel *et al.*[55] In another study, Onso-Garbayo and Maben[62] conducted face-to-face interviews with IRNs from India (n=6) and the Philippines (n=15) in London. They found that migration was influenced by economic, professional and social aspirations.[62]

Although several studies identified better remuneration as one of the reasons for migration, there seemed to be a reluctance to declare this in other studies.[52;69] Winklemann-Gleed[69] surveyed 358 practising IRNs in London in 2005. Only 12% of their participants stated a financial motive as a reason for migration, despite the fact that 40% of the sample had an underlying economic purpose for migration. This

unwillingness to state a financial motive as the reason for migration could, in part, be explained by a study by Smith *et al*.[66] They identified a stigma attached to being an 'economic migrant' and the negative connotation it carried in the white British context. This indicate that perhaps a qualitative methodology and use of appropriate questions and prudent interview techniques are necessary for a more realistic evaluation.[52]

These studies of fully qualified healthcare professionals have avoided the problems mentioned previously concerning the use of students. However, they still suffered from other limitations. For example, some of these studies used relatively small focus groups/interviews or surveyed doctors and nurses mainly from one nationality.[55;62;70] Thus the findings cannot be applied on an international scale.

1.8.3 Other reasons for migration

Apart from the push and pull factors identified, another important factor in international mobility of healthcare professionals is the globalisation of labour markets and mutual recognition of qualifications.[59;64] EEA-trained healthcare professionals with an EEA passport can move freely within the EEA following rules on automatic recognition of qualifications.[64] The expansion of the EU in 2004 and 2007 (appendix 3), with poorer Central and Eastern European countries joining, caused fear of uncontrollable migrant inflow amongst the original EU-15 member states.[64] To compensate, they imposed various levels of restrictions. For example, workers from eight of the ten countries that joined in 2004 should have registered under the Work Registration Scheme (WRS) if they intended to work for a UK employer for one month or longer.[75] However, under the EU law, the WRS had to be stopped by the end of April 2011.[75] Bach believes that there are indications that the movement of doctors and nurses from countries such as Poland, the Czech Republic and Hungary will be a more significant feature of healthcare professional mobility in the EU than in the past.[71] Health professionals from former Eastern Bloc countries may be attracted to migrate to take advantage of higher salaries and better working conditions in other EEA countries.[71]

Another factor that could be relatively important is the importance of the similarity of language and culture in the pairing of the source and the destination countries.[56;65;72] This could, in part, explain the migration of doctors between Australia, Canada, the UK,

Ireland and the US and between Belgium and France. Geographical proximity also plays a part for some of these countries.[56;65;72] Previous colonial ties are usually the root cause of similarity of language between the developing countries and the host country. This, for example, could explain movement of professionals from India and South Africa to UK.[62;63;76]

1.8.4 Permanent migration vs. temporary migration

It was crucial to see if, and how, the motives for migration, differed between professionals who migrated from the developed and the developing countries and if this difference had an impact on the permanence of movement. In 1997, Buchan *et al*.[77] developed a typology of different 'groups' of IRNs in the UK. This typology distinguished between the 'permanent' and the 'temporary' move. The permanent move was described by three types of nurses: the economic migrant (attracted by a better standard of living), the career migrant (attracted by enhanced career opportunities) as well as those with a migrant partner (unplanned move because of a partner moving). The temporary move was described by four types of nurses: the working holiday (using qualification to finance travel), the student (to gain basic or post-basic qualification), the study tour (to acquire new skills and expertise for use in the home country) and the aid worker (providing care to a host country). This study, as well as others,[74;78] concluded that nurses from Africa, India, the Philippines, Pakistan and other developing countries are permanent migrants mainly motivated by economic factors and career moves, while nurses from countries such as Australia, New Zealand and Canada are temporary migrants, motivated by travel and adventure.

In 2003, a study was commissioned by the RCN to explore the motivations and experiences of IRNs in the UK.[54] The study aimed to understand why overseas nurses come to work in the UK, what experiences they undergo and whether they plan to stay in the UK or return to their countries of origin. Sixty-seven IRNs from 18 different countries participated in 11 focus groups in Leeds, Cardiff and London. Allan and Larsan classified the IRNs' reasons for migration under: professional (exposure to first world healthcare and the possibility of further education), financial (earning a living and sending money to the home country), personal (urge for adventure and experiencing life in a different part of the world) and social (joining spouse) motives. This study

differentiated between the motives of IRNs from developed and developing countries. In this study, IRNs from former Australia or from western European countries came for a temporary travelling holiday and the majority stayed in London. On the other hand, IRNs from developing countries migrated to experience life in the UK, to practise nursing in a first world country and to experience professional development. The financial motive was also important for this group as they expected to support families back in their home countries. In general, their migration was described as a permanent move.[54]

Although, there is little hard evidence about how much nurse migration may be permanent or temporary, the studies described indicate that nurse migration from developing countries into the UK is likely to be permanent, while the opposite is true for migrant nurses from EU countries, Australia and New Zealand.

1.8.5 Active recruitment vs. passive recruitment

Push and pull factors, liberalisation of labour markets and similarity of culture and language could all encourage the internationally trained healthcare professional to take the initial step and apply for work in the UK. This is referred to as 'passive recruitment'.[73] However, due to a shortage of some of the healthcare professionals, what is known as 'active recruitment' is being practised.[73] 'Active recruitment' refers to employers or agencies actively seeking internationally trained healthcare professionals to fill the gaps within their organisations. For example, the Department of Health (DoH) was supporting international recruitment through a range of initiatives, such as a recruitment website for nurses.[73] This active targeting, combined with 'push' factors in some developing countries, caused large scale migration from African countries, where the population carries the burden of 25% of the world's disease, yet it has only 1.3% of its healthcare workers.[79] The UK has been the first country to introduce an 'ethical' code to underpin active recruitment. In 1999, the DoH initially established guidelines which required NHS employers not to target South Africa and the West Indies.[65;80] Code of Practice for international recruitment for NHS employers was then introduced in 2001.[65;81] This code required NHS employers not to target third world countries for active recruitment, unless there were mutual arrangements in place between UK and the source country. This Code was reinforced and extended in 2004,

and now also covers recruitment agencies, temporary staff working in the NHS and organisations providing services to the NHS.[65;82;83]

This section described the literature on reasons for migration of healthcare professionals. Many scholars referred to 'push and pull' theory to explain the migration of nurses and doctors. A review of the literature demonstrated that the decision to move abroad was complex and not based exclusively on economic expectations. Motivation for migration and permanence of movement varied by source country and individual circumstances. Findings also demonstrated the practise of 'active recruitment' by employers, however, a Code of Practice was introduced by DoH to ensure ethically acceptable recruitment of internationally trained healthcare professionals.

Whether passively or actively recruited, one of the first steps after employing internationally trained healthcare professionals is the provision of appropriate induction programmes that meet their needs when they have just arrived into this country. The early experiences of internationally trained nurses and doctors and their adaptation and orientation are explored in the following section.

1.9 Experiences of adaptation and orientation

How much adaptation internationally trained healthcare professionals have to undertake to register with the appropriate regulatory body depends on the country of origin. Once the equivalence of their qualification has been established, EEA-graduates are entitled to full registration and have no requirements to take any language or competency tests.[84] However, the process of registration for non-EEA doctors and nurses is different. To register with the NMC (nursing regulator), non-EEA nurses have to prove English language proficiency by sitting and achieving a score of seven in the IELTS test.[85] After this score has been achieved, to register they then need to complete the Overseas Nurses Programme (ONP) which includes a compulsory 20-day period of protected learning and, where appropriate (based on NMC evaluation), a period of supervised practice, which should last a minimum of three months and a maximum of nine months.[85;86] [e] To register with the GMC (the medical regulator), non-EEA doctors have

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[e] The ONP was fully implemented in 2006. Before this, to register, the nurses had to undertake a supervised training programme for a minimum of three to a maximum of six months. [86;87]

to pass the IELTS test with a score of seven, followed by the Professional and Linguistic Assessment Board (PLAB) examinations.[88] The former is intended to assess English language proficiency and the latter to assess clinical competence.

The bulk of the literature with regards to adaptation programmes for internationally trained healthcare professionals in British healthcare was concentrated on IRNs.[52;54;66;87;89-97] The paucity of literature on adaptation of ITDs could possibly be explained by the fact that doctors do not need to undertake a supervised period of adjustment to register with the GMC. Due to the scarcity of national literature on adaptation of ITDs, international studies that explored the orientation process of ITDs in other countries were identified.[98-102] This section mainly draws on the national literature to describe the early experiences of IRNs in the UK. However, data from international studies are also utilised whenever it was felt further insight into the orientation process could be gained from these studies.

The early experiences of IRNs and their orientation to British healthcare have been explored by several studies in the UK.[52;54;66;87;89-97]Although positive examples of welcome and adaptation packages were described in the literature, others described poor or even exploitative experiences. Nurses reported 'being thrown into a different world,' with no support and adaptation, which gave way to feelings of anxiety and frustration.[89;91] The negative and positive experiences of IRNs with their adaptation packages are described in the following sections.

1.9.1 Negative experiences with adaptation programmes

Nurses who had been actively recruited usually felt that initial support such as transportation from airport and arranging accommodation were lacking. Even in cases where logistical support or adaptation programmes were offered, the majority were thought to be insufficient and imprecise to IRNs' needs.[93] Many of the nurses who had been actively recruited by agencies had paid expensive fees to get into the UK and access adaptation. For example, in a report for the RCN (2002), some nurses stated being charged between £500 and £2000 by nursing agencies.[103]

Smith *et al*.[66] conducted a study 'researching equal opportunities for overseas recruited nurses and other healthcare workers'. This study explored the experiences of 93 IRNs

and other healthcare professionals in the UK by conducting interviews with them across the UK. To gain further insight, interviews were also conducted with national and local managers and mentors in the NHS and independent sectors in different regions (n=37). IRNs who carried out their adaptation in private care homes stated not being adequately supervised by trained nurses during their adaptation but instead worked with healthcare assistants (HCAs) to do care work. Several IRNs felt embarrassed by the fact that the unskilled carers in care homes were allocated to introduce them to the work and functioned as their supervisors. They believed this system of introduction to UK nursing practice is not safe and effective. The findings in this study were echoed in other studies.[52;54] Nurses who worked in care homes felt they were left to work without any proper induction and under miserable conditions. They felt working in care homes did not give them sufficient opportunities to practise nursing duties, which led to a feeling of being undervalued and deskilled. Working with HCAs in care homes also appeared to have been problematic for the IRNs as nurses found their HCAs indifferent to providing support and, in cases, directly hostile.[52;54]

Unhelpful manners from British nurses were also not uncommon during adaptation. For example, in Alexis and Vydelingum's[89] qualitative study, 12 face-to-face interviews were conducted with IRNs. Nurses in this study described that they received limited support from their UK counterparts. This is consistent with the findings from a similar study undertaken by Matiti and Taylor[93] who investigated the cultural experiences of IRNs in the Trent Region by interviewing 12 IRNs. Unsupportive behaviours and problems adjusting to a new environment were also identified in this study.

1.9.2 Positive experiences with adaptation programmes

The negative experiences described by IRNs in studies described above may have been improved due to the changes that have taken place in the recent years. The adaptation programmes for IRNs were replaced by the ONP in 2006, as directed by NMC.[86] This switch over occurred in response to concerns over irregularities in adaptation programmes, which led to some IRNs being exploited during their adaptation period.[104] Now, all placements take place in a setting that has been approved by NMC.[86]

As explained previously, the literature also reported on positive early experiences of IRNs in the UK, through well-structured, individual adaptation and welcome packages.[87;90;92;94-97] Seven programmes and packages were identified that were well-evaluated and received high praise from IRNs. The most common evaluation measures included questionnaires and/or interviews with the participants.[90;92;94-96] Another outcome measure was the rate of registration with the regulatory body at the end of adaptation.[87;97] To see what led to the success of these seven adaptations, the programme components are extracted and presented in the following subheadings (see table 2 for an overall summary):

'Meet and Greet'- The importance of logistical support during the 'settling down' period was highlighted in the literature.[54] Meeting the nurses at the airport, helping them find appropriate accommodation, setting up bank accounts and linking them with other international recruits could affect IRNs' immediate quality of life after migration.[105] Of the seven studies listed, two had provided actual logistical support to their new recruits.

Mentoring- all seven programmes had used a mentor or an equivalent figure who provided on-going personal and professional support and guidance to IRNs. The RCN had recognised the role of mentors as 'crucial' in taking the IRNs through their adaptation.[105] Xu et al.[106;107] identified mentorship as one of the critical factors for the successful adaptation of IRNs in the US and Western countries. Lockyer et al.[101] explored the importance of mentorship for ITDs in Canada by conducting focus groups with this group of doctors and interviews with medical leaders. Both leaders and the doctors described mentorship as vital in adaptation of ITDs. The use of mentors in all of these studies suggests the central role that mentors could play in orientation of ITPs to British healthcare.

Communication training- the RCN has labelled communication as a key skill for nurses.[105] However, communication difficulties have frequently been identified as one of the top challenges to IRNs, suggesting that this issue is the underlying reason for other concerns, both at work and in life outside work.[54;95;108] Language and communication skills were also identified as an important issue to address as part of ITDs training.[100;102] Of the seven studies, only three provided communication training as

Study	Evaluation of adaptation program	Length of Program	Mentoring?	Meet and Greet	Single/multiple Components	Communication Training?
Gandhi and French (2004)[87]	Registration rate with NMC after completion	6 months	Yes	None stated	Multiple	Yes
Gerrish and Griffith (2004)[90]	Interviews	None stated	Yes	None stated	Multiple	No
Horner (2004)[92]	Questionnaire	3 to 6 months	Yes	No	Multiple	No
Parry and Lipp (2006)[94]	Questionnaire	12 weeks	Yes	Yes	Multiple	Yes
Smith (2004)[95]	Questionnaire and interviews	None stated	Yes	No	Multiple	Yes
Ugiagbe (2005)[96]	Questionnaire and interviews	None stated	Yes	None stated	Multiple	No
Witchell and Osuch (2002)[97]	Registration rate with NMC after completion	Up to 6 months	Yes	Yes	Multiple	No- mention language in a course

Table 2– Profile of adaptation programs for IRNs in the UK

part of their adaptation programme.[87;94;95] This further highlighted the gap that exists between the reality and this identified need of IRNs.

Multiple component programmes- all seven studies described multiple component adaptation programmes. Examples of the incorporated components included: management, mentorship, communication, ethics, safety and professionalism. In their study, Curren *et al.*[100] also suggested that orientation of ITDs needs to be multi-component. Mentoring, effective integration within the community and cultural sensitivity emerged as important components of an effective orientation process.

This section mainly described the literature on adaptation of IRNs. Accounts of both positive and negative adaptation programmes were given. Seven adaptation programmes were identified that received high praise from IRNs. The multiple components of these programmes included logistical support, mentoring and communication training.

Once the internationally IRNs and ITDs were trained, they started practising as registered professionals in the host country. The working experiences of IRNs are described first in section 1.10, before moving on to describe the working experiences of ITDs in section 1.11.

1.10 Working experiences of internationally recruited nurses

Several studies explored the work experience of IRNs in the UK following their registration.[52;54;55;66;70;78;89;93;108-123] Table 3 provides a summary of these studies. The main themes from these studies are discussed under the following subheadings:

1.10.1 Expectations vs. reality

In section 1.8, professional development was identified as one of the main reasons for migration. IRNs expected an advanced level of nursing in the UK with state-of-the-art equipment, up-to- date, hygienic hospitals, high staff-patient ratios and positive work ethics.[54;55] However, the reality did not meet the IRNs' expectations. They were disappointed with 'a century old hospital',[70] low hygiene standards,[54] lower nurse to patient ratios[54;55] and a lack of technological advancement.[54;70]

Author (year)	Methodology	Sample size	Some of the emergent themes
Aboderin (2007)[52]	In depth interviews	25 Nigerian IRNs working in independent care homes in England, nursing tutors (n= 5) and returnee migrants in Nigeria (n = 2)	Loss in professional and social status in the UK
Alexis and Vydelingum (2004)[89]	One to one, semi-structured Interviews	12 black and ethnic minority IRNs working in the NHS	Communication difficulty, being seen as 'others', feeling unwelcomed, not appreciated, lack of support from British peers
Alexis and Vydelingum (2005)[111]	One to one, semi-structured Interviews	12 black and ethnic minority IRNs working in the NHS	Feeling unwelcomed, feeling inadequate, unfairness in practice
Alexis and Vydelingum (2009)[112]	Survey	188 IRNs	Lack of equal opportunities
Alexis et al. (2006)[109]	One to one, semi-structured Interviews	12 black and ethnic minority IRNs	Unequal opportunities in career advancement, skill development and training
Alexis et al. (2007)[110]	Focus groups	24 black and ethnic minority nurses working in the NHS	Self-blame and invisibility, experiencing fear, discrimination, lack of equal opportunities
Allen and Larsen (2003)[54]	Focus groups	67 IRNs	Communication difficulty, communication issue as stigma, narrow scope of practice leading to feeling of being deskilled, different legal framework, discrimination and exploitation
Allen et al. (2004)[113]	Focus groups	67 IRNs	Discrimination and racism, Communication difficulty
Allen et al. (2009)[114]	Semi-structured interviews	3 IRNs	Racism and bullying, communication difficulty, response to bullying
Ball and Pike (2005a)[116]	Survey	298 IRNs	Long shift work, inappropriate grading

Ball and Pike (2005b)[115]	Survey	RCN members including 155 IRNS	Discrimination and racism
Ball and Pike (2007)[117]	Review of previous surveys	811 IRNs	Discrimination and racism
Buchan *et al.* (2005)[78]	Survey	380 IRNs working in London	Reported on experiences and career plans of IRNs
Daniel *et al.* (2001)[55]	Focus groups	24 newly recruited Filipino nurses working in London	Difficulty understanding and communicating, differences in nursing duties, nursing as physically demanding
Henry (2007)[118]	Semi-structured interviews and focus groups	20 Ghanaian nurses and midwives in UK and 40 doctors, nurses and students in Ghana	Cultural differences and communication skills, formal and informal support
Larsen (2007)[119]	In depth interviews	2 IRNs	Discrimination and racism
Lemos and Crane (2001)[120]	Focus groups	500 black and ethnic minority IRNs	Discrimination and racism
Matiti and Taylor (2005)[93]	Semi-structured interviews	12 IRNs	Communication difficulty, not being trusted by colleagues, not used to providing basic care
O'Brien (2007)[121]	Semi-structured interviews	40 IRNs, 8 managers, 15 home nurses across 3 NHS Trusts	Deskilling
Shields and Wheatley Price (2002)[122]	Survey	14000 nurses	Racial harassment
Smith *et al*. (2006)[66]	Semi-structured interviews	93 internationally trained healthcare professionals mainly IRNs and	Deskilling, communication difficulty, discrimination and racism
Taylor (2005)[123]	Observation, focus groups and individual interviews	11 IRNs working in the NHS	Communication difficulty, differences in roles, deskilling, discrimination
Winklemann-Gleed and Seeley (2005)[108]	Survey and semi-structured Interviews	Survey = 140 IRNs Interviews = 22 IRNs	Experiencing prejudice, communication difficulty
Withers and Snowball (2003)[70]	Questionnaire and semi-structured interviews	Questionnaire = 45 Interviews = 8 Filipino IRNs working in Oxford	Communication issues, differences in nurse's role, exploitation

Table 3– Summary of the literature review related to IRNs' experience in the UK

The emphasis on providing basic personal care (such as washing and cleaning) to patients and care of the elderly was unfamiliar to IRNs because those needs were seen to by families of patients[55;66]or HCAs in their home countries.[89] Consequently, many IRNs found this new role as heavy and tiring[55;70;97]and perceived providing basic personal care as deskilling and devaluing.[54;66;89;93] Whilst some IRNs commented that British nurses practise with greater autonomy and were impressed by a more equal relationship between doctors and nurses,[70;95;115;123] others believed the scope of practice in the UK to be narrower because of the existence of different protocols, policies and guidelines.[54;121] While some level of documentation was generally recognised to be a necessary aspect of modern nursing some blamed it for moving interest away from actually nursing the patients.[54]

1.10.2 Recognition of previous skills and experience

Lack of recognition of skills was a recurring theme.[54;66;70;90;93;121] Studies explaining IRNs' experiences found that some UK employers did not recognise skills, qualifications and the previous experience of IRNs and this led to feelings of frustration, bitterness and disappointment amongst the IRNs.[54;66;70;90;93;121] Apart from the disappointment of missing the chance to become exposed to high quality nursing practice, IRNs felt hurt and saddened that they were junior to less experienced nurses.[54] Some even concealed their previous knowledge and experience in front of junior British nurses as they wanted to appear humble and not superior.[66] Some IRNs felt that they were losing their technical skills and knowledge because they were not allowed to practise them in the UK setting.[66;90]

O'Brien[121] specifically explored the process of deskilling amongst IRNs by conducting 63 semi structured interviews with IRNs, hospital mangers and home nurses. He concluded that there was a tendency to employ IRNs on a lower grade than their skills and experience may otherwise suggest. This was supported by further evidence that suggested that, despite having gained many years' experience overseas, IRNs occupied junior positions in the UK.[66;70] Being employed in lower grades and having problems progressing up the career ladder[113;118;119] begged the question of whether institutional discrimination directed at IRNs, exists within NHS.

1.10.3 Discrimination and racism

Many studies identified discrimination and racism as a frequent theme.[54;66;89;110;112;115;117-120;122] Smith *et al.*[66] identified two types of discrimination. Overt discrimination emerged as blatant racism, xenophobia and/or deliberate strategies to exclude or harm the IRN. These were evident in insignificant but repeatedly occurring events, for example working in a pairs but leaving IRNs to work on their own. Indirect discrimination was not motivated by the intent to treat the person being discriminated against less favourably. It was described as a failure to identify individual attributes and needs of IRNs and applying social pressure on IRNs to act and behave according to the dominant culture. An example was given of where other nurses talked about personal relationships during lunch breaks.

The people responsible for imposing discrimination were UK staff, patients, relatives or other migrant nurses.[54;89;122] Using a survey, Shields and Wheatley Price[122] explored the determinants of racial harassment and its impact on job satisfaction from NHS nurses. The survey showed that 40% of black and minority ethnic (BME) nurses suffered racial harassment from work colleagues in their careers. A Market and Opinion Research International (MORI) poll in England (2002) examined the experiences of IRNs on behalf of the RCN. In this poll, 14% of 1119 IRNs working in England named racism as the worst aspect of living and working in the UK.[124] Ball and Pike[115;117]demonstrated discrimination occurring against IRNs and BME nurses through grading, working circumstances, pay and equal opportunities. Data also revealed that IRNs were more likely to work for longer hours, have additional jobs and think that their grades were unsuitably low and did not match their roles and responsibilities.

Nurses in Allan and Larsen's[54] study also reported discrimination and racism. Some believed their differences in language, colour and culture affected their relationships with colleagues before their attributes could be judged. They also experienced rejection by patients and their families. Furthermore, they were exploited in various ways, but particularly by their managers who used them to cover undesirable shifts. Nurses described having to prove themselves in order to be trusted by peers, patients and supervisors.[54;89;93] Consequently, based on these experiences the feeling of 'otherness'

and 'lack of belonging' was prevalent.[89;110] This further negatively affected IRNs performance and integration into the workforce.

1.10.4 Culture displacement

Living and practising in a new country often presents cultural challenges. Oberg[125] first introduced the term 'culture shock' to explain the experience of migration from one culture to another. Oberg[125] described the most frequent symptoms of culture shock as feeling isolated, a sense of helplessness, feeling rejected by members of the new culture and anxiety and confusion regarding the new role. For IRNs, cultural adjustment ranged from learning new communication styles and body language, to customs and ways of life. Because they were unaware of the cultural norms, it was difficult to build up trust and good working relationships.[54] There was also frequent miscommunication and misunderstandings.[126] IRNs generally felt that they had to learn, and adapt to, the new culture in a relatively short period of time. This was, however, not easy as IRNs' values and beliefs sometime clashed with the British norms and culture.[54] Although adaptation programmes were provided for IRNs, there seemed to be a lack of support for cultural transition.[93]

1.10.5 Positive experiences

Up to this point, the researcher has mainly presented negative experiences of IRNs. However, it is important to mention that the literature also highlighted some positive experiences. For example, two focus groups were conducted with IRNs on their work experiences by Daniel *et al*.[55]. The findings revealed that white, British nurses were supportive of Filipino nurses. Positive experiences were also reported by nurses in Allan and Larsan's[54] study. These included some IRNs highlighting that colleagues were supportive and the adaptation programme was beneficial. These findings were consistent with the positive experiences reported by Filipino nurses in Withers and Snowball's study.[70] Although as reported, positive experiences have been described in the literature, most of the literature described negative experiences. While this might seem a negative conclusion, the researcher did not intend to diminish IRNs' positive experiences and the lessons that could be learnt from these experiences.

1.11 Working experiences of internationally trained doctors

Although the literature on experiences of ITDs in the UK is not as extensive as that of IRNs, findings from the literature suggested that ITDs experienced similar problems. Smith[127] demonstrated that nearly two-thirds of ITDs ended up in careers that were not their first choice. In comparison to British doctors, ITDs were more likely to become General Practitioners against their preference and, to feel that they had progressed more slowly in terms of postgraduate training and experience. Similarly Goldacre *et al.*'s[128] analysis of official databases of consultants indicated that of consultants appointed before 1992, 15% had trained abroad whereas, of those appointed in 1992-2001, 24% had trained abroad. The percentage of consultants who had trained abroad and were non-white was significantly higher in specialities that can be hard to fill, that is, geriatric medicine, genitourinary medicine, paediatrics, old age psychiatry, and learning disability. Research by Esmail *et al.*[129] also indicated that ethnic minority doctors were disadvantaged and faced discrimination in the allocation of distinction awards. He showed that ethnic minority doctors were nearly three times less likely to receive awards than white doctors. In another paper, entitled 'Asian doctors in NHS: service and betrayal', Esmail[130] explained how immigrant Asian doctors occupied the lower-grade positions, in the less-liked specialities, with a high tendency for shift work and long hours, from which promotion was limited and pay and conditions were also equally affected.

Grant *et al.*[131] explored expectations and experiences of ITDs in the UK by carrying out interviews with doctors (10 UK trained, 9 EEA and 31 non-EEA doctors), nine Medical Royal Colleges and 21 interested bodies, before conducting a national survey of ITDs. The findings revealed that non-EEA doctors experienced less satisfactory career progression in the UK and had difficulty finding posts. In the survey, two-thirds of the EEA doctors and nearly three-quarters of non-EEA doctors reported that their experience had differed from their expectations. For non-EEA doctors, their main disappointment was in the amount of education and training they received. For EEA doctors, workload, facilities and equipment were worse than expected. Language difficulty was experienced by more EEA doctors (18.9%) than non-EEA ones (11.3%). Conversely, more non-EEA (33.4%) than EEA (22.7%) doctors had experienced cultural problems since arriving in the UK. Over half of the non-EEA doctors reported

feeling discriminated against by senior colleagues, while 37.8% of the EEA group reported peers and colleagues as the source of discrimination. Non-EEA doctors viewed that available posts went first to UK graduates rather than themselves.

1.12 Migration within pharmacy

As has been seen, there has been a great deal of focus on migration within the medical and nursing professions. However, there was little empirical research into migration within pharmacy. The only peer-reviewed study on immigration of ITPs into GB was conducted by Schafheutle and Hassell.[27] The findings of this study are discussed in section 1.12.1 and this is followed by the most recent and longitudinal data on the ITPs on the GB Pharmacy Register (see sections 1.12.2 and 1.12.3). Finally, other national and international literature on movement of pharmacists across borders is discussed in section 1.12.4 and 1.12.5.

1.12.1 Findings from the Register analysis by Schafheutle and Hassell

The cessation of the reciprocal route in 2006 (for pharmacists from Australia and New Zealand) and expansion of EU member states in 2004 and 2007, from 15 to 27 members, prompted Schafheutle and Hassell[27] to conduct secondary data analysis of the GB Register of Pharmacists. The aim of the analysis was to explore the Register for differences in pharmacists' characteristics, depending on route of entry. The 2007 Register extract, the Register extracts between 2002 and 2006 and data from the 2005 Pharmacist Workforce Census formed the basis of their analysis.[27]

In August 2007, there were 3802 ITPs with an address in GB; this represented 8.8% of the GB Register. Of those, 40.6% gained entry onto the Register through the European route, 33.6% through the adjudication route and 25.8% through the reciprocal route.[27] Schafheutle and Hassell's[27] analysis, presented here, was based on pharmacists with a registered address in GB, as they were the ones available to the GB pharmacy labour market.

Route of entry	% of Women*	Mean age	% London address*
GB-trained	55.8%	43.1	7.6%
Adjudication	55.3%	43.0	19.5%
European	67.8%	31.7	13.9%
Reciprocal	56.3%	40.0	28.9%

Table 4– Demographic data of ITPs and GB-trained pharmacists with an address in GB in 2007[27]

*number of women and number of pharmacists with a registered address in London were not provided in the Schafheutle and Hassell's[27] paper. Only percentages were given.

The percentage of women who entered the Register via the adjudication route (55.3%) was similar to those who were GB-trained (55.8%), but there were proportionally more women among pharmacists who entered via the European (67.8%) and reciprocal (56.3%) routes (see table 4).[27]

The mean age of the pharmacists who entered through the European, adjudication and reciprocal route was 31.7, 43.0 and 40.0 respectively. Pharmacists who entered the Register via one of the overseas routes were younger than GB-trained pharmacists. ITPs were also more likely to live and work in England than Scotland or Wales. Furthermore, 19.5%, 13.9% and a much higher proportion, at 28.9%, of ITPs who entered via adjudication, European and reciprocal routes respectively had a London address (see table 4).[27]

The sector of employment also differed considerably depending on the route of entry onto the Register.[27] ITPs who gained entry via the reciprocal route were more likely to work in the hospital sector (30.0%) and less likely to work in the community (57.2%) than those who came through the adjudication (16.9% vs. 76.3%) and European routes (29.3% vs. 62.8%).[27]

In this study, adjudication pharmacists appeared most similar to the GB-trained pharmacists. Not only did they have similar age and gender profiles, they were also more likely to work in the community sector than GB-trained pharmacists. They were also more likely to remain on the Register for longer, hence being available to the workforce for a longer period. Schafheutle and Hassell[27] suggested that the reason for

this group of ITPs being more likely to stay on the Register for a longer period is may be because of the substantial investment they had made, in relation to amount of time and money spent, to enter the Register when compared with the other groups.

The analysis also demonstrated that reciprocal pharmacists tended to be hospital pharmacists with an address in England, particularly in London.[27] The impact of the abolition of the reciprocal route is therefore expected to be most profound in recruitment into hospital positions in London.[27;43] Whether these posts could be filled with an increasing number of EU pharmacists coming into GB remains to be seen.[27] Schafheutle and Hassell's[27] work also suggested that reciprocal and European-entry pharmacists were younger than GB-registered pharmacists, but also left the Register relatively young, suggesting that many of them stay in GB for only a few years. This provided support for anecdotal evidence, which suggested that reciprocal-entry pharmacists initially came for a two-year period, the length of time for which a holiday working visa could have been obtained, possibly after which they returned to their home countries.[27;132]

1.12.2 Findings from the 2010 Register analysis

As mentioned previously (see section 1.5), since 2004 an annual review of the Register has been conducted.[50] To see if there had been any recent changes in EU, adjudication and reciprocal pharmacists' characteristics, Seston and Hassell's[2] analysis of 2010 Register was drawn upon.

Of the 50,664 pharmacists on the 2010 Register, 6,128 (12.1%) qualified overseas. Of those, 44.6% gained entry onto the Register through the European route, 29.2% through the adjudication route and 26.2% through the reciprocal route. The proportion of ITPs on the Register had risen by 0.9% in 2010, since 2009.[2]

The mean age of pharmacists who entered through the European, adjudication and reciprocal route was 33.5, 43.3 and 42.0 respectively. Although the mean age of adjudication pharmacists was slightly higher compared to GB-trained pharmacists, ITPs were still, on average, younger than home (England, Scotland, and Wales) pharmacists (38.6 years vs. 42.1 years).[2]

The feminisation of the pharmacy workforce continued in 2010, with women constituting 58.1% of the total workforce. Similar to 2007, female pharmacists were more likely to have registered through the European route than any other route.[2]

1.12.3 Changes between the Register extracts

While analysis of 2010 Register provided an up-to-date snapshot of ITPs on the GB Pharmacy Register, it was also important to see if there had been any significant changes over time in the proportion of ITPs on the Register by subgroup. Consequently, table 5 was compiled to provide such longitudinal data.

In the previous nine years, the percentage of pharmacists registering via the adjudication route has remained fairly static while the proportion of pharmacists entering via the European route has increased since 2002.[27] Entry via this route was relatively slow in the first 15 years until 2001, when a total of 217 pharmacists joined.[27] The largest increases have happened after 2004, with 311 new admissions in 2005 and 392 in 2006 alone, more than doubling European entries in the previous three years. The increase could partly be explained by the addition of the 10 new member states of the EU in 2004 and employers' recruitment initiatives targeting pharmacists in these new countries to work in GB. This is further supported by the fact that Polish pharmacists made up the largest proportion (35%) of new European registrations since January 2005, overtaking Spanish pharmacists (32%), a trend which continued in 2006, 2007 2008.[27;133;134]

Route % (n)	Adjudication route		European route		Reciprocal route		N
	%	n	%	n	%	N	
2002	2.5	1,041	1.4	592	4.5	8,972	43,727
2003	2.8	1,242	2.2	1,013	4.4	1,976	45,110
2004	3.0	1,371	2.6	1,203	4.5	2,077	46,183
2005	3.1	1,429	3.0	1,392	4.2	1,926	46,396
2006	3.0	1,427	3.5	1,665	4.6	2,182	47,066
2007	3.0	1,417	4.1	1,982	4.2	2,015	47,962
2008	3.7	1,805	4.7	2,293	3.7	1,807	48,794
2009	2.8	1,390	4.9	2,423	3.5	1,737	49,646
2010	3.5	1,773	5.4	2,735	3.2	1,621	50,664

Table 5– Route of registration of ITPs on the Register[2;7;27-29]

The decrease in the number of pharmacists entering via the reciprocal route was particularly noticeable after 2006. There was a slight increase in the number of reciprocal-entry pharmacists registering, particularly in 2006, before this route of entry ended in June 2006 for Australian and New Zealander pharmacists. In 2010, only a small number of registrants from Northern Ireland entered through the reciprocal route.[2]

Following this description of ITPs' proportions, the subsequent sections will present findings from the literature on pharmacists' migration, starting with reasons for migration.

1.12.4 Reasons for pharmacists' migration

In 2008, Hassell *et al.*[7] evaluated reasons for migration and permanence of movement of British-trained pharmacists who were living overseas. Initially, secondary analysis of the Register of Pharmacists was conducted to compare and contrast different groups of pharmacists according to route of registration. This was followed by qualitative data collection from 35 British-trained, overseas-domiciled pharmacists to inform the design of a large self-completion survey of all British-trained pharmacists with an overseas address. The survey achieved a 54.7% response rate. Buchan *et al.*[77] 'mobile nurse' typology was adapted and used as a baseline to describe reasons for emigration of British-trained pharmacists. The most important reason for migration was returning home (15.1%), moving for career opportunities (13.8%), for life style or economic reasons (14.7%) or as a 'spouse trailer' (13.1%). More than half of the (54%) pharmacists did not intend to return back to GB.[7]

In 2004, Lithuania joined the EU. Smigelskas *et al.*[135] looked at attitudes of Lithuanian pharmacists towards migration to other EEA countries by surveying 654 pharmacists (response rate of 47.5%). The findings indicated that more than 25% of Lithuanian pharmacists intended to work in other EEA countries and the most common chosen destination was the UK (48.8%). The study identified that pharmacists with a good command of English were four times more likely to state that they may work abroad. Intention to migrate was also associated with age; those who were less than 30 years old were three times more likely to respond that they would work abroad than older pharmacists. The main factor influencing migration was the income gap that existed

between Lithuania and the destination countries. Better quality of life, better professional opportunities and better living conditions were the other reasons mentioned.[135]

Wuliji *et al.*[136] conducted a survey of 791 final year pharmacy students, in nine developed and developing countries, on their intention to migrate. There was a significant difference towards the professional and socio-political environment of the home country and perception of opportunities abroad between those who had no intention to migrate, or short term migration intention, and those who intended to migrate long term. The findings also provided evidence to reveal that economic incentive for emigration was not an independent factor in itself, but rather a piece of the jigsaw that fitted in with other motives to encourage emigration. [136]

Owusu-Daaku *et al.*[137] conducted a qualitative study exploring the professional aspirations of final year pharmacy students in Ghana, with particular focus on their perceptions of opportunities for achieving those at home and/or abroad. In interviews, students described a desire to surpass in their professional roles and described a commitment to education beyond their first degree. They wanted to have the opportunity to use their knowledge in clinical practice to improve quality of care. However, barriers to their ambition within the profession were described. All respondents perceived a lack of recognition of the potential role of pharmacists in the healthcare system. In contrast, the participants believed that was not the case in the UK or the US. Participants stated post-graduate education as the most common reason for leaving Ghana, as they perceived the quality of education to be better elsewhere. All participants expressed a desire to return to Ghana, sometime after their migration, to contribute to healthcare. However, the authors concluded that this idealism might change, as the students graduated and gained experience in different settings in Ghana.[137]

Austin[138] set out to assess the reasons for migration and the experiences of ITPs in Ontario, Canada. In this study, a purposeful sampling technique was adopted to select 30 individuals for qualitative semi-structured interviews. Participants in this study were recruited from the ITPs who had made contact with the Ontario College of Pharmacists (the OCP, the licensing body for pharmacy practice in the province). Interviews were

also conducted with 15 ITPs who had already been licensed in Ontario as pharmacists for at least three years. One of the main reasons given by ITPs for migration to Canada was the prospect of providing better opportunities for their children, even though some of the ITPs did not even have children at the time they emigrated. Other reasons for emigration included family reunification and encouragement from family and friends who were already settled in Canada. Few participants spoke about the opportunities for professional development as a motivation for migration. Several participants also talked about the potential business opportunities and economic gain that were achievable in Canada.[138]

A wide range of push and pull factors have been identified as important to other healthcare professionals in their decisions to migrate (see section 1.8).[137] Although only a limited number of studies existed on pharmacists' migration, it was clear that many of these factors also applied to pharmacists. For example, pharmacy students in Owusu-Daaku et al.[137] suggested migration as being driven by a desire to achieve professional development, while the majority of pharmacists in Smigelskas et al.[135] indicated financial motives as the cause for migration. Earlier in the literature, based on Buchan 'mobile nurse' typology, different key migration categories were identified, including the career migrant, the economic migrant and the migrant partner. These, in large, could also be applied to pharmacists, as demonstrated by the work of Hassell et al.[7] However, the study by Austin et al.[138] identified the prospect of providing better opportunities for children as the main motive for immigration of pharmacists into Canada. This was not accounted for in Buchan's typology and thus requires further examination. Findings of Wuliji et al.[136] confirmed previous conclusions, that better remuneration in the host country is not the only key reason for intended international migration of pharmacy students, but that reasons for migration are multidimensional and often interwoven in complex ways. This requires further investigation concerning the ITPs in Britain.

1.12.5 Working experiences of internationally trained pharmacists

Cavaco et al.[139] explored the perceptions and adaptation of the immigrant pharmacists' community in Portugal, concerning their practice and life in general. The study involved distribution of questionnaires that comprised a qualitative section. Questionnaires were sent out to all immigrant community pharmacists registered with the Portuguese

Pharmaceutical Society (n=771). Of the 125 pharmacists who replied, 36 fully completed all sections of the questionnaire, resulting in a relative response rate of 28.8% (or 16.2% of all mailings). Descriptive statistics and reflexive coding of the qualitative data were used to obtain perceptions and attitudes. Immigrant pharmacists were mostly from Europe and South America. Most (61.1%) pharmacists were satisfied with their decision to migrate to Portugal. However, they also reported that Portuguese colleagues were biased against them and this restricted their professional integration. There were mixed perceptions concerning Portuguese community pharmacy practice. Some expressed negative aspects, such as a strong profit-based approach on the part of pharmacy owners and managers, while others reported positive aspects of the practice, such as professional autonomy.

In the study conducted by Austin,[138] which was described in the previous section (1.12.4), as well as investigating reasons for migration, he also set out to assess the personal and professional experiences of ITPs in Ontario, Canada. ITPs in this study described a 'double-culture shock' experience: becoming accustomed to both a new national and a new professional culture. Most pharmacists initially relied on co-nationals for support and help and described being excluded from professional social networks. This led to devaluing and dissociation from professional culture, and defensiveness regarding the professional culture of their home country.

This section provided an overview of the literature on migration of pharmacists across borders. Although only a limited number of studies existed on the migration of pharmacists, findings suggested that ITPs' migratory reasons are in large similar to reasons given by IRNs and ITDs for their migration. The researcher only identified two studies on working experiences of ITPs in their new host countries and 'feeling excluded' and 'being treated with bias' reflected parts of the literature on the experiences of IRNs and ITDs.[138;139] Following this review of the literature identified by the initial literature search, the subsequent sections described the findings from the second and third cycle of the literature search.

1.13 Communication as a challenge

The second cycle of the literature search involved exploring the communicative proficiency of ITPs and its potential impact on patient safety. The findings from the literature on communicative proficiency of IRNs, ITDs and ITPs are described in this section.

Communication is vital in healthcare settings, especially for doctors, nurses and pharmacists who have direct contact with patients. However, because of a range of factors, IRNs and ITDs encountered difficulties that hindered their ability to communicate. In total, 11 out of the 24 studies in table 3 documented communication difficulty, especially immediately after arrival. Despite being prepared linguistically, IRNs still found themselves not equipped enough to meet the communication demands in the UK.[83;110;112;126;140] Unfamiliarity with accent and pronunciation limited understanding and, in addition, usage of slang, idioms, abbreviation and jargon caused major obstacles at work for IRNs.[55;83;110;112;126;140] In other words, there was a gap between the formal 'BBC English' and informal 'Street English'.[54] Communication via telephone was particularly difficult, due to the loss of non-verbal cues.[54] On the other hand, British nurses often found it difficult to understand IRNs' accents.[54;108] Additionally, lack of knowledge about the cultural norms, which are intimately related to verbal and non-verbal communication, aggravated the communication gap.[54;126;140] IRNs made a general recommendation that they should have a better cultural introduction to the local dialect and colloquialisms, as well as British nursing practices.[54]

With regards to ITDs, one study revealed that communication problems exist even when ITDs were proficient in English.[142] Another study reported that ITDs were more likely to be referred for problems in communication than home-trained doctors.[141] Doctors expressed disappointment with their lack of ability to show compassion towards patients in a different culture both, through choice of words and non-verbal actions.[102;143] ITDs and their mentors in McDonell and Usherwood's Australian study reported persisting communication problems relating to understanding 'Australian jargon'.[144] ITDs experienced difficulties explaining treatment options in everyday language,[145] reported that they received no training in doctor-patient communication skills and experienced difficulties with understanding informal language and the different dialects.[102;146-149]

Sully and Dallas believed dissimilarities in regional dialect can mean that even fellow-countrymen can have difficulty understanding each other.[150] As an example, they stated that a Yorkshire accent could be incomprehensible to an older person born and grown up in the East End of London.[150] This partly puts into perspective some of the challenges nurses and doctors faced when they started practising in a new country.

Communication difficulty resulted in stress, frustration and disappointment, especially when it prevented the ITDs and IRNs from performing at their best.[54;151] It affected their confidence in themselves, particularly when they had to reassure patients of their capability and skills.[143] In the US, it was not uncommon for patients to reject care by IRNs due to lack of mutual understanding[106] and in extreme cases nurses left their jobs for the very same reason.[152] Some IRNs felt that the language barrier was used as a 'social marker' for stigmatisation and became a vehicle for racism among British nurses and carers.[54;66]

In the US and Canada, the potential impact of communication problems on patient safety and quality of care have been highlighted in the literature on IRNs.[153-155] Although the researcher was unable to find studies linking communication difficulty with patient safety, results from indirect research [f] suggested that communication difficulty, and breakdowns in some instances caused both real and potential risks in patient safety and quality of care.[106;107] For example, the potential to cause harm was shown in Yi's study when a Korean nurse did not ask questions because they were too frightened.[156]

For pharmacists in patient facing roles, the ability to communicate effectively with both healthcare professionals and patients about medicines and related healthcare needs is fundamental to both patient trust and safety.[157-161] Unlike other healthcare professionals, who use different skills, such as physical manipulation, pharmacists in general must rely solely on communication and observation to aid clinical decision making.[162] The new, expanded services being offered in community pharmacies, such as Medicine Use

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[f] The researcher refers to indirect research in this paragraph. These are studies that did not aim to directly link communicative proficiency to clinical outcomes and patient safety, nevertheless, the theme of communication difficulty and its potential impact on patient safety was raised by participants during data collection.

Review (MUR), [g] add to the level of interaction with patients and, perhaps, the level of communicative proficiency the position requires.[157;162]

The literature search on communicative proficiency of ITPs in GB only identified a handful of grey literature.[134;164-166] These questioned the communicative proficiency of EU pharmacists and called for language testing of this group of pharmacists before they could transfer their registration.[134;164-166]

The only other empirical study identified, was conducted by Austin[167] on ITPs in Ontario. This study included a survey of 300 ITPs and two focus groups with unlicensed ITPs (n=9) and recently, within the past three years, licensed ITPs (n=10). In this study, the majority of the ITPs identified communication as a barrier. This primary research was part of a bigger study to identify the educational needs of ITPs in Ontario, Canada. The researcher will describe the findings from this study in the next section, in conjunction with other findings from this systematic study.

1.14 Perspective of pharmacy regulators and employers

The preliminary findings in this study identified communication difficulty as a source of anxiety when ITPs initially started to practise in the British healthcare setting. In this preliminary stage, EU pharmacists also spoke about poorly designed adaptation programmes and lack of language support during their orientation. Consequently, the third cycle of the literature search involved exploring employers' perceptions of ITPs' communicative proficiency, its potential impact on patient safety and to see if, and how, employers provide language support to assist their recruited ITPs. There was no empirical study on the perspective of ITPs' employers in GB, however, this search yielded a number of empirical studies from the perspective of the pharmacy regulator in Canada.[6;162;167-172]

In 1990, there was an increase in the number of ITPs migrating to Canada. This was to such an extent that, in 2003, 50% of all newly-registered pharmacists in Ontario, Canada had received their education and training from outside Canada or the US.[169;170]

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[g] An MUR is an appointment between a patient and a pharmacist to focus on how the patient is getting on with his/her medicines.[163]

This highlighted the need to conduct research to explore ways in which the pharmacy profession could best assist these individuals in meeting the standards and expectations of practice in Canada.[170] [h] In order to identify ways to assist ITPs, Austin[167] conducted a comprehensive study to explore the educational needs of ITPs in Ontario. A variety of research methods were employed in this study. Desk research was conducted to review 11 years of disciplinary records against ITPs. In addition, five years of peer review quality assurance audits were reviewed.[172] [i] Primary research was also conducted, which included a survey of 300 ITPs (with a response rate of 64.2%) and focus groups with unregistered ITPs, ITP supervisors, employers and recently registered ITPs. Retrospective analysis of 11 years of discipline records indicated that ITPs represented more than half of all guilty findings, despite representing only a quarter of all registered pharmacists. These pharmacists were commonly referred for practice related errors, including dispensing errors and incorrect interpretation of the prescription.[170] The examinations of the peer review quality assurance records between 1996 and 2001 revealed that, approximately 14% of the 992 pharmacists in Ontario, who were randomly selected to complete the direct assessment, did not meet standards of practice and were directed to a peer-assisted process to facilitate professional development. While, on average 7.5% of the Canadian and US pharmacists in Ontario were in this category, the proportion for ITPs was more than triple this at 28.9%.

Results from the primary, qualitative research in this study indicated that some pharmacist struggled with the relative lack of structure and training support and experienced difficulty passing examination requirements, despite passing the language test.[170] Results from the survey indicated that ITPs required most assistance with patient interviewing skills, interpersonal communication skills and professional ethics, in order to prepare for the licensure exams. The study concluded that scope of practice, the role of the pharmacist in Canada, patient-pharmacist relationships and maintenance of competency were new to some ITPs, who were used to different styles of practice.[167]

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[h] In his studies, Austin described ITPs as those pharmacists who received their education and training outside Canada or the US.

[i] Since mid 1990, the pharmacy profession in Canada put in place a mandatory peer-review process, to ensure competency of its members. Each year, a group of pharmacists who are randomly selected undertake the peer rreview process in Ontario. Direct assessment of pharmacists' competencies through use of tests and clinical examinations is a part of this process. Based on the results of the direct assessment, pharmacists are categorised as Self-Directed in their professional development or Peer-Guided.

Based on Austin's[167] research, the OCP recognised the need to develop a more formal system to assist ITPs to meet the standards of practice and pass the examination requirements. Consequently, the OCP provided funding to the University of Toronto to design programmes aimed at issues recognised through needs assessment.[170] This investment plus additional government funding, eventually led to the development of the International Pharmacy Graduate (IPG) programme at the University of Toronto in 2000.[6;170] This structured university-based curriculum means that, ITPs have access to practical courses delivered by an experienced faculty. A crucial part of the IPG programme is a 16-week series of bridging courses. These courses are based on third and fourth year pharmacy courses at the University of Toronto.[170]

Similar to non-EU pharmacists in GB who have to achieve at least level seven in the academic IELTS examinations before they can be admitted onto the OSPAP in order to register with the regulator,[41] a necessary requirement for registering as a pharmacist in Ontario is exhibiting fluency in English. Measurement of this requirement is through performance on standardised, generic tests of English, such as the Test of English as a Foreign-language (TOFEL) or IELTS. Failure to meet established standards prevents registration as a pharmacists in Ontario.[6;170]

Initially IELTS was designed to assess English language skills for admission to programmes of academic study.[173] However, this test has now been adopted by a number of regulatory bodies including the GMC and NMC as a reliable means to test English language skills for the workplace.[85;88;173] Merrifield designed a study to examine the language testing for professionals in UK, Canada and Ireland. The author contacted 24 registering bodies who officially included IELTS as the language assessment benchmarking system.[173] Of these, 14 agreed to take part in semi-structured interviews. The study found that there were variations in the number and range of assessments accepted by regulatory bodies in different countries. In the UK, eight out of ten regulatory bodies (including the RPSGB) only accepted IELTS as the assessment system of English language proficiency. In Canada, a more diverse range of testing systems was used, with some nationally-produced, occupation-specific benchmarking systems also accepted.[173]

Austin and Galli[162] have argued that examinations such as IELTS are not enough and do not capture all the communication related deficiencies of pharmacists. They indicated that the high levels of speaking, listening, reading and writing skills required by a pharmacist are basically not measured in a trustworthy manner through standardised, generic tests, which measure fluency in a informal, rather than professional, context.[6] Therefore, despite achieving OCP established standards for language fluency, many ITPs still experienced difficulty with other components of the registration process, including internship and the clinical examination.[6;162] These findings were further supported by Xu *et al.*[174] who believed one of the limitations of these standardised tests is their inability to assess the socio-cultural dimension of language which they believe is crucial in effectiveness of interpersonal communication between IRNs and their patients and colleagues.

Based on these findings, English for Specific Purposes (ESP) training was ingrained in all courses across the IPG curriculum in Ontario.[170] ESP is defined as *"customised language support designed around the advanced requirements of professional practice"* (P.146).[170] For example, through ESP training, support was provided to pharmacists so that sound alike drug names such as 'Lasix' and 'Losec' do not become confused, which could affect patient safety.[170]

Unlike the non-EU pharmacists who have to sit and achieve level seven in IELTS in order to register with the GPhC, the registration criteria for EU pharmacists who seek registration with GPhC are not as strict. EU law currently prohibits healthcare regulators from testing the language proficiency of EU healthcare professionals, a restriction that a number of regulators have lobbied to lift on the basis of its implications for patient safety.[157; 173] At the moment there are no data available to explore whether patient safety is being compromised because a pharmacist is operating in a second language.

Currently, Principle Seven of the GPhC standards of conduct, ethics and performance states:

"Make sure that you and everyone you are responsible for have the language skills to communicate and work effectively with colleagues"[175]

According to this principle, pharmacists are obligated to ensure that they, and those they employ, have sufficient language proficiency to communicate and work effectively with colleagues.[157;175] Although pharmacists have a personal responsibility to observe this obligation, the onus is on employers to ensure that staff have sufficient technical and linguistic skills to perform their job safely.[157;173] This was no different when the RPSGB acted as the regulatory body for pharmacists.

As mentioned previously (see section 1.6.3), no empirical studies on the perspectives of ITPs' employers in GB were identified. However, some grey literature existed on the topic.[157;176;177;178] In 2007, the superintendent pharmacist of a Brighton company was reprimanded for her failure to ensure that an employed Italian pharmacist was sufficiently competent in English.[176] Consequently, one of the possible questions for employers faced with candidates from the EU is what steps they should take to ensure EU pharmacists' proficiency in the English language. However, according to a RPSGB survey in 2009, most pharmacy employers did not test English language proficiency of EU applicants.[157]

Between May and June 2009, the RPSGB conducted an online survey of issues relating to English language abilities of pharmacists working in the UK. The survey was sent to 1,500 pharmacy employers and 162 responses were received (a response rate of 11%). Over half of pharmacy employers (63%) disclosed that language testing of European job applicants was not routinely undertaken and more than a third (40%) had experienced problems with employees' grasp of English. For example, difficulties talking to patients and colleagues, problems understanding standard operating procedures (SOP) and difficulty with reading prescriptions were mentioned. The survey also revealed that 55% of employers were unaware of the restrictions that prohibited the Society from testing the language proficiency of EU applicants. Another finding was that induction programmes for EU pharmacists were not consistently provided.[157;177;178]

However, other anecdotal evidence suggested a different picture.[176] In October 2008, the Chemist and Druggist reported that large multiples had turned to external providers for an alternative measure of language skills designed specifically for the pharmacy profession.[176] They reported that Boots was looking for a suitable test, but found those available "alien to community pharmacy and very academic in their nature." Consequently, in 2003, Boots got in touch with the English Language Centre at the

University of Bath, with a vision to develop a pharmacy-specific test.[176] The result was the 'University of Bath English Language Test' (UBELT), an occupation-specific test designed to examine pharmacists on the language skills they need to work in a community pharmacy.[157]

Tesco began using UBELT for its EU pharmacists in 2007.[176] Lloyds Pharmacy employs the services of an external company to carry out language proficiency tests for pharmacists.[157] In 2005, they started using a company called Linguarama to examine the language skills of their EU recruitment.[176] A brief summary of what each test involves is provided in figure 1. The UBELT and Linguarama are pharmacy-specific language tests, meaning that the test tasks are designed based on an analysis of language communication needs in the community pharmacy workplace and the test questions draw on a variety of health-related topics in community pharmacy. As in IELTS, there are separate tests for the four skills of listening, reading, writing and speaking in UBELT.[179- 181]

The listening section requires listening to a recording of a simulated professional interaction based on typical work day scenarios and answering questions. In the reading section, the candidates are required to read texts and answer questions on topics dealing with everyday and professional issues. In the writing section, candidates use given information to complete a task with a specific purpose, such as describing or summarising a problem or a condition, whereas the speaking section involves role plays with an interviewer, who could play the part of a patient.[179;180] In Linguarama, the test comprises of two parts: speaking and a written structure test. The oral test consists of a set of questions relating to both general and everyday work issues. Similar to UBELT, the candidate should take part in a pharmacy role-play.[181]

Figure 1: Common language assessment tools used by pharmacy employers[179-181]
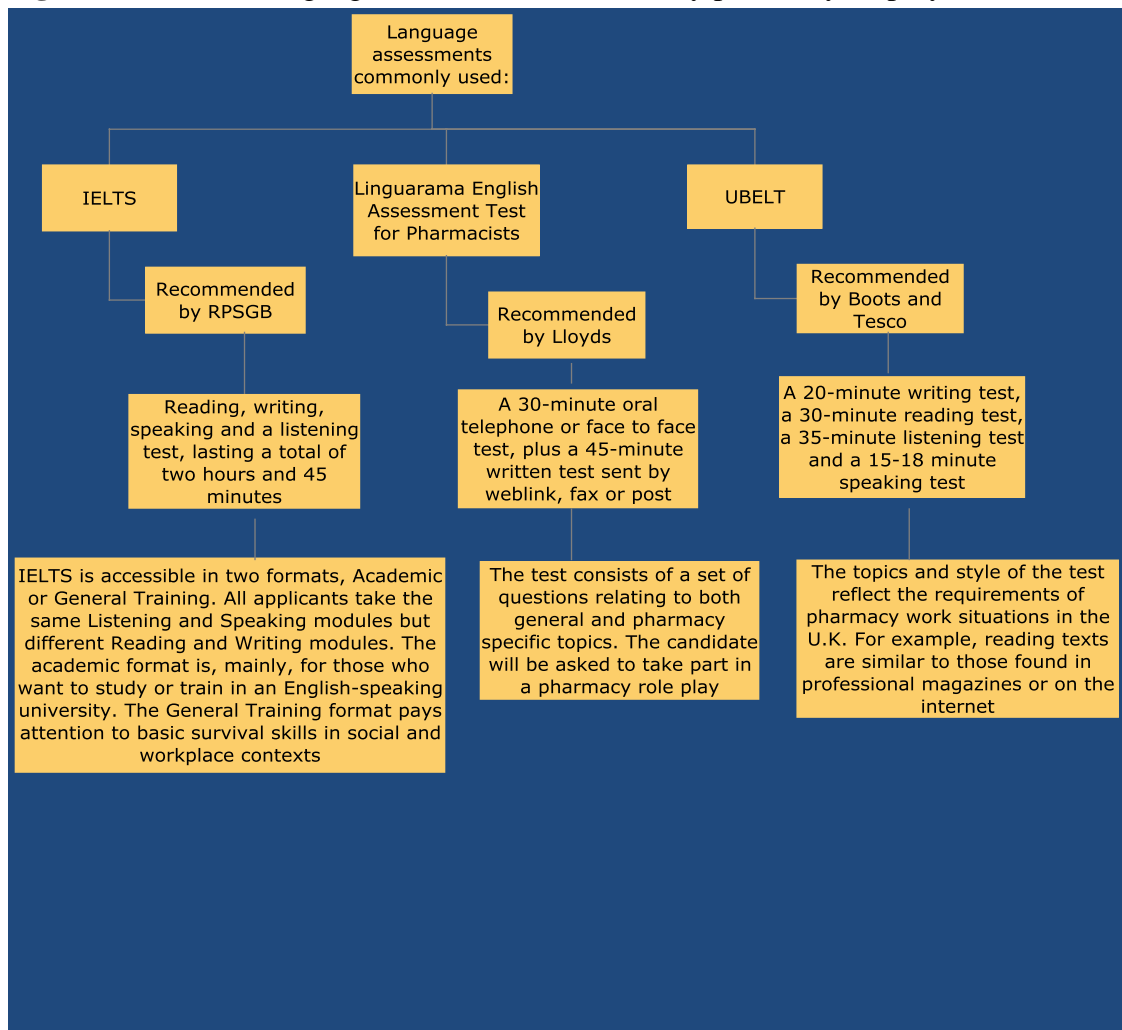
Although some scholars have argued on the effectiveness of generic tests such as IELTS in measuring the communicative proficiency of ITPs, no studies have been conducted to see if achieving minimally acceptable scores on these new pharmacy specific tests, ensures communicative proficiency of ITPs to provide safe and effective patient care.[162;175]

1.15 Chapter summary

The aim of the literature review conducted was to describe what was already known about the migration of ITPs into GB. However, the literature search resulted in a limited number of studies and grey literature on this topic. This further established the fact that ITPs' characteristics, experiences and proficiency in English, the perspective and

experiences of their employers and the impact of their employment on patient safety was generally based on impression rather than pragmatic evidence.

The one and the only study on immigration of ITPs into GB was conducted by Schafheutle and Hassell.[27] This study provided background information on size and composition of the ITPs in GB. The findings not only described the overall proportion of pharmacists on the Register by route of entry and location, but also identified trends and characteristics. The data available was, however, limited as it failed to shed light on other questions, such as: underlying root causes of ITPs' migration, ITPs experience of work in GB, their future plans and if their intention to return to their home country was influenced by their experience of work in GB. The analysis could not provide any indication of the quality of care provided by ITPs and if there should be concerns with regards to patient safety. Further primary data collection is required to answer these questions.

Considering the lack of empirical research on this particular topic, data on the migration of other healthcare professionals, that is, nurses and doctors, were presented. The literature suggested that there was a combination of push and pull factors that encouraged healthcare professionals to migrate. Motivation and intentions varied by source country and individual circumstances. One important finding was the 'mobile nurse' typology. This typology made a distinction between permanent and temporary migrants based on their country of origin and their reasons for migration. This typology was later adapted and used as a baseline to describe reasons for emigration of British-trained pharmacists by Hassell et al.[7] This study will seek to explore the appropriateness of this typology to ITPs movements into GB

Although there were descriptions of positive experiences, the literature suggested that many IRNs and ITDs had negative experiences of working. These experiences included lack of adaptation programmes, poor pay, isolation, discrimination and racism, lack of respect and recognition and problems progressing up the promotion ladder. Primary data is required to see whether ITPs in GB experience similar problems. This study will address this topic because of its prominence in the literature on IRNs and ITDs and the relevance of the topic to delivery of high quality care by pharmacists.

The literature on IRNs and ITDs also identified language and communication barriers as a root cause for issues related to adaptation and integration of these healthcare professionals into the workforce. Moreover, in the US and Canada, the potential impact of communication problems on patient safety and quality of care were raised in the literature on IRNs.[153-155] 241 To the best of the researcher's knowledge, there was no empirical evidence on the communicative proficiency of ITPs in GB and its impact on patient safety. There was also a lack of literature on employers' perception of ITPs' communicative proficiency in GB. Several studies on the perspective of the ITP regulator were identified in Canada. These studies highlighted patient interviewing skills, interpersonal communication skills and professional ethics as areas where ITPs required most assistance in order to prepare for the registration exams. Based on these findings, a more formal programme was developed to assist ITPs to meet the standards of practice and pass the examination requirements in Ontario. ESP was embedded in all courses across this programme.

In GB, research needs to be undertaken to explore ITPs' perceptions of the challenges they face in communicating in a second language and to learn if, and how, specific language issues give rise to concerns for patient safety. Although the RPSGB survey achieved a low response rate, employers indicated that they had experienced problems, which could be attributed to the employees' language proficiency. It is crucial to investigate this matter further, as difficulties talking to patients, reading prescriptions and understanding SOPs could affect patient safety.

With an aging population, growth in the prescription volume and the extended roles of pharmacists, the demand for ITPs is arguably likely to rise. Recruitment of ITPs should be more than just „filling the gaps". Listening to these professionals and learning from their experiences will help to establish the best way to look after their wellbeing and optimise the potential for retention in the British healthcare system.

Chapter 2

Overview of the programme of work

2.1 Introduction

In the previous chapter, the history of pharmacy in GB, the current policy context, the different routes that exist to enter the Pharmacy Register and the literature on migration of ITPs was presented. In the absence of empirical work on ITPs, the literature on the migration of ITDs and IRNs was also drawn upon.

Due to the limited empirical evidence on ITPs, pilot work was undertaken by the researcher to further inform the aims and objectives, the research design, and the programme of work for this thesis. This chapter describes the pilot work, the aims and objectives set for this study and an outline of the different stages of the work undertaken. The description of each stage also includes a brief summary of the different methodologies employed, the subjects included in the study and an explanation of how the different stages were linked together. Finally, the ethical approval process is described.

2.2 Pilot work undertaken

The pilot work undertaken by the researcher is described in this section. This included secondary analysis of the 2008 Register dataset and also carrying out informal discussions with ITPs and different stakeholders involved in the training and employment of ITPs.

2.2.1 Exploratory analysis of the 2008 Register

As discussed previously, Schafheutle and Hassell[27]conducted a study on the immigration of ITPs into GB using secondary data analysis of the GB Register of Pharmacists. The researcher started her PhD in 2008 and, at the time, this Register was the most recent and reliable data source on ITPs registered in Britain. The researcher decided to analyse the 2008 Register extract to:

- Familiarise herself with the Statistical Package for the Social Sciences (SPSS)
- Decide on a sampling strategy for the main research
- Establish whether there were any major changes since the last analysis conducted by Schafheutle and Hassell[27] in 2007

After requesting access and being granted consent by the RPSGB, the researcher conducted an exploratory analysis of the anonymised 2008 Register. The Register extracts for 2008 and data from the 2005 Census were merged and analysed using SPSS 14.0, producing simple frequencies. There were no major changes in the size and composition of the ITPs since the last analysis conducted by Schafheutle and Hassell.[27] Additional analysis, such as exploring the locations of ITPs in GB, was conducted so that these findings could assist the researcher with her sampling strategy. The findings are described in the next chapter (see section 3.3.2).

2.2.2 Discussion with internationally trained pharmacists and different stakeholders

To further familiarise herself with the topic, to establish any other gaps in knowledge, to understand issues from the perspective of other stakeholders involved, to establish the validity of literature findings and to ensure the topic of investigation was grounded, the researcher conducted preliminary discussions with:

- One ITP undertaking the OSPAP course at the Robert Gordon University
- Two adjudication pharmacists on the GB Register
- Directors of the OSPAP courses at three universities
- The Human Resource leaders for the international recruitment programme of three community pharmacy multiple chains
- Individuals in 'overseas registration' and 'pre-registration' departments of the RPSGB (n=3)
-

ITP undertaking the OSPAP course

This pharmacist was introduced to the researcher through a friend, who was an ITP himself. This pharmacist qualified in Malaysia and migrated to GB because he believed there were limited opportunities for his development as a pharmacist back in his home country. He decided to migrate to GB in order to excel in his professional activities and hoped that one day he could be a supplementary prescriber. He referred to the registration process as "a long, tough and expensive journey" but the desire to be a "real pharmacist" was what kept him focused.

ITPs on the GB Register

These two ITPs were known to the researcher through her personal network. They both, initially graduated from a developing country and were eventually registered in GB through the adjudication route. They were after a better lifestyle and a better working environment and believed these were attainable in GB. One of the pharmacists referred to himself as an "economic migrant" and part of the brain drain but saw no alternative to a life in the GB at least for the next decade or so.

Directors of OSPAP course at three universities

The directors were contacted through the researcher's supervisors' personal networks. All the directors reported that some of the ITPs undertaking the OSPAP course did not understand the necessity for undertaking further education before they could register as pharmacists in GB. They stated that some of these pharmacists felt that their education and training were devalued and considered to be "inferior" compared to their British counterparts and hence the need for further training. Another issue raised by all the directors was that some students believed the scope of pharmacy practice in GB to be restrictive because of the totality of the legal framework and the rules and regulations imposed upon pharmacy in GB.

Human Resources leaders for the international recruitment programme in private companies

The researcher had worked as a locum pharmacist prior to her PhD and so she was known to different private companies. Based on these personal contacts, the Human Resources leaders in three community pharmacy multiple chains agreed to take part in a telephone conversation with the researcher, after a brief explanation about the research was given to them. All of these individuals reported that strategies for recruiting pharmacists from other EU countries had benefited their organisation. They were able to fill vacancies especially in rural areas. However, they mentioned that the source country does dry up eventually and therefore there is an inevitable need to shift focus to a new country. All the companies started recruiting in Spain but as the EU expanded they shifted towards the Eastern European countries such as Poland. All companies provided an adaptation which varied in length. The biggest problem outlined was standardizing the level of knowledge of all the recruited pharmacists.

Individuals in 'overseas registration' and 'pre-registration' departments of the RPSGB
The researcher visited the RPSGB and spoke to individuals in the 'overseas registration' and 'pre-registration' departments of the Society. The discussions which were conducted clarified some conceptions regarding the different registration routes.

These discussions offered the participants the opportunity to express themselves in a way ordinary life rarely affords them. ITPs, especially, found it flattering and even cathartic to discuss their opinions and life experiences and to have someone listen with interest. The three ITPs who participated in the discussions believed the topic of research, is of an enormous interest to ITPs in general and they asked to be contacted if the researcher required further help with her research in the future. Similarly, directors of the OSPAP courses and Human Resource leaders seemed genuinely interested in the topic and offered further help and support in terms of arranging talk time with their ITPs' employees/students if need be. It became clear through this process that the participants, ITPs as well as their employers and educators were able and willing to discuss and share their experiences with the researcher.

All of these discussions provided crucial information to generate an overview of the situation of ITPs in GB and informed the overall approach to the research design. Given the novelty of this programme of work, it was decided that a qualitative approach was most appropriate. This allows for the use of a flexible approach to questioning and facilitates a more grounded and realistic evaluation of ITPs' reasons for migration, experiences of working in GB, communicative proficiency and future plans. This is discussed further in the next chapter (see section 3.2).

The review of the literature and the pilot work undertaken by the researcher informed the aims and objectives of this programme of work presented in the next section.

2.3 Aims and objectives

This programme of work had three main aims:

- Firstly, to understand more about the migration of ITPs and to gather information and understand ITPs' expectations and experiences of working in GB and their future plans

- Secondly, to understand more about the communicative proficiency of ITPs who speak English as a second language and its potential implication on patient safety from the perspectives of the ITPs

- Thirdly, to explore the communicative proficiency of ITPs who speak English as a second language and its potential implication on patient safety from the perspective of ITPs' employers

The objectives were to explore:

- ITPs' reasons for migration to GB and expectations prior to their arrival
- ITPs' experiences while working in GB
- ITPs' future plans
- ITPs' perceptions of cross-cultural communication challenges when communicating in a second language
- ITPs' perspective on the level of support provided by the employing bodies for communication
- Strategies ITPs had used to overcome potential communication barriers
- ITPs' perspectives on the potential impact on patient safety resulting from operating in a second language
- How employers viewed their responsibilities in terms of testing language proficiency and supporting ITPs
- Employers' perspectives on the potential impact on patient safety resulting from operating in a second language

2.4 Outline of programme of work

To address the main aims, the work for this thesis consisted of three stages (see also figure 2). The first of these involved semi-structured qualitative interviews with ITPs. The interviews were designed to provide a better understanding of ITPs' migration into GB, including: their reasons for migration, their experience of working in GB and their future plans. The interviews identified a number of issues relating to ITPs' experiences in GB. However, communication difficulty was a common theme through the majority of the interviews, and its widest sense, did cause nearly all non-native speakers some level of anxiety This finding, in addition to the restriction imposed on UK regulators,

Figure 2: Summary of the stages in this programme of work

Stage One

Qualitative interviews with ITPs (n= 29)
Aim and objectives:
To understand more about the migration of ITPs and to gather information and understand ITPs' expectations and experiences of working in GB and their future plans. To explore:
- ITPs' reasons for migration to GB and expectations prior to arrival
- ITPs' experiences while working
- ITPs' future plans

Stage Two

Eight focus groups (n=40) and two face-to-face interviews with ITPs in four distinct geographical locations

Aim and objectives:
To understand more about the communicative proficiency of ITPs who speak English as a second language and its potential implication on patient safety from the perspectives of the ITPs.
 To explore:
- ITPs' perceptions of cross-cultural communication challenges when communicating in a second language
- ITPs' perspectives on the level of support provided by the employing bodies for communication
- Strategies ITPs had used to overcome potential communication barriers
- ITPs' perspectives on the potential impact on patient safety resulting from operating in a second language

Stage Three

Qualitative interviews with employers of ITPs (n= 9)

Aim and objectives:
To understand more about the communicative proficiency of ITPs who speak English as a second language and its potential implication on patient safety from the perspective of ITPs' employers.
To explore:
- How employers viewed their responsibility in terms of testing language proficiency and supporting ITPs
- Employers' perspectives on the potential impact on patient safety resulting from operating in a second language

including the RPSGB and the new GPhC, with regards to language testing of EU candidates stimulated the researcher's interest to take this forward to inform and shape the further stages in her programme of work. This interest was further motivated by the data revealed by the Society's survey, where 63% of employers disclosed language testing of EU job applicants was not routinely undertaken and more than a third had experienced problems with employees' grasp of English.[157;177;178] Therefore, the emphasis in the subsequent stages of this programme of work is concentrated on the communicative proficiency of ITPs. A qualitative methodology wasused to explore this relatively un-researched topic. In the second stage, focus groups were conducted with ITPs to understand more about their communicative proficiency and its potential implication for patient safety.

Pilot discussions held with employers of ITPs highlighted the difficulties they faced in terms of standardising the level of English and knowledge of their newly recruited EU pharmacists. On the other hand, findings from semi-structured interviews in stage one also revealed that adaptation programmes and language support were not consistently provided to all EU pharmacists. The Society's survey also indicated a lack of awareness amongst the employers about the restriction placed on the regulatory body with regard to testing the language competence of EU pharmacists and the expectation from them to check the language skills of this group of pharmacists. Moreover, there was deficient literature on employers' perceptions of ITPs' communicative proficiency and its potential impact on patient safety. This lack of literature, the findings from the Society's survey, in addition to the findings from stage one about the lack of language support for EU pharmacists, prompted the researcher to conduct qualitative telephone interviews with employers of ITPs in the community and the hospital sector. The third stage followed on from the first stage, in conjunction with the second stage, and intended to capture employers' perceptions of the challenges ITPs face in communicating in a second language, its potential implication on patient safety and how they view their responsibilities in terms of testing the communicative proficiency and supporting ITPs during their adaptation period.

2.5 Ethics approval

This programme of work required approval from a Local Research Ethics Committee (LREC). For stage one, a NHS REC application form, along with the research protocol, interview topic guide (appendix 4) and relevant letters and documents (appendices 5 to11) were submitted to Oldham LREC. Attendance at an Ethics Committee meeting took place on 11th December 2008 and a brief synopsis of the project was given to the panel by the researcher. The researcher also responded to a number of questions from the panel. The committee asked the researcher to include a paragraph in the participant information regarding the issue of breaking confidentiality. Ethics approval was granted on 8th January 2009. A copy of the letter of approval can be found in appendix 12.

For stage two and three, a NHS REC application form, along with other relevant documents (appendices 13 to 23) was submitted to Lancaster LREC. Attendance at an Ethics Committee meeting took place on 11th March 2010 and a brief synopsis of the project was given to the panel by the researcher. The committee pointed out that the participant information sheet needs to explain that if a bad practice is identified, there is a duty to disclose. Following amendments to information sheet ethical approval was obtained on 23rd March 2010. A copy of the letter of approval can be found in appendix 24.

The University of Manchester Ethics Committee also had to give authorisation for the study to be conducted. To get authorisation the research protocol and NHS REC forms were submitted to the University Research Committee and approval was obtained on 15th January 2009 for stage one and 20th April 2010 for stages two and three respectively.

2.6 Chapter summary

This chapter has described the pilot work undertaken, the aims and objectives, an outline of the programme of work and the ethical approval process. The next chapter describes the methodology employed, the sample of participants and the data analysis for this programme.

Chapter 3

Methodology

3.1 Introduction

The methodology employed for this programme of work is described in this chapter. The initial stage of the research was a literature review, which identified what is generally known about the pharmacy workforce and, more specifically, about the migration of pharmacists and what could be learned from the migration of other healthcare professions. This was part of setting the scene for the research undertaken here and the findings have been described in chapter one. Desk research was also used to describe the registration process in GB, largely to learn how it might impact on decisions to migrate and what barriers to migration might exist in GB. Again, the findings from this have been brought together as part of the context in chapter one.

The pilot work undertaken to inform the study design and the sampling was explained in chapter two. This included secondary analysis of the 2008 Register data and also carrying out discussions with ITPs and the different stakeholders.

Finally, the methods for the primary research undertaken for this programme of work are described in this chapter. To answer the research questions, data were generated in three stages, involving semi-structured interviews and focus groups; these are described in detail in this chapter, including sampling, recruitment, their conduct and method of analysis.

3.2 Overall approach to this programme of work

Various approaches to tackle the aims and objectives were considered. An early decision was made that a qualitative approach would be most suitable for this programme of work. Qualitative research involves participants giving their own descriptions and interpretations of their attitudes, behaviours and motivations.[182] It basically provides information about the 'human' side of an issue.[182] Quantitative research, on the other hand, is concerned with the systematic and statistical measurement of the relationships between variables.[183] The decision made was based on the fact that there was very little prior knowledge about the ITPs and their employers in GB and this research could provide the basis for further, perhaps more quantitative work. Another advantage of this approach is that it allowed for a flexible research

design.[184;185] In an unexplored area, such as experiences of ITPs and their employers in GB, this was thought to be the most appropriate approach, as it enabled the follow-up of the initial findings. This flexibility also allowed greater spontaneity and adaptation of the interaction between the researcher and the study participants. Participants had the chance to reply more elaborately and in greater detail than is typically the case with quantitative methods.[186] In turn, the researcher had the opportunity to react right away to what participants said by tailoring following questions to information the participant had provided.[186]

3.3 Stage one – semi-structured interviews with internationally trained pharmacists

3.3.1 Data collection method

Given the novelty of the topic of this study, it was decided that a qualitative approach was most appropriate for this programme of work. Consequently, qualitative approaches, such as observations, focus groups and individual interviews were considered for data collection. Observations were ruled out fairly quickly because achieving the aims and objectives by observation technique alone was impossible at this stage. On the other hand, focus groups would have stimulated debate and reflection. However, in this preliminary stage, the researcher was aiming to obtain individual narratives from participants to ascertain their motives and behaviours. Therefore, qualitative interviews were chosen as the method of data collection.

One-to-one interviews allow a great deal of information to be gathered in a short space of time. Interviews are described as a 'conversation with a purpose'[187] and a qualitative interview can be used to obtain subjective descriptions of life experiences, in order to develop a greater understanding of the issues being considered.[187] At this particular stage, a qualitative interview was seen to be appropriate because the main aim was to explore ITPs' experiences, the way they do things, their motivations, their attitudes, their knowledge and their future plans.

Semi-structured interviews are a sort of half-way house between qualitative in-depth interviews and more fully structured interviews.[188] In a fully structured interview, the interviewer uses a detailed schedule and the questions are asked in a specific order.

Questions are mostly closed and use numerical rating scales and/or tick boxes.[188] Such interviews are suited to situations where there is a considerable body of knowledge to help prepare relevant questions and where data from interviews is to be collected for quantitative analysis.[189] Structured interviews were not suitable for this stage because the aim of the project was to gain a greater understanding of migratory reasons and experiences of ITPs in GB. On the other hand, in-depth interviews are defined as relatively spontaneous, unstructured discussions.[188] Such interviews are suited to situations where relatively little is known about the topic under investigation, as they allow the subject the freedom to discuss issues that the researcher may not have considered. At this stage, unstructured interviews would have produced rich but less focused data. In addition, Lee[189] had suggested that an unstructured approach requires researchers with strong interviewing skills. As this was the first set of interviews to be carried out by the researcher it was considered to be an inappropriate way to start.[189] Semi-structured interviews were selected for this part of the work as there was a wide range of literature on the reasons for migration and the experiences of work of IRNs and ITDs in the UK to draw upon, in addition to the limited literature on migration of ITPs. It would have been inappropriate to use literature on migration of doctors and nurses to produce a highly structured interview, as there was no comparative studies that attempted to address whether IRNs and ITDs migrate for the same reason as ITPs and if they share similar experiences to ITPs in their new host country. A broad ranging semi-structured interview topic guide was therefore devised, based on the migration literature and the early discussions held with the different stakeholders (see section 2.2.2).

The literature describes several advantages in using semi-structured interviews.[183;184;186;188] Firstly, the dynamics of an interview allow for discovery of the participant's own meanings, which can be clarified by the interviewer during the interview. A less standardised and less rigid interview topic guide ensures that the questioning is appropriate to the participant and the particular interview situation and this flexibility could increase the trust between the participants and the researcher. The flexibility also gives participants freedom to raise issues that the researcher did not anticipate. At this stage, the prepared interview questions were open ended and non-directive. This gave the respondents the opportunity to relate to the topic in their own way and to use their own language when answering, with little or no direction in how to answer from the interviewer.

Semi-structured interviews, like any research method, are not without their disadvantages.[186] Interviews can be expensive and time-consuming and there is the potential for interviewer bias. Techniques for reducing potential bias include good interviewing techniques[186] and, to achieve this, a two day workshop entitled "How to conduct a good interview" was undertaken by the researcher at the University of Manchester. Techniques picked up during this workshop, such as establishing rapport with participants, putting them at ease and appearing to be non-judgmental, helped to minimise bias during data collection.

For this study, it would have been ideal to conduct all the interviews face-to-face. Face-to-face interviews would have allowed the researcher to pick up on non-verbal cues such as body language and facial expressions.[188] However, for practical convenience, the participants were given the option of taking part in a telephone interview as well. It was possible that participants would have preferred to discuss sensitive issues, such as discrimination, over the telephone rather than face-to-face. In general, there is a possibility that face-to-face respondents report sensitive behaviours or attitudes less truthfully, since they are more aware of the interviewer's reaction to their answers than a telephone respondent would be.[190] On the other hand, it may be easier for the interviewer to establish rapport in a face-to-face setting and thus encourage openness[190] and, as a result, the participants might feel more comfortable reporting issues of a sensitive nature.[191] In fact, in a study carried out by Jäckle *et al*.[191] the most prominent finding was that telephone interviewees were more likely to give socially desirable responses across a range of indicators. This suggested that the advantages of building up trust in the face-to-face interview outweighed any disadvantages due to lack of anonymity. At this stage, although the researcher's preference was to conduct face-to-face interviews, ITPs chose to take part in a face-to-face or a telephone interview based on their preference.

3.3.2 Sampling

To get a detailed picture of the migration phenomena, there was a need for a diverse sample in order to get a spread of attitudes and behaviours of practising ITPs who had entered the GB Register via the different routes. A purposive sample was therefore selected to obtain a diverse range of ITPs. Purposive sampling is a deliberately non-

random method of sampling, which aims to sample a group of people or settings with particular characteristics.[186] In this type of sampling, participants are selected because they have knowledge that is valuable to the research process. A more quantitative sampling strategy, such as systematic random selection, was not chosen as the intention of the research was not statistical generalisability of results, but rather an exploration and description of a complex phenomenon.[186]

ITPs were identified for qualitative, semi-structured interviews through their professional registration with the RPSGB. Initially, the Society's sample request form was completed and submitted to the RPSGB to obtain permission to use the Register of Pharmacists as the sampling frame. Permission was obtained on 17th June 2008. At the time of sampling, this Register contained information on individual pharmacists' date of birth, gender, location of registered address, ethnic background, date of first joining the Register and practising status. It also identified ITPs by their route of entry, that is, European, adjudication or reciprocal routes. To obtain reliable data on the pharmacists' sector of work, information from the 2005 Workforce Census was merged with the August 2008 Register extract so, as well as these facts, the ITPs' sector of employment was known to the researcher before sampling.

According to the 2008 Census, 70.1% of practising pharmacists worked in the community pharmacy sector and 21.7% in the hospital sector.[48] Consequently, ITPs who worked in the two main sectors of pharmacy, community and hospital, were selected for interviews. It was also thought that the situational context that the participant worked within would, to some extent, affect their experiences, thoughts and feelings. Hence, ITPs who were employed or worked as a locum for hospitals or large, medium or independent community pharmacies were sampled for the interviews.

London and Manchester were selected as the research sites. This was because the analysis of the 2008 Register by the researcher identified London (n=654) and Manchester (n=102) as the two top locations where ITPs were living at the time. A sample from these two cities was therefore likely to capture a range of ITPs' characteristics, which were expected to impact on the findings. For practical reasons, the researcher decided to start her data collection in Manchester as this was where she was based. This gave her better access to the participants and therefore a higher

chance of conducting face-to-face interviews. It was decided that, if this strategy did not provide sufficient participant numbers, or a range of views were not captured, further pharmacists with an address in London would then be identified.

3.3.3 Inclusion and exclusion criteria for the one-to-one interviews

Inclusion criteria

Practising ITPs registered with the RPSGB who:

• gained entry to the Register via one of the European, adjudication or reciprocal routes

• were practising within the community or hospital sector

• had their registered address within Manchester or London

 Exclusion criteria

Those who did not meet the inclusion criteria

3.3.4 Sample size

It is recommended that the size of purposive samples be established inductively and sampling continues until 'saturation' occurs.[192] Glaser and Strauss first defined 'saturation' as the point at which "*no additional data are being found whereby the [*researcher*] can develop properties of the category. As s/he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated …. when one category is saturated, nothing remains but to go on to new groups for data on other categories, and attempt to saturate these categories also*" (p. 61).[193]

According to Guest, Morse stated at least six participants are needed for qualitative interviews, while Bertaux argued that 15 is the smallest acceptable sample size in qualitative research.[192;194] In this specific study, based on the sample heterogeneity and the research objectives, it was anticipated that at least 25 interviews would be needed to reach saturation. This was later confirmed once the interviews were conducted and analysed.

3.3.5 Recruitment strategy

At the time of the data collection, there were 102 ITPs with a registered address in Manchester. Based on the 2005 Workforce Census, the sector of employment for 54 of these pharmacists was known. In total, 49 ITPs in Manchester were practising in the community or the hospital sector (see table 6).

Total number of ITPs with an address in Manchester	Number of ITPs in Manchester whose sector of employment was known	Number of ITPs in Manchester practising in community or the hospital sector	Number of ITPs in Manchester whose sector of employment was unknown
102	54	49	48

Table 6 – Sector of employment for ITPs in Manchester

Initially, a letter of invitation (appendix 5) was sent to all 49 ITPs known to work in the hospital or community pharmacy sector, with a registered address in Manchester. The invitation also included an interview information sheet (appendix 6) and a reply slip (appendix 7). The pharmacists were asked to send back the reply slip in the Free-post envelopes provided and to indicate whether or not they were interested in taking part. In total, nine ITPs sent their reply slip back within 14 days of receiving their invitation letter, expressing an interest in taking part. In order to encourage a response, a second follow up letter was sent to the remaining 40 ITPs (appendix 8). It was decided that if no response were received after two attempts, then no further contact would be made. Individuals who did not want to take part were asked to state why, so the reasons given could be taken into consideration for future work. On the reply slip, participants were asked to provide brief demographic details (country of origin, nationality/ies and sector of employment). These details were used to ensure that a range of pharmacists, with a range of characteristics, were selected for the interviews. After the reminder letter was sent out, six more ITPs posted back their reply slips and expressed their interest in taking part.

In 2006, Nichols, a PhD student at the School of Pharmacy at the University of Manchester, aimed to explore reasons for migration of two groups of pharmacists - ITPs in Britain and British-trained pharmacists overseas. She sent out 80 letters to ITPs in Britain to recruit them for her preliminary qualitative study. Only 18 ITPs took part in

her email interviews. This low response rate (22.5%) eventually lead to Nichols only concentrating on British-trained pharmacists residing overseas for her thesis.[195]

Based on Nichols' experience, and having only managed to recruit 15 pharmacists for semi-structured interviews in this study, the researcher decided to maximise recruitment by sending a letter of invitation, an information sheet and a reply slip to the remaining 48 ITPs in Manchester whose sector of employment was unknown. Seven ITPs sent their reply slip back within 14 days of receiving their invitation letter, expressing an interest in taking part. After the reminder letter was sent out, five more ITPs posted back their reply slips and expressed their interest in taking part. All 12 of the ITPs who expressed an interest in taking part were practising in the community or hospital sector.

Altogether, 27 individuals in Manchester were interested in taking part. In total, 26 ITPs agreed to participate in a face-to-face interviews and one in a telephone interview. These individuals were contacted again by phone/email to arrange a time and a place for an interview. A confirmation letter (Appendices 9 and 10) was then sent out detailing the venue (if applicable), date and time of the interview. Phone/email reminders were sent two days before the interview to remind participants and to confirm participation. A summary of the recruitment of ITPs in Manchester is given in figure 3.

From the 27 ITPs who agreed to take part in an interview in Manchester, only two were reciprocal pharmacists. Schafheutle and Hassell[27] noted that, in 2007, 28.9% of reciprocal pharmacists registered in GB had a London address. Consequently, a decision was made to target London in order to attract reciprocal entry route pharmacists into the study. However, through the researcher's supervisors' personal networks, individual reciprocal pharmacists in London, had heard about the study and had expressed their interest in taking part. Consequently, invitation letters and information sheets were emailed to the interested pharmacists (n=3). Two reciprocal pharmacists in London consented to taking part in a telephone interview. As a result, four interviews were conducted with reciprocal pharmacists and no further invitation letters were posted out to ITPs in London.

Figure 3– Summary of ITP recruitment in Manchester

Invitation letters sent to 49 ITPs, practising in the community or the hospital sector in Manchester

Invitation letters sent to 48 ITPs in Manchester whose sector of employment was unknown

Nine sent their reply slip within 14 days and agreed to take part

After reminders sent out to the remaining 40 ITPs, six sent back their reply slip and agreed to participate.

Seven sent their reply slip back within 14 days and agreed to take part

After reminders sent out to the remaining 41 ITPs, five sent back their reply slip and agreed to participate

Overall 26 face-to-face and one telephone interview were conducted

Eight interviews were conducted at the University of Manchester

14 interviews were conducted at participants' homes

Four interviews were conducted at participants' places of work

3.3.6 The interviews – where, when and how long

Invitations were sent out between February and May 2009 and interviews began in March 2009. In total, 29 ITPs were interviewed of which 18 were male and 11 were female. The sample captured the range of characteristics, including age, gender, sector of employment, route of entry, nationality, country of origin and length of time on the Register as these were expected to have an impact on the findings. Face-to-face interviews were conducted at locations throughout Manchester on specified times and dates with locations and venues selected being convenient for the participants. Venues included offices in the University of Manchester and home or work places of individual

pharmacists. The interviews lasted between 40 to 90 minutes and were tape recorded and transcribed verbatim.

The interview was started by the researcher giving a brief overview of the research. The participant was then asked to raise any questions s/he might have. Usually no questions were raised. One participant was concerned about the issue of confidentiality and asked if his name would appear in any research paper that might be published. This concern was dealt with appropriately and he was assured that an ID number would be used, not his name. A consent form (appendix 11) was posted to individuals who agreed to take part in a telephone interview and they were asked to complete, sign and post back the consent form. The individual who agreed to a face-to-face interview gave informed, written consent before the interview began. Field notes were generally taken during the interviews with the researcher keeping a research diary throughout the study and making further notes in this after each interview was finished.

3.3.7 The interview topic guide

A broad ranging semi-structured interview guide (see textbox 1) was devised, based on the migration literature and the early discussions held with the different stakeholders (see section 2.2.2).

Textbox 1: Semi-structured interviews with ITPs

Before migration
Why did you decide to migrate to GB?
What were your expectations before you came here?
What was the most important factor in your decision to work in GB?
What other factors played a part?

Experiences of work in GB
Talk to me about what you had to go through to become registered as a pharmacist here?
Was your training satisfactory? Did it suit your needs?
Tell me about your first position as a pharmacist in GB?
Tell me about your working conditions today? Are they satisfactory?

Future intention
Do you know if you will return to your home country to settle?
What would affect your decision to stay/leave?

The draft topic guide was reviewed with PhD supervisors and minor alterations were made to the wording of some questions. The final topic guide used for semi-structured interviews with ITPs can be seen in appendix 4.

The interview topic guide was used as a preliminary guide and not as a rigid interview structure that had to be adhered to. The interview questions were arranged so that there were some relatively easy questions to start the interview with. This was done so that the participants were gently eased into the interviews and could relax before being asked potentially more difficult questions. The last question in the interview gave the interviewee the opportunity to summarise his/her thoughts and feelings. It also gave him/her a further chance to mention any points that might have been missed previously. This question also served to wind the interview down so that the interview could finish on a relaxed note.

3.3.8 Pilot interviews

As explained previously, the researcher attended a two-day interviewing workshop so that she could be trained in the technique of interviewing before going into the research field. As part of the course, an interview had to be conducted with a chosen individual on a topic of interest and an essay written to critically reflect on the interview conducted. The researcher also conducted another further practice interview with one ITD. In this interview, the ITD was very talkative, maybe because she knew the researcher as a friend. However, when it came to the sensitive questions, the researcher felt that the interviewee was reluctant to talk about issues such as discrimination. After further probing, the interviewee said that she would talk about her "bad experiences" but she did not want this part of the interview to be tape recorded, a situation that could have arisen in a real interview. This aided the researcher in dealing with this eventuality. The tape recorder was turned off and written notes were made for the rest of the interview. To gain further experience, the researcher conducted an interview with an ITP who was a friend. No major changes were made to the interview guide itself following this interview; however, the manner in which the introduction and certain questions were phrased was modified to make the interview a less formal affair.

3.4 Stage two - focus groups with internationally trained pharmacists

Communication difficulty was a common theme that arose in the majority of the interviews and, in its widest sense, did cause nearly all non-native speakers some level of anxiety. In stage two, the researcher decided to look at the issue of communication in more depth, in order to understand more about the communicative proficiency of ITPs who spoke English as a second language and to see if communication difficulties have a potential negative impact for patient safety.

3.4.1 Data collection method

Given the novelty of this topic, the communicative proficiency of ITPs and its impact on patient safety, it was necessary to explore feelings, attitudes and experiences of ITPs. Qualitative approaches, such as individual interviews and focus groups were considered. Individual interviews would have allowed specific and probing questions to be asked. However, based on the findings from stage one, the researcher anticipated that the older pharmacists, who had been on the Register for a longer period, would struggle to remember the language difficulties they initially experienced. Therefore, a technique was required that would stimulate debate, discussion and reflection and allow stories and statements to be clarified and put into context. Consequently, focus group discussions were chosen. Focus groups are a form of group interview that capitalises on communication between research participants in order to generate data. In a focus group, people are promoted to talk to one another: asking questions, exchanging narratives and commenting on each other's ideas and experiences.[196] It is hoped that this group processes can help people to explore, explain and clarify their views in ways that would be less easily reachable in an interview.[197] This is especially useful when discussing issues that are difficult to remember.[186]

The disadvantage of focus groups is that the "*articulation of group norms may silence individual voices of dissent.*"[197] The confidentiality of the session is also compromised due to presence of other research participants. However, one should not assume that focus groups are unsuitable when researching sensitive subjects. Actually, discussion in a group can actively aid the debate of taboo topics because the bolder members of the group break the ice for more reserved participants. Participants can also provide

reciprocal support in expressing feelings, thoughts and ideas that are common to their group, but which they consider to diverge from mainstream culture.[54;197] This is especially significant when exploring stigmatised or taboo experiences.[197]

For this stage, based on the explanations given, focus groups were selected as the appropriate method of data collection from the ITPs. However, getting ITPs to come to group gatherings was anticipated to be problematic as, similar to other pharmacists, ITPs are busy people with full schedules. They live and practise in different regions and getting them together for a focus group was considered to be challenging. Consequently, initially, during recruitment, if the pharmacist was unable to take part in a focus group, a one-to-one interview (face-to-face or telephone) was offered instead (appendix 16). However, as will be seen later on, after conducting two face-to face-interviews, the researcher came to realise that interviews were not the most suitable method of data collection for this stage. Consequently, when recruiting further participants, the option of an interview was not given and participants were only invited to take part in focus groups.

3.4.2 Sampling

ITPs practising in the community and the hospital sector were identified in the same manner as in the previous stage, by purposive sampling through their professional registration with the RPSGB. Permission was obtained from the RPSGB to use the Register as the sample frame on 22nd January 2010. Subsequently, information from the 2008 Workforce Census was merged with the August 2009 Register extract so, as well as pharmacists' age, gender, location of registered address, ethnic background, date of first joining the Register, practising status and route of entry, the ITPs' sector of practice was known to the researcher before sampling.

For the purpose of this stage, only pharmacists who spoke English as a second language were invited for participation. Consequently, invitation letters were only sent out to EU and adjudication pharmacists. To further ensure that this criteria was met, participants were asked on the reply slip to indicate whether or not they spoke English as a second language and only those who indicated that this was the case were invited to attend the focus groups.

London, Manchester, Liverpool and Glasgow were selected as the research sites. As described previously, the analysis of the 2008 Register identified London and Manchester as the two top locations where ITPs were living at the time. Liverpool and Glasgow, with 76 and 24 ITPs residing in each respectively, were also popular locations with the ITPs. London was chosen as a site because the largest number of ITPs lived in the capital. The other popular locations of Manchester, Liverpool and Glasgow were selected with the aim of capturing areas where language and dialect were likely to be challenging. A sample in these locations was therefore likely to capture a range of ITPs' characteristics, which were expected to impact on the findings.

For each focus group, the researcher attempted to put together pharmacists who had registered with the Society within the last five years with those who had been registered for longer, as the newly registered pharmacists were more likely to remember the language difficulties they had experienced. However, the older pharmacists, who had been on the Register for longer, could also draw on their experience of adaptation and adjustment. This strategy allowed the researcher to capture views of both older and younger EU and adjudication pharmacists, who were practising in different geographical locations. The researcher intended to conduct a maximum of 10 focus groups with a maximum of eight pharmacists in each group, as the recommended number of people per group is usually four to eight.[197] The aim was to conduct two focus groups in each city and a further two were planned in case data saturation was not reached after the initial eight focus groups. However, as will be seen later (see section 3.4.4), conducting two focus groups in each city did not become a reality due to the low response rate; nevertheless, the researcher ensured data saturation by conducting more than two focus groups in two of the research sites.

To prepare herself for moderating the focus groups, the researcher took part in a workshop at the University of Manchester entitled "Running a successful focus group".

3.4.3 Recruitment strategy

Manchester

At the time of data collection (April 2010), there were 100 ITPs with a registered address in Manchester. In total, 49 of these pharmacists practiced in the community or

the hospital sector. For the remaining 51 pharmacists, the sector of employment was unknown. Based on the low response rate in stage one, it was decided to send a letter of invitation (appendix 14) to all the 100 ITPs with an address in Manchester on April 2010. The invitation also included an information sheet (appendix 15) and a reply slip (appendix 16). The individuals were asked to send back the reply slip in the Freepost envelopes provided and to indicate whether or not they were interested in taking part. In order to encourage a positive response, a second follow-up letter was sent if a reply was not received within 10−14 days (appendix 17). If no response was received after two attempts, then no further contact was made. On the reply slip participants were asked to provide brief demographic details and if English was their second language. These details were used to ensure second language speakers with a range of characteristics were selected for the focus groups.

From the 100 letters that were posted out to ITPs in Manchester, 18 pharmacists sent their reply slip back and expressed an interest in taking part.[j] Two of these respondents indicated their preference for taking part in a face-to-face interview instead of a focus group. All the potential participants were contacted by phone/email to arrange a time, date and a convenient location for focus groups/interviews. The ITPs interested in taking part in a focus group, were happy to come to the University of Manchester for data collection. Face-to-face interviews were arranged to be conducted at the homes of the participants. A confirmation letter (appendix 18) was then sent detailing the venue, date and time of the focus groups/interviews. Phone/email reminders were sent two days before the focus groups/interviews to remind participants and confirm their participation.

As can be seen from figure 4, three focus groups were arranged and conducted at the University of Manchester using a topic guide (see section 3.4.5). During the focus groups, drinks and snacks were provided, travelling expenses were reimbursed and, to show the researcher's appreciation, a £20 voucher was also given to each participant. ITPs were also given a Certificate of Attendance so that they could submit their participation in this study as a Continuing Professional Development (CPD) entry on their online log.

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[j] Two EU pharmacists with a registered address in Manchester who participated in semi-structured interviews in stage one also participated in a focus group in stage two.

Figure 4– Summary of ITP recruitment in Manchester

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                    ┌─────────────────────┐
                    │  Invitation letters │
                    │  sent out to all 100│
                    │  ITPs in Manchester │
                    └─────────────────────┘
                              │
                 ┌────────────┴────────────┐
        ┌────────────────┐        ┌────────────────┐
        │ 16 ITPs        │        │ Two ITPs       │
        │ expressed      │        │ expressed      │
        │ interest and   │        │ interest       │
        │ took part in   │        │ and took part  │
        │ focus groups   │        │ in interviews  │
        └────────────────┘        └────────────────┘
```

| Focus group one. Conducted on 10/05/10. Five participants: three Spanish, one Polish and one Swedish pharmacists | Focus group two. Conducted on 21/05/10. Six participants: two Polish and one Spanish, Pakistani, Nigerian and Egyptian pharmacists | Focus group three. conducted on 18/06/10. Five participants: three Spanish and one Italian and one Sudanese pharmacists |

The two adjudication pharmacists who took part in face-to-face interviews had been living in GB for over eight years. They clearly struggled to remember the initial difficulties they had experienced with the language. Although the researcher used prompts, the pharmacists could still not remember specific incidents. This was not the case in the focus groups. Many EU pharmacists described the initial difficulties they had had with the language and this prompted the memories of the adjudication pharmacists, who had been in GB for a longer period, into also remembering and commenting on their problems, as well as their coping strategies. The dynamics of the group discussion produced valuable data and, through this process, it became clear to

the researcher that an interview was not the best method of data collection for this specific study. Consequently, the letters that were sent to ITPs in other cities only invited them to take part in focus groups and the option of interviews was not provided.

London

At the time of the data collection, there were 655 ITPs with an address in London. Based on the 2008 Workforce Census, the employment sector for 379 of these pharmacists was known. In total, 351 ITPs in London were practising in the community or the hospital sector (see table 7).

Total number of ITPs with an address in London	Number of ITPs in London whose sector of employment was known	Number of ITPs in London practising in community or the hospital sector	Number of ITPs in London whose sector of employment was unknown
655	379	351	276

Table 7– Sector of employment for ITPs in London

To decide who should be invited to the focus groups, the 351 eligible ITPs, practising in the hospital or community sector, were randomly assigned to group A, B or C, each comprising of 117 pharmacists. Invitation letters and subsequent reminders were sent to ITPs in group A (n= 117) in the same manner as the Manchester letters. From the letters that were sent out, 12 ITPs sent their reply slips back and expressed an interest in taking part. Two of these pharmacists spoke English as their first language and consequently could not participate in the study. To arrange the focus groups, the researcher contacted the eligible candidates. However, it proved more difficult to arrange focus groups in London as the majority of interested pharmacists worked longer hours compared with the Manchester participants and they did not want to travel far to get to the focus group venues. To ensure a good turnout for her focus groups, the researcher decided to overbook each focus group by about 20% since it was possible that ITPs may just decide not to show up on the day or be caught in traffic. Therefore, invitation letters and subsequent reminders were sent to ITPs in group B (n= 117). In total, 16 ITPs sent back their reply slips and expressed their interest in taking part.

To arrange the focus groups, the researcher pre-booked four venues in four different districts of London, at different dates and times (see table 8) and a poll was created using a website called Doodle, used for scheduling events. The use of Doodle allowed

the researcher to collect the availability of participants and then make an informed choice from the results obtained.

An email was sent to the interested individuals, in which ITPs were advised to access the Doodle link provided and use their unique ID numbers, which had initially been sent to them with their invitation letters, to indicate their availability in the poll (see table 8). ITPs were advised to tick the boxes for ALL the group sessions that they were able to attend.

	Date: 30/06/10 Time: 8-10pm Venue 1: Jurys Inn Chelsea, SW6	Date: 01/07/10 Time: 7- 9pm Venue 2: Jurys Inn Islington, N1	Date: 08/07/10 Time: 7- 9pm Venue 3: Kings College London, SE1	Date: 09/07/10 Time: 8- 10pm Venue 4: Brunei Gallery, WC1H
ID number	√	√	√	√
ID number		√		
ID number	√		√	

Table 8 – Example of the poll participants had to complete on Doodle

After the link was sent to the potential participants, three ITPs replied and stated that they could not attend any of the sessions. Four of the ITPs who sent back their initial reply slips, did not respond to the email and so, after being sent a reminder email, no further contact was made. Based on the result obtained from Doodle, three focus groups were organised across London with a total of 19 participants. However, five ITPs failed to attend the focus groups on the day and so, eventually, three focus groups were conducted in London with a total of 14 participants. A summary of ITP recruitment in London is provided in figure 5. Similar to the focus groups conducted in Manchester, drinks and snacks were provided, travelling expenses were reimbursed and a £20 voucher and a Certificate of Attendance were given to each participant.

Figure 5– Summary of ITP recruitment in London
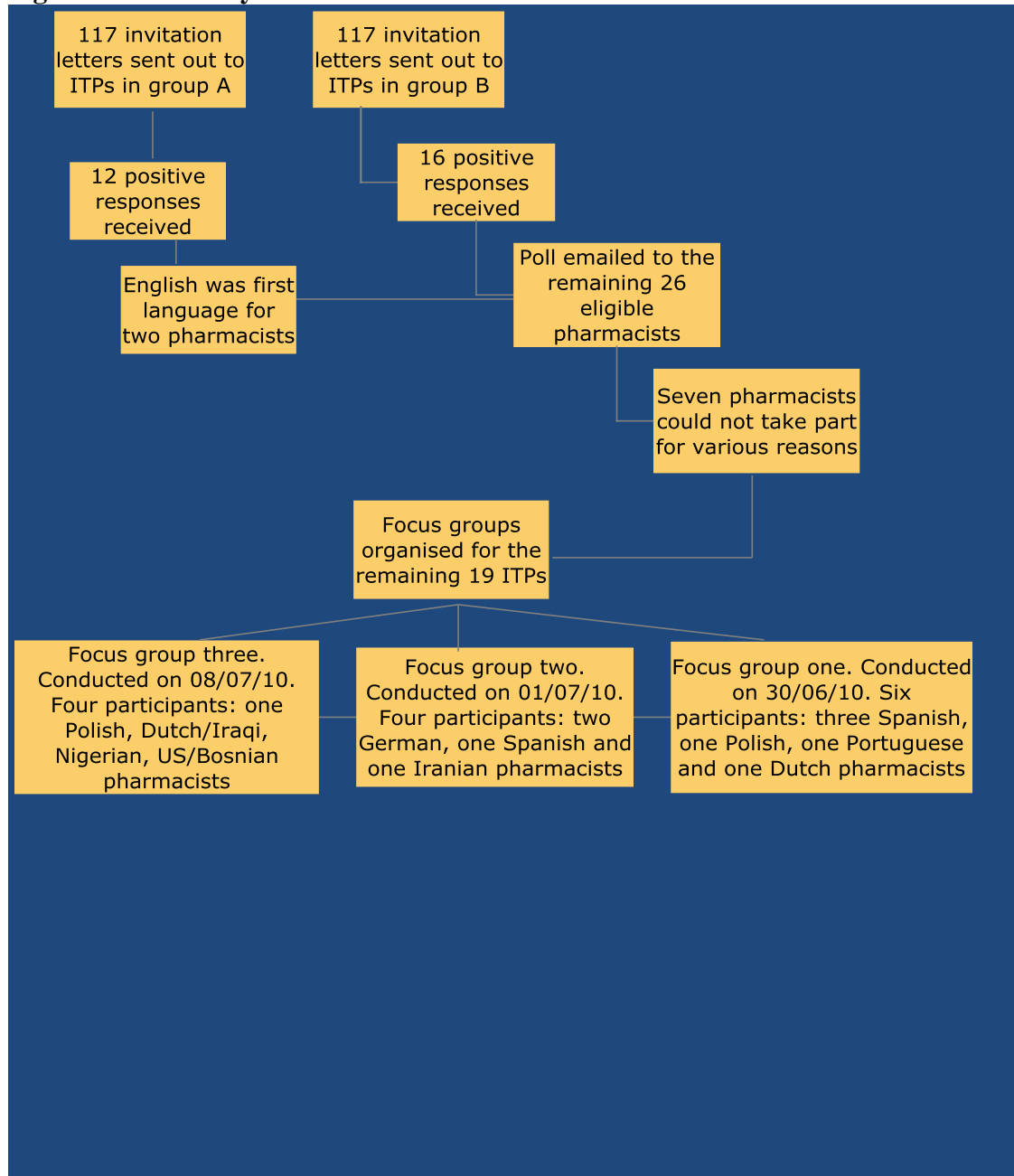
Liverpool and Glasgow

At the time of data collection, there were 100 ITPs with an address in Liverpool (n=76) and Glasgow (n=24). Based on the 2008 Workforce Census, the sector of employment for 53 of these pharmacists was known. In total, 50 ITPs in Liverpool and Glasgow were practising in the community or the hospital sector (see table 9). Based on the low response rate in stage one, it was decided to send out an invitation letter to all ITPs who

practised in the community and the hospital sector and also to those whose sector of employment was unknown.

Total number of ITPs with an address in Liverpool and Glasgow	Number of ITPs whose sector of employment was known	Number of ITPs practising in community or the hospital sector	Number of ITPs whose sector of employment was unknown
Liverpool: 76 Glasgow: 24	Liverpool: 39 Glasgow: 14	Liverpool: 38 Glasgow: 12	Liverpool: 37 Glasgow: 10

Table 9– Sector of employment for ITPs in Liverpool and Glasgow

Invitation letters were sent to ITPs in Liverpool (n=75) and Glasgow (n=22) in the same manner as the Manchester letters. From the 97 letters that were sent out, 15 pharmacists (Liverpool (n= 6) and Glasgow (n= 9)) sent their reply slips back and expressed an interest in taking part. Arrangements were made for the focus group in Glasgow to take place in Strathclyde University. A hotel was booked for the focus group in Liverpool and all six ITPs attended the focus group in Liverpool. However, five ITPs failed to turn up to the session in Glasgow. A summary of ITPs recruitment in Liverpool and Glasgow is provided in figure 6. Similar to the focus groups conducted in Manchester and London, drinks and snacks were provided, travelling expenses were reimbursed and a £20 voucher and a Certificate of Attendance were given to each participant.

3.4.4 The focus groups – where, when and how long

In addition to two face-to-face interviews, eight focus groups, with a total of 40 participants, were conducted in four cities in GB. Focus groups were conducted between May and July 2010. The sample captured the range of characteristics, including age, gender, sector of employment, route of entry, nationality, country of origin and length of time on the Register as these were expected to have an impact on the findings. Consent forms (appendix 19) were filled in by the participants before the focus groups started.

The interviews lasted for thirty minutes. Focus groups lasted for an average of 120 minutes. Interviews and focus groups were tape recorded and transcribed verbatim. As anticipated, after eight focus groups saturation was reached. Although the researcher initially aimed to conduct two focus groups in each city, that was not achieved in

Liverpool and Glasgow because of the small number of qualified participants and a low response rate. To reach saturation, more focus groups were conducted in London and Manchester, where a higher response rate was achieved. Field notes were taken during the focus groups and the researcher kept a research diary throughout the study and made further notes in this after each focus group was finished.

Figure 6– Summary of ITP recruitment in Liverpool and Glasgow

Invitation letters sent to 75 ITPs in Liverpool	Invitation letters sent to 22 ITPs in Glasgow
Six ITPs expressed interest in taking part	Nine ITPs expressed interest in taking part
Focus group conducted on 11/06/10. Six participants: Four Spanish, one Polish and one Maltese pharmacists	Focus group conducted on 08/07/10. Four participants: One Swedish, one German, one Kenyan and one Argentinean pharmacists

3.4.5 The focus group topic guide

There were no studies describing the communicative proficiency of ITPs in GB at the time that this stage of work was undertaken. Consequently, in addition to the data obtained from the first stage, it was necessary to draw upon the literature on migration of IRNs and ITDs yet again to produce a broad ranging focus group topic guide (see textbox 2).

The final topic guide used for focus groups with the ITPs can be seen in appendix 13.

Textbox 2: Focus groups with ITPs

Initial difficulties with communication
What was it like communicating for you, once you came here? How would you describe it?
What were the biggest barriers in communicating, particularly in professional settings?
Can you give me examples of things that you didn't understand initially at work because of language?

Coping strategies
How did you manage to overcome communication difficulties?
What strategies did you use to overcome these challenges?

Support from employers
Did you get any language training from your employers?
What was the training like? Was it useful?

3.5 Stage three - semi-structured interviews with employers of internationally trained pharmacists

The third stage followed on from the first stage, in conjunction with the second stage, and was intended to capture communicative proficiency of ITPs (who spoke English as a second language) and its potential implication for patient safety from the perspective of the ITPs' employers in GB.

3.5.1 Data collection method

The researcher anticipated that this topic would be considered sensitive by the employers because they might not wish to report problems with their recruited ITPs, as it would show their organisation in a poor light. Consequently, in this stage, the aim was to use a qualitative approach, which would allow the employers to discuss the communicative proficiency of their recruited ITPs confidentially. As a result, one-to-one, semi-structured interviews were chosen as the method of choice for this stage. The grey literature on British employers' perspective of their recruited ITPs, and the literature on the perspective of the pharmacy regulator on ITPs in Canada, were used to produce a broad-ranging topic guide. The interviews gave the ITPs' employers the

opportunity to discuss confidentially the communicative proficiency of their recruited ITPs.

3.5.2 Sampling

The employers of ITPs in community and hospital pharmacies were identified and recruited via personal networks and snowball sampling. Initially, to recruit for her interviews, the researcher decided to contact the Director of Human Resources, the Superintendent Pharmacist or the Area Manager in a selection of small, medium and large-sized community pharmacy chains. The Director of Human Resources was considered to be involved in direct recruitment of ITPs and thought to be in the best position to comment on the selection criteria, training and the level of support provided for ITPs. The Superintendent Pharmacist of a company is the individual who has the general responsibility for setting out the benchmarks and strategies for the provision of pharmacy services within that company.[198] He/she must ensure that procedures are in place to record and report errors or near-miss incidents.[198] Therefore, if a serious error had occurred because of an ITP's poor linguistic proficiency, it was thought that the Superintendent Pharmacist would be in the best position to comment on the nature, significance and implications of the mistake. The Area Manager in a community pharmacy is a person leading the pharmacy team in an area, ensuring all pharmacies operate ethically and legally.[199] It was believed that the Area Manager was more likely to have had direct contact with ITPs on a daily basis and so would be in a position to comment on the issues that had been raised by ITPs themselves or their co-workers.

A selection of community pharmacy companies listed below was contacted for requirement purposes.

- National chain/multiple pharmacies
- The national supermarket chains
- A selection of smaller to medium chains

Initially, in order to recruit hospital employers for her interviews, the researcher decided to contact the Chief Pharmacist in hospitals. The Chief Pharmacist is the head of a pharmacy department within a hospital and one of his/her responsibilities is to make certain that all the necessary training is provided for staff, to ensure safe and effective

running of the pharmacy. Therefore, the Chief Pharmacist was considered to be in the best position to comment on the language proficiency of ITPs in the hospital and if any training programme was provided to assist them with their communication skills.

Through the researcher's, and her supervisors' personal networks, individuals in each of these organisations were known to the researcher or her supervisors. The researcher was intending to conduct face-to-face or telephone interviews. However, based on a study about poor performance carried out in the School of Pharmacy at the University of Manchester, the researcher thought that telephone interviews would probably be a more viable option.[200] Findings from this study suggested that telephone interviews with employers were actually an easier and more efficient way of obtaining a full and speedy response. Employers of ITPs are busy people with full schedules and arranging a time to see them face-to-face for an interview was considered to be a prohibitive issue whereas telephone interviews are generally shorter and easier to schedule. Therefore, it was decided that, if the ITPs' employers were not able to take part in a face-to-face interviews, telephone interviews should be conducted instead.

3.5.3 Recruitment strategy

Individuals in each organisation were contacted via email. The email contained an invitation letter (appendix 20) and an information sheet (appendix 21) as attachments. Individuals were asked to reply to the email expressing their interest in taking part. In order to encourage a positive response, a second follow-up email was sent if a reply was not received within 10−14 days (appendix 22). Individuals who showed an interest in taking part were contacted by the researcher to arrange a time and date for the interview. Phone/email reminders (appendix 23) were sent two days before the interviews to remind participants and confirm their attendance. A consent form (appendix 19) was emailed to individuals who agreed to take part in a telephone interview and they were asked to complete, sign and email back the consent form. The individual who agreed to a face-to-face interview gave informed, written consent before the interview began.

Recruiting employers of ITPs was difficult as there was a low response rate. Initially, emails were sent to two Superintendents and two Chief Pharmacists but no responses were received. Seven emails were sent to the Directors of HR or Resourcing Managers

and, if a response was received, it was mainly a negative one. For example, one said "*We are currently involved in a business change programme and it isn't appropriate for our leaders to be involved in external work like this at the moment.*" To have a better chance of recruiting, colleagues at the University of Manchester who had retained a practical element in pharmacy chains and hospitals were contacted and several email addresses were obtained. Through this process the researcher managed to recruit two participants. As the researcher was a locum pharmacist before starting her PhD she had contacts with different companies, so another two individuals were recruited through her personal networks. These four initial interviewees introduced other people within their organisations who they deemed to be knowledgeable about the recruitment and training of ITPs and they were contacted. Overall, the researcher was able to conduct eight telephone and one face-to-face interview with a purposively selected sample of ITP employers in community and hospital settings in GB.

3.3.4 The interviews – where, when and how long

In total, two hospital and seven community employers were interviewed between May and July 2010. The one face-to-face interview was conducted at the work place of the employer being interviewed. Interviews were conducted at a convenient time for participants, lasted between 30 and 40 minutes and were tape recorded and transcribed verbatim.

3.3.5 The interview topic guide

A summary of the topic guide used for the semi-structured interviews are presented in the textbox 3 below.

Textbox 3: Semi-structured interviews with employers

Initial difficulties with communication
What challenges do ITPs face in terms of language when they start to practice in GB?

Language testing
Do you check ITPs' language abilities before they start to work in your organisation?

Responsibility
Do you think it is your responsibility or the Society's responsibility to check the language proficiency of ITP?

The final topic guide used for the interviews with the ITPs' employers can be seen in appendix 13.

3.6 Data analysis

All the interviews and focus groups in stage one, two and three were recorded and transcribed verbatim. The transcribed data were managed and analysed using the qualitative data analysis package NVivo 8. The data analysis started shortly after each interview/focus group was undertaken. The framework approach was the technique that was used to analyse the qualitative data.[201] Framework was selected because this approach is better adapted to research that has specific questions, a limited time frame and a pre-designed sample, all of which applied to this programme of work.[201] This approach to qualitative data analysis allowed the researcher to set categories and themes from the beginning based on the research questions and the available literature but also allowed for categories and themes to emerge from the data during analysis. Therefore although this approach reflected the original accounts and observations of the ITPs (that is, "grounded" and inductive), it started deductively from pre-set aims and objectives. This analytical process also tends to be more explicit as developers offer a guide to their method which is clearly expressed, and presents detailed instructions on how to go about each stage of the analysis.[201] This proved to be advantageous as this was the first time the researcher was attempting to analyze qualitative data. Other methods of analyses such as grounded theory were not used because the grounded theory approach stresses the generation of theory as the final output of research and that was not the aim in this programme of work.

Ritchie and Spencer describe five key stages to qualitative data analysis using the 'framework'. These are familiarisation, identifying a thematic framework, indexing, charting and mapping.[201] Each of these stages, with its relevance to this programme of work, is described below:

Familiarisation
Ritchie and Spencer[201] describe familiarisation as becoming "*familiar with the range and diversity* (of the data)*"(P.178). As the researcher undertook all the data collection herself, she was close to the data from the beginning. As described, notes were usually taken during and after the data collection and, consequently, early evolving themes were

being noted. Each transcript was read and re-read. Notes were made in the margins of the transcripts while transcribing, to summarise the context, possible codes, suggestions for improving the questioning technique and areas requiring further exploration. For example, in stage two, after the first four focus groups, notes in the margins led to the decision to concentrate on the ITPs' views on cross-cultural communication challenges at the next focus group discussions, as 'problems with telephone' and 'technical language' had been described comprehensively by ITPs in the previous discussions.

Identifying a thematic framework and indexing

Ritchie and Spencer[201] describe identifying a thematic framework as identifying *"key issues, concepts and themes according to which data can be examined and referenced"* (P.179).

Indexing as *"the process whereby the thematic framework or index is systematically applied to the data in its textual form"* (P.181).

While reading the transcripts, the researcher created a list of themes and, using NVivo, assigned codes to parts of the data. Many of the early themes and codes were based on questions from the topic guide, for example 'what were your reasons for migration?' was a 'theme', while particular building blocks, such as 'better pay' or 'professional development', were 'subthemes'. Eventually this process allowed the researcher to view the data by codes and themes, across different transcripts. During this process, further related concepts were identified, some of which then also became themes or subthemes within the index.

Charting

Ritchie and Spencer[201] describe charting as *"build up a picture of the data as a whole, by considering the range of attitudes and experience for each issue or theme"* (P.182). In order to compare the views of the different groups, that is, EU, adjudication and reciprocal pharmacists, summarised accounts of the data were entered into charts. These charts had the main themes as the column headings, for example, what pharmacists thought about the training provided for them, and the different participant groups as row headings, for example, EU pharmacists. Charting allowed the range within key issues and themes to be mapped out so that association between different codes could be identified.

<u>Mapping</u>
Ritchie and Spencer[201] describe mapping as the process to *"pull together key characteristics of the data, and to map and interpret the data set as a whole"* (P.186). Once the coding, indexing and charting was completed, the researcher built up an overview of the data by finding associations between themes, with a view to provide explanations for the findings. This process of interpretation was influenced by research objectives and themes that emerged from the data.

3.7 Reflection on data collection

This part reflects upon the actual conducting of the interviews and focus groups. The researcher's interest in researching the ITPs' experiences was sparked by the fact that she was a female pharmacist, from an ethnic minority background, who migrated to Britain at a young age because her parents wanted to continue with Further Education in this country. She believed from the beginning that her position as a Middle Eastern pharmacist interviewing other ITPs would enable her to connect with these pharmacists on a deeper level. Similar to other researchers, there were points during her research when she assumed that she and her interviewees would be "them" and not "others" to each other. Even though, as a British/Iranian, British-trained pharmacist, she was aware of the differences in culture, religion, language and, most importantly, the system they were educated in, all this seemed insignificant to her before she started her interviews. To use Hurd and McIntyre's[202] term, she fell victim to the "seduction of sameness".

However, once interviewing started, it did not take her long to realise the elements that she shared with her interviewees were only superficial. She realised that her interviewees were definitely "others", because of their reasons for migration and the experiences they had once they arrived in Britain. She could not claim that her status as a Middle Eastern pharmacist gave her any deeper understanding into the fear, excitement, happiness or the stress these ITPs experienced. M17, a pharmacist from the Sudan, told her:

"To leave Sudan as a political activist is not something very easy… condition in Sudan at the time was not improving, if anything it worsened terribly and because I was also dismissed from the government job on what they called public interest it made things really, very difficult for me... My passport and all the sundanese travelling documents had expired and the Sudan government wouldn't renew it."

This quote, in addition to other extracts, highlights why her interviewees remained "others" to the researcher. However, the researcher still does believe being a female, Middle Eastern pharmacist encouraged her interviewees to open up and describe some potentially upsetting personal experiences. During data collection, participants invariably asked the researcher her country of birth and academic background. Once this information was revealed the interview often took on a different tone, with the interviewee revealing more information and generally warming to the interviewer. Being an ethnic minority pharmacist herself, and revealing the fact that she works part-time in the community, seemed to engage the interviewees considerably, increasing their confidence and leading them to reveal further information. Hirsh[203] discussed this effect stating that better answers to questions are given when interviewers display sound knowledge than if they appear ill-informed. Disclosure can also equalise power, as Aldridge[204] found when he revealed information about himself and his connection with a particular university to Anglican clergymen he was studying. This disclosure resulted in his interviewees seeing him as occupationally similar and allowing him greater access to information. Equally, in this study, disclosure of the researcher's status as an ethnic minority pharmacist may have equalised power within the interview, resulting in greater information flow from the interviewees. Oakley believes "*the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship*"(p.41).[205]

Nevertheless, the researcher could not claim in any way that her status made her an expert on this group of pharmacists. She positioned herself as the "wise" rather than the "own", based on Goffman's[206] concept. She acknowledged that, while she was not even close to being "own", that is, an ITP, she was "wise", that is, knowledgeable about and, in cases, sympathetic to the experiences of ITPs.

3.8 Chapter summary

This chapter has outlined the rationale for using a qualitative approach for the study. It has also described the methodology employed, the sample of participants and the data analysis for this programme of work. The next chapter describes the sample of participants and explains how the data are presented in the finding's chapters.

Chapter 4

The study sample and presentation of data in this thesis

4.1 Introduction

The methodology employed for this programme of work was described in the previous chapter. Data were collected in three stages, using semi-structured interviews and focus groups. This chapter provides the background to the respondents from whom the data were collected. The characteristics of the respondents at each stage are described, before the following chapters address the key themes and objectives of this programme of work using the data collected from the interviews and focus groups.

4.2 Research participant profile

This section provides an overview of the 71 ITPs and the nine ITPs' employers who took part in each stage of this programme of work.

4.2.1 Stage one: interviews with internationally trained pharmacists to explore their migratory reasons, work experiences and future intentions

In stage one, interviews were conducted with 29 ITPs. On the reply slip (appendix 7), participants stated their nationality/ies, country of origin and their employment sector. This data, and the demographic data from the Register, were used to establish the profile of the ITPs who took part in the interviews. The researcher was successful in capturing the diversities of gender, age, race, country of origin, sector of employment and length of time on the Register in her sample. In general, the sample was broadly typical of the 2008 Register of Pharmacists.

Table 10 shows ITPs' nationalities listed alphabetically, according to the route of entry on to the Register. Of the 29 pharmacists who took part in stage one, the majority, 14 (48%), registered through the EU route, approximately reflecting the 42.1% proportion of European pharmacists on the practising part of the 2008 Register. Eleven (38%) of the interviewees came through the adjudication route and four (14%) through the reciprocal route. Polish pharmacists made up the largest proportion (35%) of new European registrations since January 2005, overtaking Spanish pharmacists, a trend that continued in 2006, 2007, 2008.[27;133;134] This was reflected in the study sample. Poland and Spain were the largest contributors of ITPs to the interviews with four participants each. Pakistan and Nigeria contributed three each while Sudan and New Zealand contributed two participants. Eight ITPs in this study were the lone representatives of

their country of origin. Eleven (38%) female pharmacists took part in the interviews, six (55%) of whom joined the Register through the EU route. This approximately corresponded to the proportion of practising European-entry female pharmacists on the 2008 Register. All the adjudication pharmacists who took part had dual nationalities. As well as keeping their original nationality, they had also become British citizens. On the other hand, only two EU pharmacists had dual nationality. One was originally from the Middle East but had trained as a pharmacist in Norway. The other was originally from Eastern Europe but had trained in France.

		Male (n=18)	Female (n=11)	Total (n=29)
European Route (n=14)	France/ Romania		1	1
	Germany		1	1
	Netherlands		1	1
	Italy	1		1
	Norway/ Iran		1	1
	Poland	3	1	4
	Spain	4		4
	Sweden		1	1
Adjudication Route (n=11)	Britain/ Canada		1	1
	Britain/Ghana	1		1
	Britain/ Nigeria		3	3
	Britain/Pakistan	3		3
	Britain/ Sudan	2		2
	Britain/ Zimbabwe	1		1
Reciprocal Route (n=4)	Australia	1		1
	Northern Ireland	1		1
	New Zealand	1	1	2

Table 10 – Nationality of interview participants

As illustrated in table 11, the average age of the participants was 38 years old, with a range between 27 and 58 years of age. The European pharmacists interviewed were, on average, younger than both the adjudication and reciprocal pharmacists, as expected. This is because the legal foundation for the recognition of European pharmacy qualification was only laid in 1985, about 35 years after recognition of the reciprocal and adjudication routes.[27;207] Consequently, pharmacists who entered via the EU route were expected to be younger than any other group, which is reflected by the research participants. On average, the participants had been in Britain for 11 years. Again, there were differences between the routes of entry with adjudication pharmacists emerging as having the longest average length of stay in GB. However, mainly due to deciding to

register with the RPSGB sometime after their arrival and a lengthy registration process, they had been registered in GB for a shorter period compared with their reciprocal counterparts.

	Average age	Average length of stay in GB	Average length of time on the GB Register
European pharmacists (N=14)	32	5 years	5 years
Adjudication pharmacists (N=11)	45	16 years	11 years
Reciprocal pharmacists (N=4)	37	12 years	12 years
Total (N=29)	38	11 years	9 years

Table 11 – Participants' average age, length of time on the GB Register and stay in GB

Table 12 shows the employment sector of the ITPs who took part in stage one. Twenty (69%) of the interviewees were working in the community sector, compared with nine (31%) in the hospital sector. There was, again, some difference between the routes of entry, the majority of the European (71%) and adjudication (91%) pharmacists interviewed worked in the community sector, while all four reciprocal pharmacists worked in the hospital sector as lead pharmacists. This approximately corresponded with the data collected through the 2005 Census, where the European and adjudication pharmacists were more likely to work in a community pharmacy, compared with their reciprocal counterparts (section 1.12.1).

The adjudication participants in the community sector were working mostly as salaried employees in chain pharmacies. Their role involved being the pharmacy manager of a branch, while European pharmacists mostly worked as locums, moving from one branch/company to another. When asked about their marital status and number of children they had, most European and reciprocal pharmacists said they were single with no children, while adjudication pharmacists were mostly married and had migrated with their partner and children.

	European (N=14)	Adjudication (N=11)	Reciprocal (N=4)	Total (N=29)
Community				
Manager	3	7	0	10
Relief	3	0	0	3
Locum	4	3	0	7
Hospital				
Pharmacist	4	0	4	8
Locum	0	1	0	1

Table 12 – Sector of employment in GB

4.2.2 Stage two: focus groups and interviews with internationally trained pharmacists to explore their communicative proficiency

In stage two, eight focus groups and two interviews were conducted with ITPs. This section provides an overview of the 42 ITPs who took part in stage two of this programme of work. Again, similar to the previous stage, the researcher aimed to capture a spread of male and female pharmacists in different age groups who had been on the Register for various lengths of time.

		London (n=14)	Manchester (n=18)	Liverpool (n=6)	Glasgow (n=4)	Total (n=42)
European Route (n=31)	Germany	2			1	3
	Netherlands	1				1
	Netherlands/Iraq	1				1
	Italy		1			1
	Malta			1		1
	Poland	2	3	1		6
	Portugal	1				1
	Spain	4	7	4		15
	Sweden		1		1	2
Adjudication Route (n=11)	Argentina				1	1
	Britain/Egypt		1			1
	Britain/Iran	1				1
	Britain/Kenya				1	1
	Britain/ Nigeria	1	2			3
	Britain/Pakistan		2			2
	Britain/ Sudan		1			1
	Bosnia/US	1				1

Table 13 – Nationality of focus group participants

Similar to stage one, of the 42 ITPs who took part in stage two a clear majority – 31 (74%) – entered the Register via the European route while 11 (26%) gained entry via the adjudication route (see table 13). The reciprocal route was not represented as the aim was to only capture pharmacists who spoke English as their second language. Spain

was the largest supplier of ITPs to the focus groups. All but one adjudication pharmacist had dual nationality. On the other hand, only one EU-entry pharmacist had dual nationality. She was originally from Iraq but had trained in Netherlands.

A higher proportion of female pharmacists participated in stage two (64.3%). The higher number of European-entry pharmacists who were recruited for this stage could explain this (see table 14). The average age was 36 years old and there were only minor differences in the average age between the four locations examined. The majority of participants practised in the community sector (69%). However, more than half of the ITPs in London practised in the hospital sector (57%). This may further indicate that junior hospital posts that were usually occupied by reciprocal pharmacists are now being filled with an increasing number of European-entry pharmacists coming into London.

	London (n=14)	Manchester (n=18)	Liverpool (n=6)	Glasgow (n=4)	Total (n=42)
Gender	Female=11 Male=3	Female=10 Male=8	Female=2 Male=4	Female=4	Female=27 Male=15
Average age	34	36	37	38	36
Sector of employment	Community=6 Hospital=8	Community=17 Hospital=1	Community=5 Hospital=1	Community=1 Hospital=3	Community=29 Hospital=13

Table 14 – Participants' gender, average age and sector of employment

As is apparent in table 15, the distribution of the number of years each participant had practised in GB differed considerably depending on the route of entry onto the Register. The majority of the adjudication pharmacists (82%) had been practising in GB for an average length of six to ten years. On the other hand, more than half of the European-entry pharmacists (58%) had been practising in GB for less than six years. The distribution of the number of years practising in GB amongst the adjudication route was greatest compared with the EU route.

Length of practising in GB	Number of participants		
	European pharmacists (N=31)	Adjudication pharmacists (N=11)	Total (N=42)
Between 1-5 years	18	1	19
Between 6-10 years	13	9	22
More than 10 years	0	1	1

Table 15 – Average length of practising in GB

4.2.3 Stage three: interviews with employers to explore their perceptions of internationally trained pharmacists' communicative proficiency

In stage three, nine interviews were conducted with employers of ITPs. Two hospital employers and seven employers in the community were recruited and took part in semi-structured interviews. The community employers who participated in interviews were based in:

- Two large national pharmacy chains
- One medium pharmacy chain
- One national supermarket pharmacy chain

The profile of interviewees is provided in table 16. The first two colour-coded categories contain personnel who were broadly responsible for the recruitment, placement of ITPs, course provision, induction and adaptation. All but one of these were pharmacists. The Area and Cluster Managers in the last category were those most closely involved with ITPs on a day-to-day or weekly basis and who provided on-going support and guidance. As explained in chapter three (see section 3.5.2), the Area Manager in a community pharmacy is a person leading the pharmacy team in an area, ensuring all pharmacies operate ethically and legally. One of the interviewees described her role as a Cluster Manager, which involved managing her own community branch as well as line-managing six other pharmacies in her area. She explained that this scheme was put in place by her company to give the individuals the experience and the expertise before taking on the responsibility of managing a larger number of branches as an Area Manager. She had the responsibility of visiting her six branches on a weekly basis and had to report to the Area Manager at regular intervals.

The participants were working, or had worked, directly with ITPs and this gave them a good awareness of ITPs' abilities, including communication, and their standard of care. Securing interviews with pharmacist and non-pharmacist employers, who had a range of responsibilities in terms of recruiting, training, supporting and managing ITPs, helped the researcher to capture the diversity of views on ITPs' competence from their employers' perspective.

	ID number	Sector	Employed in	Employer code	Role	Background of the interviewee	Location of interviewee
1	E1	Hospital	Children's NHS Trust	Hospital one	Chair of Safety Medication Practice	Pharmacist	North West of England
2	E3	Hospital	Mental Health Trust	Hospital two	Training and Education Pharmacist	Pharmacist	North West of England
3	E6	Community	Medium chain	Company one	Business Development Manager	Pharmacist	Head office
4	E5	Community	Supermarket chain	Company two	Pharmacy Training Officer	Pharmacist	Head office
5	E8	Community	National chain	Company three	UK Resourcing Officer	Non-pharmacist	Head office
6	E9	Community	Medium chain	Company one	Operation Manager	Pharmacist	Head office
7	E7	Community	National chain	Company four	Area Pharmacy Manager	Pharmacist	North West of England
8	E2	Community	National chain	Company three	Area Pharmacy Manager	Non-pharmacist	North West of England
9	E4	Community	National chain	Company three	Cluster Manager	Non-pharmacist	North West of England

Table 16 - Profile of the interviewed employers

4.3 Presentation of data in this thesis

The four chapters that follow present the findings generated during the three stages of this study (see textbox 4). The findings chapters are arranged thematically, each one addressing a specific theme. When exploring the communicative proficiency of ITPs in stage two, the dynamic nature of the focus groups resulted in participants discussing many aspects of their work experience in GB. Issues that were covered in stage one, such as ITPs' training, their relationships with patients and colleagues and their experiences of discrimination and racism, were often raised. Consequently, it was decided to combine the data from stages one and two, this provided the opportunity for triangulation of the data in order to maximise the reliability of the findings. Consequently, chapters five and six contain data from both stages one and two. Chapter seven draws on the findings from stage two on communicative proficiency of ITPs. Chapter eight describes the findings from stage three on communicative proficiency of ITPs, and its implication on patient safety, from the perspective of ITPs' employers.

Textbox 4: Results chapters in this thesis

Chapter 5: Reasons for migration, future intention and early experiences in moving
Chapter 6: Working experiences of internationally trained pharmacists in GB
Chapter 7: Communicative proficiency of internationally trained pharmacists
Chapter 8: Employers' perspective of the internationally trained pharmacists they had recruited

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4.4 Chapter summary

This chapter was an introduction to the results of the study. It described the background of the research participants and explained how a diverse range of pharmacists and employers were captured for data collection. The four following chapters present the findings generated during the three stages of this programme of work.

Chapter 5

Reasons for migration, future intentions and early experiences in moving

5.1 Introduction

The interviews undertaken in stage one of this programme of work generated a considerable amount of discussion on the reasons for migration and the future intentions of the ITPs. These are presented in sections 5.2 and 5.3. During the interviews in stage one, pharmacists also discussed their early experiences on moving to GB. Moreover, the dynamic nature of focus groups in stage two also led to discussion on this topic. Consequently, data obtained on the early experiences of ITPs in GB from the interviews and the focus groups were merged and are presented in section 5.4.

5.2 Internationally trained pharmacists' reasons for migration

The literature described in section 1.8 suggested that there is a combination of 'push' and 'pull' factors that encourage health professionals to migrate. One important finding was the 'mobile nurse' typology, which distinguished between the permanent and temporary migrants. This typology was later adapted by Hassell *et al.*[7] and used to classify and describe the reasons for emigration of British-trained pharmacists.

The researcher found the 'mobile nurse' typology particularly useful when working to conceptualise and shape the different reasons for immigration of ITPs into GB. Four categories of this typology, including economic migrant, career migrant, working holiday migrant and migrant partner, were adapted and used to describe the motives for immigration of ITPs into GB. However, to cover all the reasons described, another category named 'personal migrant' was created. Each of these are described in the following sections.

5.2.1 Economic migrant

For the European pharmacists from Poland and Spain and the adjudication pharmacists from the developing countries, the prospect of earning more money and being economically better off compared to their home country was important. Despite this, all the Polish and Spanish pharmacists also emphasised that practising pharmacy in a different setting, the chance to improve their English language and experiencing life in a different country also played a major role in their decisions to migrate:

"I wanted to experience a bit of work abroad, that's one thing. Second thing, two and a half years ago, when I was making my decision of moving to England, the pound was much stronger than it is at the moment so money affected my decision." (Male, Poland, M9)

"I just wanted to leave [home] and get a bit of challenge and start in a different way. I knew that pharmacy in England was quite different and you are better considered as pharmacists, rather than just sale assistants, as is the case in my country. I could also have improved my English but money was important too; I would have earned much more by working here." (Male, Spain, M5)

For eight of the 11 adjudication pharmacists (n=8/11), the prospect of earning more and being able to practise pharmacy in a 'modern' country and the opportunity to have access to 'up-to-date knowledge' were the most important triggering factors for migration:

"I began to think that there was more to pharmacy practice than what I was seeing in Ghana, so I would say I came for both professional and economic reasons. Those were the main two triggering factors that got me to come to the UK... so, yes, to broaden my horizons as far as pharmacy practice is concerned and to earn a bit more money than I would have had I stayed in Ghana." (Male, Ghana, M24)

These quotes suggested the financial drive for migration was an important influence but not an independent factor in itself. It was a piece of the jigsaw that fitted in with other motives to encourage the ITPs to migrate. This was supported by some of the recent literature available on migration of healthcare professionals.[54;60;62;136]

Spanish and Polish pharmacists talked about how expensive it was to live back in their home countries. They mentioned that, although the amount of tax they have to pay here is much higher in comparison to their home country, they could still afford more luxuries in GB:

"Properties in Spain are extremely expensive and some people have to put lot of their pays into their mortgage." (Male, Spain, M3)

"You have to pay a lot of tax here.....but living in UK is cheaper than living in Poland." (Male, Poland, M9)

Earnings in GB allowed these pharmacists a lifestyle they could not exercise in their home country and permitted them to make savings, possibly before returning back:

"My lifestyle is great here. It is not comparable to Poland. My wage also gives me the opportunity to save. The savings would be useful if I decide to go back." (Male, Poland, M12)

From the interviews conducted with the EU pharmacists, it seemed that those from Poland and Spain were very dissatisfied with their financial situation in their home country and earning more was an important reason for migration. The other European pharmacists, however, were relatively satisfied with the amount they earned back in their home country:

"I think on a whole my earning here should be about the same as back home." (Female, Netherlands, M14)

"My wages here are a bit higher compared to France …but you could afford more luxuries in France." (Female, France, M13)

"My earning here as an employed pharmacist is on a similar scale compared to Germany. It might be a bit more in England." (Female, Germany, M8)

When adjudication participants talked about their earnings back in their home country, two points of view emerged. One of the Nigerian pharmacists and the pharmacist from Canada believed that they had a good standard of living back home and expected a comfortable life in the event of returning back, while others believed that their standard of living had vastly improved following their migration:

"My colleagues back at home, people of my own level then [hospital pharmacists] have a very, very high standard of living now. The house they live in is twice the size of the house I'm living in now. They don't drive themselves, people drive them. So if I go back I also would be comfortable." (Female, Nigeria, M23)

"What I was getting in Sudan was nothing compared to what I'm getting here…You may not have certain things like a car because the money is not enough to buy a car." (Male, Sudan, M18)

"You cannot compare the standard of living I have here to Pakistan. It is basically not comparable." (Male, Pakistan, M16)

5.2.2 Career migrant

One of the main reasons for migration was ITPs' desire for professional satisfaction and the chance to see pharmacy being practised in a different way and to learn from this experience. They had come to see if they could be 'proper pharmacists':

"I thought it [working here] could offer me something I hadn't seen in pharmacy practice, or something I hadn't been able to imagine as far as pharmacy practice was concerned, and I also thought that I would get some professional satisfaction, you know, through getting to know what

pharmacy practice was about and exploring areas that I hadn't been exposed to." (Male, Pakistan, M19)

All the interviewees had been working in their home country before moving to GB and consequently could comment on the practice of pharmacy within their home country. This provided an important context for better understanding of the professional motive. All pharmacists interviewed commented on the existence of the three main sectors of community, hospital and industry in their home country:

"Fundamentally, it's the same...You've got community pharmacy practice, you've got hospital pharmacy practice and you have got pharmacists also working for pharmaceutical companies as medical reps so those are the three main channels of pharmacy." (Male, Ghana, M24)

However, all the adjudication pharmacists from developing countries mentioned that the community sector in their home country was not as well established and organised as it is in GB. Due to this, nine of the eleven adjudication pharmacists (n=9/11) mentioned that pharmacists back at home preferred to go into industry, which usually involved working for an international pharmaceutical company who paid well:

"Loads of pharmacists there, prefer to go to industry rather than the community because the community set up is not organised and it's not that much recognised by the government of health of Pakistan....The foreign industry there is like Pfizer or GlaxoSmithKline, they give good money to pharmacists so that's why more pharmacists go into industry rather than the community." (Male, Pakistan, M16)

After probing further it became apparent that, although the overall pharmacy structure, in terms of existence of the three different sectors, was similar to GB, there were many differences too. Non-existence of chains and relaxed laws and regulations that governed the sale and supply of the medication were some of the points mentioned by the interviewees.

All the adjudication pharmacists from the developing countries and the EU pharmacists from Poland, Spain and Italy mentioned that there were no big pharmacy chains in their home country and independent pharmacist owners owned the pharmacies. For these respondents this meant that, unless the pharmacist owned his/her own pharmacy business, the prospect of earning more was minimal:

"All the owners of community pharmacies are independent. There are no companies like Lloyds or Boots so, if you're lucky and have a million pounds, then you can buy a chemist or if you are

lucky enough to have a father who owns a chemist, otherwise you will be just a pharmacist who will earn 1200 Euros for the rest of your life without any prospects. So it is always the same, because there are no managerial positions because there is just the owner who owns the pharmacy." (Male, Italy, M6)

All the adjudication respondents from the developing countries and the European pharmacists from Poland, Spain and Italy raised the issue that community pharmacy was seen more as a business and a means to make money, rather than providing health services to the public. Some of the adjudication pharmacists went further in adding that, in their home country, money comes first and no healthcare is provided unless it is paid for in advance:

"It's [community pharmacy] just a business that belongs to the pharmacist. I mean if you see something wrong and there is a need for your intervention, you can do that, but it's not like here. It's more a business. They don't provide any services." (Male, Poland, M2)

"There is a lot of greed and people prefer money to patient healthcare so, if you can't afford the basic health treatments, they'd rather let you die than treat you." (Female, Nigeria, M20)

All the adjudication pharmacists from developing countries and the European pharmacists from Poland and Spain spoke about the lack of interaction between healthcare professionals in their home country. They also expressed concern about the relaxed rules and regulations that govern the sale and supply of medication and how this needs to be changed urgently:

"Here, there is so much more interaction between the pharmacists and the other healthcare professionals. Doctors phone you and want your advice on dosage and formulation. Back at home such interactions do not exist. You hardly ever see a doctor or speak to a nurse." (Male, Poland, M2)

"I must be frank here, the way pharmacists practice here is totally different from in Sudan and now I feel that, in the Sudan, things needs to change. Pharmacy practice in Sudan is not good. You can sell anything over the counter." (Male, Sudan, M18)

One of the push factors highlighted by some of the adjudication pharmacists and most of the European pharmacists (including all of the Spanish pharmacists) was the difficulty/impossibility of obtaining a job in their desired pharmacy sector back in their home country:

"The way it works in hospital is different. You have to pass an exam [to get into hospital] and it's an extremely difficult exam to do. There are, like, 300 or 400 vacancies and you have to pass that exam and also they look at average marks from your university years…people take an average of three years to get into a hospital." (Male, Spain, M5)

"Hospital pharmacy in Holland is very different.....There are only very few positions available within a hospital, like four or five positions in an average size hospital. If you want to become a hospital pharmacist, first you do your six year degree, but in order to apply for a training post to become a hospital pharmacist you would have to build up about five years of relevant experience on your CV, so it'll actually take you forever to get into a hospital." (Female, Netherlands, M14)

When asked to compare the way pharmacy is being practised in their home country to pharmacy practice in GB, all the adjudication interviewees (apart from the Canadian pharmacist) and the majority of the European pharmacists (n=12/14) believed that the way pharmacy is practised in GB is much more advanced compared with in their home country. They believed pharmacists in GB have a much greater clinical role and a direct involvement in patient care. These respondents believed that pharmacists back in their home country were still concentrating on supplying medicines and did not have a professional identity like pharmacists in GB:

"Service wise, I think it's much more advanced in England....You are actually able to use your knowledge much more so you get more satisfaction. In Germany you just end up finding the right product for the patient." (Female, Germany, M8)

"I like the way it is in England because it is more professional and the role of the pharmacist is bigger in the practice.....Pharmacists here, the job they do is more professional. Here you have things like substance misuse prescriptions in pharmacies, needle exchange." (Male, Spain, M3)

A few of the adjudication pharmacists, the Dutch and a Polish pharmacist had heard of 'clinical pharmacy' back in their home country and had come to GB with the expectation of being exposed to the most advanced pharmacy practice in the hospital sector:

"I started working in a Polish chemist and I think somehow I really wanted to go into clinical pharmacy so that's obviously why I'm in England; there is a high level of clinical pharmacy and that's why I decided I want to come here and to work in a hospital. I decided that England is a great place for development as a young pharmacist; you can get a lot of experience." (Female, Poland, M1)

For adjudication pharmacists these expectations were sometimes related to identifying GB as a developed country:

"In England, being a 1st world country, I felt I could get more up-to-date knowledge, especially in clinical pharmacy where basically my interest is."(Female, Nigeria, M20)

ITPs coming from former British colonies expected an advanced pharmacy practice in GB, based on the British references they used back in their home country, while the reciprocal pharmacists expected a similar practice:

"I was coming from a third world to a first world country. A country which we had seen its BNF and its Martindale. So I was just expecting a massive difference in pharmacy." (Male, Zimbabwe, M21)

"I expected the pharmacist job here, in the community, to be very similar to home." (Male, Australia, M26)

5.2.3 Working holiday migrant

When European respondents talked about their reasons for migration, a strong theme that emerged was their personal desire for adventure, to face new challenges and to experience life in a new country. This was mainly due to the dissatisfaction they felt with their home country:

"I was happy for a while but then I wanted to do something different. I wanted to come and see a different country, to give myself a chance to travel." (Female, Sweden, M11)

"I was bored by working in San Sebastian, which is a small city, and everyone knows each other. To be honest, I wasn't really satisfied with being a pharmacist back at home. I just wanted to leave and leave my family as well and get a bit of challenge and start in a different way." (Male, Spain, M5)

For the majority of the European pharmacists (n=11/14), the fact that they could use their professional qualifications to live and work in a country where they could improve their English language was important. Some (n=4/14) went further, explaining how knowing the English language would open up valuable avenues for them back in their home country:

"To learn English, yeah, that was the key issue and then, yeah, I can learn English and also practice my profession, so why not come?" (Male, Spain, M4)

"If you go back to Poland and want to work there, language is important because all companies are international, so the main issue is if you are able to speak another language." (Male, Poland, M2)

To learn the English language and truly experience life in GB, EU pharmacists (n=9/14) preferred to be away from their fellow compatriots:

"I knew other Spanish pharmacists but I didn't really want to mix with them. Otherwise, there was no pint in coming." (Male, Spain, M7)

Coming to GB to travel around Europe was the prime reason for Australian and New Zealander pharmacists, when they decided initially to emigrate:

"I came overseas as a trip experience, as I initially came here on a two year working visa and just worked and travelled." (Male, New Zealand, M27)

"England is a great place. I used it as a base to travel everywhere in Europe." (Female, New Zealand, M28)

However, the 'travelling period' only lasted for a few years, after which this group of pharmacists had to pursue a career either back in their home country or in GB:

"I was travelling with four other pharmacy friends and they all went back to New Zealand over their five year period to continue with their careers and it was just me left. I decided to stay...I really enjoyed what I did here and I preferred to work here in an area of pharmacy that I'm really interested in." (Female, New Zealand, M28)

5.2.4 Migrant partner

In total four female adjudication pharmacists were interviewed, three of whom were from Nigeria. Two of the female Nigerian pharmacists had originally followed their spouses into GB, who at that time were studying in Britain. These pharmacists saw this mainly as a duty, to follow the decision of the man of the house and to protect the family unity:

"Coming to England to practice pharmacy wasn't the plan. He [husband] was coming to do a PhD so that was the plan...coming from the background that I come from, the man is the one that everything revolves around." (Female, Nigeria, M23)

Another reason given for migration, by two of the respondents, was 'marriage'. A Canadian and a French/Romanian pharmacist both married British men and therefore decided to migrate and live permanently in GB:

"I came because my husband is English." (Female, France/Romania, M13)

5.2.5 Personal migrant

When adjudication pharmacists talked about their motives for migration, a strong aspiration that emerged was ensuring a brighter future for their children by providing British schooling for them. Other objectives for migration included ensuring personal

safety or joining friends or family members in GB. These motives were not identified as a migrant type in the 'mobile nurses' typology literature. Consequently, this category of personal migrant was created to cover these described reasons for immigration.

Some adjudication interviewees (n=6/11) talked about taking into account their children's future educational needs before making the decision to migrate. They wanted to give their children a head start in life by providing British schooling for them:

"Teaching in UK is excellent. I wanted to give that to my children" (Male, Pakistan, M19)

"My children will most likely have a better future here. They will get educated here, have better jobs and overall a better future." (Male, Nigeria, M22)

Ensuring personal safety of their family members was another personal motive for migration. This reason was mainly given by the two Sudanese pharmacists interviewed:

"What triggered me to stay here was my brother, right. My brother was actively involved in politics. In Sudan, as a third world country, if a member of family is involved in any political movement, the rest of the people in that family are particularly suspect, right, so that was the issue in my case. My brother was actively involved in politics and everything." (Male, Sudan, M18)

Before migration, six of the adjudication pharmacists knew at least one person from their home country who was already living in GB. For three, these individuals were family members or close friends:

"I mean, if I refer to your question, you said what triggered me to come and work in this country? There was nothing basically, just my family, who were here, who supported me." (Male, Pakistan, M16)

Friends and relatives supported the newly arrived adjudication pharmacists through the process of settling and adjustment:

"I had family and friends here so they really encouraged me to come and, to be honest, without them I would have struggled much more initially. They supported me in every possible way, emotionally and financially." (Male, Pakistan, M15)

5.3 Internationally trained pharmacists' future intentions

One of the questions in the semi-structured interviews was about the future intentions of the ITPs and whether they would stay and work in GB permanently or would consider moving back to their home or a third country. The future intentions of participants

varied by source country and individual circumstances. To best present these future intentions described, participants were grouped together according to their route of entry. These are described next.

5.3.1 European pharmacists

Family issues and satisfaction with work and life in GB played a major role in European pharmacists' decision to stay or go back. From the interviews conducted it seemed that the European pharmacists (n=8/14) who had been in GB for three years or more thought about the possibility of going home more seriously and one even made the decision to return soon. These pharmacists described how, after some years, their experience of GB were going 'down hill' and the initial excitement of living and working in a different country was wearing off. These pharmacists wanted to settle and have children in their home country:

"My experience in England is probably finishing. I don't know when it's going to finish, this year or next year, but it's coming soon, I can feel it...at the beginning I was excited about being here but, seven years later, a lot of things are happening within the family. My sister is having kids, my little brother is having kids. I'm next, do I want to have kids here, you know, with all my family there and just probably growing old and I want to go back." (Male, Spain, M3)

This group of pharmacists described how life in GB was exciting for them as young professionals; however, they considered the possibility of having children in GB as minimal because they described their lives as too hectic:

"I wouldn't like to stay here forever. I think as a young professional it's perfect, it's busy, and it's nice. But I can't imagine myself being 30 years old and still doing the same job I'm doing now and getting all the stress and coming home exhausted and then having to look after the children, no." (Female, Poland, M1)

European pharmacists (n=3/14) who were married to a Brit or had a British partner did not have any immediate plans for leaving GB:

"My husband is English and my children were born here so I think my roots are here now." (Female, France/Romania, M13)

European pharmacists (n=5/14), who had considered staying for the foreseeable future, considered further education, working in a different pharmacy sector or locuming as their future career plans:

"One option is to become a locum pharmacist and look for a permanent job as a pharmacist or, the second opportunity, which I'm considering quite seriously is do locuming and some post-grad studies in a different category, like toxicology or something like that and looking for a job like that." (Male, Poland, M9)

"I'm thinking of working in the community for some years and then I have the idea of going to hospital pharmacy." (Male, Spain, M5)

Moving to a third country, mainly Australia, the US or Canada, was a possibility that was considered by two of the European pharmacists, for personal or professional reasons. However, no realistic steps were taken by these two pharmacists to make the onward migration a true possibility:

"I've considered Australia because they obviously speak English and it is not so different from England and the biggest reason is climate and the culture with regards to my son's upbringing. I feel it is safer for him and he will have a better outdoor living type of life. However, it's more like a dream. We haven't done anything about it." (Female, Iran/Norway, M10)

5.3.2 Adjudication pharmacists

Like the European pharmacists, family issues were clearly central to adjudication pharmacists when they talked about staying or leaving GB. However, unlike their European counterparts, they talked about staying because of their children:

"Going back doesn't even cross my mind because it's totally out of the question now. Yeah, because my children would never go back to Nigeria. They are here, they are British and for me, now, they've become the priority." (Female, Nigeria, M23)

Many of the adjudication pharmacists (n=9/11) only considered the possibility of returning to their home country after retirement, when their children were independent:

"I'm just hoping that my children will be able to stand on their own two feet and, when I retire, there is a great possibility that I will go back." (Male, Sudan, M18)

When the adjudication pharmacists were asked about their future career plans, five mentioned they were waiting to retire. The rest of adjudication pharmacists talked about further education or owning their own pharmacy business:

"I've done the diploma already. I'm starting my doctorate in September, Doctor of Pharmacy, and that's for 5 years." (Female, Nigeria, M20)

"My career ambition? I want to do the independent prescribing course, hopefully this year, and also I want to start my own business in the community pharmacy." (Male, Pakistan, M16)

Adjudication pharmacists did not consider moving to a third country. It seemed that they were more settled in GB than their European counterparts. The process of registration in a new country was seen as a big burden by some of the adjudication pharmacists:

"I'm definitely not going to a third country. Because if I'm going to do that say, for example, in America, they are going to make me go through retraining if I want to work. Passing exams again? No, no. So this is my last stop." (Male, Sudan, M18)

5.3.3 Reciprocal pharmacists

The three pharmacists interviewed from Australia and New Zealand explained how the quality of life is better back in their home country. However, only one of these pharmacists said he would go back in the near future. One said she would go back after retirement and one was not sure about his future plans:

"Coming from New Zealand the quality of life is pretty good out there. The outdoors and the space is quite different from this country and Europe.....I will probably go back at some stage, probably within the next three years." (Male, New Zealand, M27)

"I would say the quality of life in New Zealand is much better than here… I really enjoy what I do here and I love working here in an area of pharmacy that I'm really interested in...I probably will go home, to New Zealand, to retire." (Female, New Zealand, M28)

"I don't know when I'm going back. It all depends on what I'm doing, who I'm with. You see, my life isn't set out in stages. I would like to have a house here, I would like to have a house there, and I would like to go between the two." (Male, Australia, M26)

Unlike the other reciprocal pharmacists, the pharmacist from Northern Ireland had made the decision, not to return home:

"Although I miss home I wouldn't go back to work and live there because I've made my life and my friends here now." (Male, Northern Ireland, M29)

5.4 Experiences of internationally trained pharmacists in moving to GB

During her analysis, the researcher categorised ITPs' early experiences in GB under the broad themes of 'living' and 'working'. As discussed in the previous part, ITPs migrated to GB for a range of reasons, which were summarised under five broad themes. ITPs' experiences in GB were shaped in the context of their reasons for migration. For the purpose of this research, and based on the objectives, during data

collection the researcher mainly concentrated on professional aspects of ITPs' experiences in GB. Nevertheless, during the interviews, ITPs also touched on the issue of living in GB, which provided the background for a better understanding of their working experiences in GB.

5.4.1 Living circumstances

Some of the EU participants (n=6/14) had difficulties starting life in a new country. Day-to-day issues, such as catching the right bus or opening a bank account, to more profound problems such as finding accommodation or signing the work contract, were some of the problems mentioned:

"At the beginning to be honest, the orientation, how to actually set up everything was hard." (Male, Poland, M9)

"I had these kind of problems, like I wasn't sure how to register for a National Insurance number." (Male, Poland, M12)

Transition to life in GB was described as "hard" by some of the EU participants, not only because of the simple practical issues, but also on a more elemental level of feeling homesick:

"I do miss home a great deal. I wish I was there. I miss it up to this day." (Male, Poland, M2)

Social and economic conditions affect quality of life. For reciprocal pharmacists, who came as working holidaymakers, the social aspect of life in GB seemed a key feature:

"....there was more accommodation at the back of the hospital so I asked if there was a room coming up and, you know, a room came up and my next door neighbour was xxx. We really hit it off. She was a ward nurse and she had friends and I became friends with her friends, then things changed…I very much enjoyed socialising with people and the friends I made." (Male, Australia, M26)

For most of the European pharmacists (n=9/14) the social aspect of life in GB seemed as important as the financial aspect. Therefore, some (n=8/14) spoke about the difficulties they had in making new friends and how they felt isolated, predominantly during the first few months of their stay in GB:

"Those first few months [after arrival] were not nice. I felt lonely, sad, mistreated. I wanted to just have a friend to talk to but nobody was there." (Female, Poland, Z8, FG 2)

"It is hard to get in touch with British people. I felt a certain coldness in the ways of meeting people and properly sitting down and chatting with them. I mean, it's better now, but initially I felt alone." (Male, Italy, M6)

For the majority of the adjudication pharmacists (n=7/11), the social aspect of life in GB did not have any significance:

"I'm not that kind of person who needs to go to the pub after work ...as far as I go home and watch a film I'm fine, you know, that's my social [life]." (Male, Ghana, M24)

"I had my family round me, my own group of friends from Nigeria. It really didn't matter to me if I was accepted socially here." (Female, Nigeria, M23)

5.4.2 Working circumstances

The knowledge of the private life of ITPs in GB was required when examining their quality of life. However, their work experiences were the main focus of this programme of work. The next part of this chapter will provide a chronological synopsis of ITPs' experiences from when they were recruited, arrived and started work in GB (textbox 5).

5.4.2.1 Recruitment of internationally trained pharmacists

As described in chapter one (see section 1.8.5), the literature described passive recruitment as when internationally trained healthcare professionals take the first step and apply for work in the UK. On the other hand, active recruitment was described as, when employers, or agencies, actively seek internationally trained healthcare professionals to fill the gaps within their organisations.[8]

Textbox 5: Early working experiences of ITPs in GB

Recruitment of ITPs
Arrival in GB
Registration with RPSGB
1. Adjudication pharmacists
2. Reciprocal pharmacists
3. EU pharmacists
Adaptation of EU pharmacists
1. Adaptation programmes EU pharmacists received in the community sector
2. Adaptation programme EU pharmacists received in the hospital sector
3. Mentoring
4. Assistance from colleagues
Communicative proficiency of ITPs

A number of European pharmacists from Poland (n=2), Spain (n=3), Sweden (n=1), and the adjudication pharmacist from Zimbabwe, described being actively recruited through different recruitment agencies. They were then put in touch with the interested recruiting companies in the community sector:

"Basically those recruitment agencies got in touch with the pharmaceutical societies all round Spain and they sent me a letter saying, "Do you want to work in England?"" (Male, Spain, M7)

Those ITPs who were actively recruited mentioned that they did not choose a particular company to work for. It was more a case of them being available on a particular day for an interview and, coincidently, the company who recruited them was interviewing on that particular day too. Therefore, working for a specific company was not an issue for these pharmacists:

"When I went to do my interview in Barcelona, it was with xxx people. The recruitment agency told me it was going to be with a big company and it wasn't like I made a choice between different companies, I just went there and it happened to be xxx." (Male, Spain, M7)

When actively recruited participants were asked about the interview they had with the recruiting companies, the majority (n=5/7) said that, as well as having to take part in a face-to-face interview, they also had to sit a test to show their clinical competency plus their proficiency in the English language:

"The clinical pharmacy test was actually quite long and we had to do an English test as well. It had four parts, you know, the usual reading, speaking, which I guess they pick up on in the interview, listening and writing." (Male, Spain, M5)

Other European pharmacists (n=8/14) interviewed, who were not actively recruited, came to GB individually to find work (n=7) or continue with their education (n=1):

"I came myself so I could find better work opportunities." (Male, Italy, M6)

"I came over with a friend. The plan was like…by September to start something like a Masters." (Male, Spain, M4)

Two of the reciprocal pharmacists came to GB directly and then found work through an agency, while the other two reciprocal pharmacists interviewed found employment through an agency first, before migrating:

"I went to the requirement agency once I got here, to get a job." (Male, New Zealand, M27)

"The recruitment agency sorted everything out for me so when I got here my training placement was ready." (Male, Australia, M26)

Apart from the Zimbabwean pharmacist, who was actively recruited, all the other adjudication pharmacists (n=10/11) came to GB by themselves:

"I just came to England myself. There was no direct recruitment by the companies back home." (Male, Ghana, M24)

5.4.2.2 Arrival in GB

The reception that actively recruited pharmacists (n=7) received when arriving in GB was mainly a positive one:

"The service was great from the recruitment company, yeah, I couldn't complain. I arrived, I was picked up at the airport and taken straight to the place, into a hotel, full attention." (Male, Spain, M3)

The recruiting company usually paid for the plane tickets and the hotel (a maximum of four weeks) for these actively recruited pharmacists. Most of the pharmacists were initially grateful to the company for providing these facilities, but a few were more apprehensive:

"They [the recruitment company] paid some of your expenditure at the beginning, which was a big plus, but sometimes I thought they must want something in return." (Male, Spain, M5)

5.4.2.3 Registration with the RPSGB

As explained in section 1.3, ITPs had to go through different routes to get registered with the Society, depending on which country they had trained in. For example, a pharmacist who had qualified in Europe did not need to undergo any form of adaptation programme and could register with the Society if all the necessary documents were provided, while an adjudication pharmacist should have undertaken the OSPAP and then completed a year of pre-registration training and also sat and passed the pre-registration exam.[27;40;41]

Registration of the adjudication pharmacists

To register, the first step for adjudication pharmacists was to apply to the Society's adjudication committee and attend an interview, if requested by the Society. Two

participants talked about this specific interview at the Society headquarters and how daunting they found it:

"I went for the interview at the Society's headquarters and then at the interview there were 20 people, you know. It might have not been 20 but there were a quite lot of them, asking you different questions from all sorts of areas…It was a bit intimidating." (Male, Nigeria, M23)

All the adjudication pharmacists managed to prove the equivalence of their pharmacy qualification and consequently started the OSPAP course. When asked about the quality of the OSPAP course, different views emerged. Most participants (n=8/11) found the OSPAP course useful:

"It was very good. Very, very good. I still, till today, find it useful." (Female, Nigeria, M23)

"To be honest, OSPAP was useful. I could definitely see the point in doing it." (Male, Pakistan, M15)

On the other hand, a few (n=3/11) felt only parts of the course were useful, while one believed that the whole course was only a refresher of what he already knew:

"The module on law and pharmacy practice you should really do, but pharmacology and chemistry? I think carbon is the same everywhere." (Male, Ghana, M24)

"The overseas pharmacy course in xxx was a brush up course really. In the sense that basically it takes you back to the early years, when you wanted to know the structure of Aspirin which is very basic." (Male, Sudan, M17)

The majority of the participants (n=10/11) talked about the difficulties they had paying for the OSPAP course and how they had to work hard to avoid failure:

"It was expensive. I had some savings and I borrowed some money, so I managed to live for one year on that." (Male, Pakistan, M19)

"I worked hard on that [the exams] because I knew that I had borrowed a lot of money from my dad. He would've killed me if I failed the exams." (Male, Pakistan, M15)

The majority of the adjudication pharmacists (n=9/11) were happy with the quality of training they received during their pre-registration year:

"It [pre-registration year] was brilliant, fabulous. It trained me a lot in terms of practical experience because xxx got the structured programme, you see, so it was very easy to follow for someone." (Male, Pakistan, M15)

"Pre-reg. was good. It helps you to put into practice what you got taught at OSPAP. You know, all the stuff about law and ethics, how you should look after your methadone dependent patients, how to supervise them." (Male, Pakistan, M19)

"The year you do as a Pre-reg. was useful. You learn all about the over the counter medication you can sell. You learn the different brand and generic names for drugs. You put in to practice the law and ethics you've been taught." (Female, Nigeria, M23)

A pharmacist from a former British colony did not find the pre-registration year useful because he felt the pharmacy he knew was similar to pharmacy practice in GB:

"For me I wouldn't say it [pre-registration year] prepared me for anything really because I've been a pharmacist before and the pharmacy in Zimbabwe and pharmacy here are slightly similar. Like I said, because we are the former colony of the United Kingdom, the only difference was trying to remember all the different formulations. That's all I did during my pre-reg. year." (Male, Zimbabwe, M21)

Of all the adjudication pharmacists who sat the pre-registration exam at the end of their pre-registration year, only one failed to pass this exam first time. This interviewee based his failure on an inexperienced pre-registration tutor he had:

"Well, the pre-reg. exam was not what I expected because the tutor I had at that time, never prepared me for the pre-reg. exam, which was quite unfortunate. He never prepared me properly; he never gave me the right information." (Male, Sudan, M17)

Registration of the Reciprocal pharmacists

A reciprocal route existed between the RPSGB and pharmacists qualifying from Australia and New Zealand until 30 June 2006. Pharmacists from these countries could join the GB Register provided they supplied the relevant paperwork, attended a reciprocity meeting at the RPSGB and completed at least four weeks pharmacy experience in GB.[43] This route now only exists for pharmacists who studied at a UK school of pharmacy, but undertook their pre-registration in Northern Ireland.[27;43] The three Australian and New Zealander pharmacists who participated in this study entered the Register via the reciprocal route and they described the registration procedure as a smooth process:

"Registration with the Society was pretty straight forward." (Male, New Zealand, M27)

"We did one month pre-registration and we had to attend the Society on one day for a meeting...they signed a form for us. It was very easy." (Female, New Zealand, M28)

"I came in July and I had to register with the Society and so one month after, in August, was the registration date. I had to go to Lambeth. It wasn't difficult." (Male, Australia, M26)

All the reciprocal pharmacists also described their four weeks pharmacy experience in the hospital sector as satisfactory:

"The training was good. Actually to be honest, it was exactly like what we did back in Australia. Very, very similar." (Male, Australia, M26)

Registration of the European pharmacists

For pharmacists who entered through the European route, a system of automatic recognition was in place. Under EU law, these pharmacists did not need to undertake any further training or education.[158] The RPSGB was also not allowed to check the language proficiency of this group of pharmacists when transferring registration.[158] The majority (n=12/14) of the European pharmacists described the registration as a straightforward process and they did not usually have any difficulties gathering the documents required by the Society:

"It was actually quite smooth. I mean we had good guidance on the Pharmaceutical Society website and if you followed that it was ok." (Female, Germany, M8)

5.4.2.4 Adaptation of European pharmacists

Once European pharmacists were registered with the Society, they could have started practising straight away. However, respondents reported that the recruiting companies usually provided an adaptation period of four to twelve weeks to prepare them for work in GB. Unlike their adjudication counterparts, EU pharmacists mostly had a negative experience with regards to their adaptation and, even in cases where they had positive experiences, they often had suggestions for improvements:

"The training was very useful. I understood about pharmacy…but things can be improved." (Male, Italy, M6)

Adaptation programmes EU pharmacists received in the community sector

To provide a realistic evaluation of the orientation, adaptation programmes provided to both actively and passively community recruited EU pharmacists are presented in this section.

Actively recruited pharmacists

In total, six European pharmacists were actively recruited by large community chains (see table 17).

M7	M9	M12	M11	M3	M5
Spain	Poland	Poland	Sweden	Spain	Spain

Table 17– European participants who were actively recruited in stage one

These pharmacists perceived that they would receive a comprehensive adaptation programme prior to their arrival:

"I was told I would be trained under the supervision of an experienced pharmacist who knows about what pharmacists do in the UK." (Female, Sweden, M11)

"To be honest, I was told in my interview that I would get this training that would cover everything, you know, pharmacy law, over the counter medication, minor ailments, when to refer, when to make recommendations."(Male, Spain, M3)

All but one EU pharmacist who had been actively recruited by large chains felt frustrated and disappointed with their adaptation:

"I was so disappointed with the training I got. You can't even call it training. I wouldn't say it prepared me in any way." (Male, Spain, M7)

Two of the six actively recruited European pharmacists (n=2/6) believed that the period of their adaptation was not long enough. They explained how they required more time under supervision to get ready for practice in GB:

"You need to do conversion training when you come from another country. But after the eight weeks, I didn't think I was ready to practise on my own and to be honest I wasn't ready for quite a long time afterwards because there are so many things that you simply don't know or have no idea about in British pharmacy. It took me a year afterwards to get used to this place." (Male, Spanish, M5)

"I was very disappointed with what I was given as training. Looking back I would say, it wasn't long enough" (Male, Poland, M9)

Three of the six actively recruited European pharmacists (n=3/6) talked about the frustration they experienced due to lack of orientation and how they were pushed to just work as another member of staff and received no adaptation at all because the pharmacy they were training in was understaffed:

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"Theoretically, the time I had in xxx was going to be my training but I didn't get any training, I just learnt by myself really. I had my tutor, and she was a pharmacist, but the problem is when you've just got one pharmacist and she happens to be your tutor and it's a busy pharmacy which is understaffed, you just help and pick up things and learn by yourself so I had no training." (Male, Spain, M7)

"I guess we were just thrown in at the deep end. To be honest, even though we weren't allowed to be pharmacists, we still had to do dispensing and try and sell things over the counter because they were short staffed. It was a bit of a shock for the first two weeks and then they put me in a small pharmacy further out in one of the dodgiest suburbs and I had to be there for a whole week and the pharmacist there sort of believed in just putting me out in the front, so it was a bit scary." (Female, Sweden, M11)

Two pharmacists (n=2/6) also mentioned that they were kept on training for a longer period to cover for staff shortages:

"I trained with xxx. At the beginning it was supposed to be for two months but you know, they are short of staff in every single branch so what they did to me there is no name for that they kept me four months[as a trainee] instead of two." (Male, Spain, M5)

Two pharmacists (n=2/6) talked about how they felt the type of adaptation they had was inappropriate and how they preferred other methods of learning:

"It would have been better if I hadn't been thrown into pharmacy straight after I had come to England. Maybe, if I had training not in pharmacy, but somebody had taught me first how it all operates, it would have been better. In the training you get briefly told how it works but it doesn't do anything for you." (Male, Poland, M9)

"We got nothing [training material] that was directed towards us specifically, it was the booklet that they gave the health care assistants. It was like two big books mostly about the over the counter products and how to give advice and when to ask for the pharmacist so it wasn't ideal." (Female, Sweden, M11)

In contrast to the participants in stage one, the pharmacists who participated in stage two of this programme of work were not specifically asked if they were actively or passively recruited. Nevertheless, 12 of the 31 EU pharmacists who participated in data collection in stage two, specifically mentioned that they were actively recruited and talked about the adaptation they received by their community employers. Their stories underlined similar problems.

In total, 10 of the 12 actively recruited pharmacists (n=10/12) had expected a standardised, structured adaptation programme but were unpleasantly surprised with what they got instead:

"My training was a nightmare. We needed proper training. They just put me on the counter as if I was a member of staff and I wasn't, really I was doing a training. So we need something more focused for all the pharmacists coming from abroad." (Female, Spain, Z13, FG 3)

One pharmacist (n=1/12) felt cheated, disappointed and abused by the way the employing company, which was an independent pharmacy, kept breaking its promises:

"Well, in my case, I was a bit disappointed because the guy who brought me, promised me three months training. I ended having three days…I was shocked. He also promised many things, in terms of pay, and he just gave me pocket money and I think I spent more money on hotels than I earned. We were abused. They were just trying to make money to bring in foreign pharmacists and if you left you had to pay back this much money." (Male, Spain, Z19, FG 4)

Some pharmacists (n=5/12) believed they did not improve their skills on a daily basis during adaptation, an expectation that they had before starting as a trainee pharmacist:

"In my opinion the training that I got was a joke…. Although xxx tried to show case themselves as the "people focused company," and as having knowledgeable pharmacists, it's not really like that. I was supposed to do three months of training, two weeks of that, my tutor was away on holiday and after one month I told my area manager, "Listen, there's nothing more I can learn here. I just wanna start working as a pharmacist." There were loads of things I still didn't know but I wasn't learning them working there so I started working and I just picked it up along the way….You know, in my opinion, the pharmacists don't get enough support. They weren't paying so much attention to what we're actually learning. It was so disorganised.... In my opinion, coming to work for a big company, they should provide some kind of standardised training." (Male, Poland, Z33, FG 7)

Other pharmacists (n=5/12) believed the knowledge that they had was because of their hard work and not the adaptation they were given:

"Basically, if we are talking about the training of the Polish pharmacists who come over to work here, it's not satisfactory. I was expecting something much more intensive, much more in depth than what I got and everything that I know, I can say I learned it myself, I did it on my own." (Female, Poland, Z8, FG 2)

In stage two, 9 of the 12 actively recruited EU pharmacists (n=9/12) also mentioned that no specific language training was provided for them:

"Nobody gave us any language training." (Male, Spain, Z2, FG 1)

"I didn't get any specific training on the language."(Female, Poland, Z8, FG 2)

"I had no language training. Nothing at all." (Female, Poland, Z4, FG 1)

"I think that the sense of communication in the training that, that was missing." (Female, Spain, Z27, FG 5)

As non-English speaking pharmacists they accepted that it would be essential to acquire language proficiency and most made efforts to achieve this. However, practical difficulties, such as finding appropriate courses and accessing them, were revealed:

"I had nobody to tell me where I can go to get proper language support." (Female, Spain, Z19, FG 4)

"I wanted to go to classes but didn't know which one suited my needs, because some were very basic." (Female, Spain, Z6, FG 2)

Actively recruited EU pharmacists (n=5/12) who recognised their inadequate language proficiency and wanted to take positive steps to improve their skills were prevented from doing so by the long working hours:

"In my case, I knew about my lack of language skills. I was trying to look for classes but it was really frustrating because everything was nine to five and my employer didn't give me any time off to go to the classes and I couldn't find any alternative to nine to five. So, you get trapped into that situation. Like you want to improve, but nobody is giving you that chance to go through a learning experience." (Male, Spain, Z2, FG 1)

Due to the fact that these adaptation programmes were designed by individual companies and there was no unified version, some of the actively recruited EU participants (n=9/12) had to sit a test after completing their adaptation period, while others were just signed off by their tutors and there was no need to pass any test:

"To be honest, my tutor just signed me off after my training period." (Female, Spain, Z13, FG 3)

"At the end [training programme], I did some exams with xxx so they tested my knowledge about law and ethics and calculation." (Male, Spain, Z2, FG 1)

This test was described as "simple" and "embarrassing" by participants:

"At the end of the one month training, when I was supposed to feel ready, I sat the test. However, the test was so simple I could really have passed it without my one month's training, which is wrong really. Because at this moment, I think I would have been better off passing something like the exam that British pharmacists have to pass and I think that would have taught me a lot. I had a calculation paper, which I could do in seconds without any training, it was so simple it was just embarrassing and the other test was just a few questions from the BNF. I think this was just an internal xxx test." (Female, Poland, Z7, FG 2)

When asked if they had raised their dissatisfaction with their adaptation programme, all the actively recruited EU pharmacists said 'no'. They went on to describe how there was no system in place to evaluate the programme:

"Of course I was dissatisfied [with the adaptation program] and I just talked about it with my friends. But nobody in xxx asked me how I felt, if the training was actually appropriate." (Female, Poland, Z4, FG 1)

Passively recruited EU pharmacists

In stage one of this programme of work, eight of the 14 EU pharmacists interviewed were not actively recruited. They had entered GB individually and had either continued with further education (n=1/8), started work as a self-employed locum (n=2/8) or applied for a job in the community (n=4/8) or the hospital sector (n=1/8) (see table 18).

M1	Poland	Worked as self-employed locums
M2	Poland	
M4	Spain	Continued with further education
M14	Netherlands	Applied for a job in the hospital sector
M8	German	Applied for a job in the community sector
M10	Iran/Norway	
M13	Romania/France	
M6	Italy	

Table 18 – European participants who were not actively recruited in stage one

These participants were successful in obtaining a job in their desired sector. EU pharmacists (n=4/8) who were recruited into the community sector were also provided with the same adaptation programme as the actively recruited EU pharmacists:

"I came to UK and applied for a job with xxx I got in but, because it was my first pharmacy job in the UK, I had to do training. I had friends who were going through similar training as me but they had secured their jobs in the UK back in Italy and the company had paid for them to come over." (Male, Italy, M6)

However, apart from the Italian pharmacist, the other three EU pharmacists were also disappointed with the adaptation they received in the community sector:

"The training was no good. I mean just dispensing in a busy shops is not what I call training." (Female, Germany, M8)

"I shadowed somebody for a week and from the second week I had to deal with things by myself. Me shadowing somebody wasn't enough, I didn't learn enough.....I know now that my training with xxx wasn't sufficient enough....If I hadn't been really, really adaptable and strong I wouldn't have been able to handle it because they didn't give me any training. They just

pushed me into it and I started dispensing after a week which I don't think now was a safe thing to do at all." (Female, Iran/Norway, M10)

"It could have been so much better. I didn't feel ready to practise on my own after the training they gave us." (Female, France, M13)

The two Polish pharmacists who started practising as self-employed locums after migration, decided to do so because they had previous experience of working in GB as pharmacy students so they were familiar with the pharmacy set-up in GB:

"To be honest, I never would have come to England to work as a pharmacist without my work experience in England because it's a big responsibility. Being here before, gave me sort of you know, the confidence. I would have never come into England to work without that experience." (Female, Poland, M1)

Adaptation programme EU pharmacists received in the hospital sector

In stage one of this programme of work, all but one EU pharmacists interviewed were initially recruited into the community sector. In stage two, however, more pharmacists were initially recruited into the hospital sector (n=9). The majority of EU pharmacists described their adaptation programme at hospitals as positive:

"I had a very good induction. I was shown almost everything...I got a really good teaching pack to start off with, where I had to sign things off if I'd read it and done it with somebody else. So, a lot of the procedures were slowly explained." (Female, Netherlands, M14)

"They [employers] gave us support and a good induction, that's my experience." (Female, Spain, Z23, FG 5)

EU hospital pharmacists also perceived that it is harder to be trained in the community sector. One said:

"I think community is harder to integrate into than hospital. The hospital is much easier because you are with ten other pharmacists. You have much more support and if you are not sure, you can ask more senior pharmacists. Community, I imagine, is much harder. For example, I was on call in hospital after six months, usually you have to be on call after three months so they skipped one rotation so I could adapt more. For the first two weeks, someone came with me to the wards. I wasn't put into the pharmacy on my own at the hospital from the first day, so it happened gradually." (Male, Malta, Z12, FG 3)

Mentoring

There was a general agreement amongst the majority of EU pharmacists (in stage one and two) that, initially, it is essential to be assigned to a tutor, another practising

pharmacist, who can introduce the pharmacists to pharmacy practice in GB and could provide ongoing support:

"Observing another pharmacist, just being with my tutor in practice, really helped and was essential."(Male, Spain, Z2, FG 1)

All actively and passively recruited EU pharmacists in stage one (n=11) and EU participants who talked about their recruitment and adaptation in stage two (n=21) were assigned a tutor (n=32). However, some of community recruited EU pharmacists (n=18/32) had been disappointed with the support they had received from their tutors:

"I wanted to have a proper mentor. Someone who could have guided me through the process, which was something that didn't seem to happen. You basically want someone who cares that you become a proper pharmacist. Of course, as somebody who is learning, I had to make an effort but having proper support makes it much easier and that wasn't the case in my experience." (Male, Spain, Z18, FG 4)

One pharmacist (n=1/32) described his tutor as "absolutely awful" and described the level of teaching he got as "very poor":

"My training was horrible and I think there are not many pharmacists able to give proper training to overseas pharmacists. I think the level of teaching was very poor. They just go and leave you in the pharmacy, well, that was my situation and, basically, the person who was training me was absolutely awful and I learnt some bad habits from her that I still have. Bad habits that I still can't get rid of." (Male, Spain, Z16, FG 3)

This bad experience was not just based on the fact that the assigned tutor did not have the necessary skills. She was also further described as being "insensitive". This insensitivity was also described by other pharmacists (n=18/32):

"It was a horrible experience. She was a really, really bad trainer. She had only been a pharmacist for two years...She had no idea how to train me and she didn't have the proper knowledge. She was also insensitive; she would make comments in front of others, patients and staff that I didn't like...really the training could be much, much better." (Female, Spain, Z19, FG 4)

"My tutor didn't treat me as a professional. Instead of taking me to on side and then discussing my mistakes she would just say it out loud in front of everyone. To be honest, I felt belittled." (Female, Poland, Z4, FG 1)

Literature is available on advantages of having a 'buddy system' in place where healthcare professionals who had arrived earlier could provide support for the new recruits.[208;209] In one of the focus groups, a Polish pharmacist described how she was assigned to a Polish tutor, a gesture which she believed was meant to be helpful, but

because the tutor had not received in-depth training herself, she could not fully train the participant:

"I have to say my training wasn't very good because my tutor was a Polish pharmacist. Maybe it was meant to be more helpful for me but I think, in fact she wasn't aware of certain things herself. She was not confident enough about certain things to pass the knowledge over to me and make me more confident. The thing is that she was provided the training by an English pharmacist but she didn't get the right training either and she wasn't 100% satisfied with it, so how could she train me properly." (Female, Poland, Z8, FG 2)

<u>Assistance from colleagues</u>

A few of the actively and passively recruited EU pharmacists (n=7/32) in stage one and two found their colleagues patient and encouraging. A German pharmacist believed that her colleagues were "very patient" with her and gave her the opportunity to learn and express herself slowly:

"In my work actually, the pharmacy colleagues were very patient and really spent time and effort and gave me a chance to learn and express myself slowly." (Female, Germany, Z31, FG 6)

However, some other EU pharmacists (n=20/32) found their colleagues impatient and intolerant about teaching the same material twice or three times:

"If you ask more than twice then really they could be a bit impatient with you. I've had that experience." (Female, Sweden, Z40, FG 8)

"I find people here in the UK don't like to teach you more than once or twice. If they tell you how to do it, you have to understand and do it by yourself the second time round." (Female, Portugal, Z24, FG 5)

One pharmacist believed being intolerant to a person who is learning is a common culture within society and also applies to British newcomers:

"There aren't many people who have patience with someone who is learning something. It doesn't just happen when you are a foreigner who doesn't know the language from birth. Even when you put an English person among English people and she is new, people lack patience and they keep saying she is stupid. So I can say that people are impatient with someone who is new to an environment." (Female, Spain, Z29, FG 6)

EU pharmacists (n=25/32) went on to describe how they felt isolated during their adaptation and struggled to find friendship and support. This issue emerged unprompted and went on at some length:

"There was nobody there to help. Your tutor is busy but the staff don't care either. Actually it wasn't just about help, you somehow felt excluded, like a foreigner. Even the term foreigner is [inaudible] I guess that is why they didn't care." (Male, Poland, M9)

"I felt so lonely at the beginning. No friends, no support at work, disorganised training." (Female, Spain, Z13, FG 3)

"Whenever people ask me about coming over, my advice is, "you need to prepare yourself for some tough times. Don't think you can just go over and make friends and live life happily ever after." My experience wasn't certainly like that." (Female, Spain, Z27, FG 5)

Ten pharmacists (n=10/32) described specific incidents where they felt humiliated and misread by colleagues. As this quote by a Polish pharmacist demonstrates:

"They [the staff] were nasty to me. The pharmacy that I was trained in, they were not helpful at all...they just chatted amongst themselves, they tried to talk quietly sometimes amongst themselves. They didn't even try to help me out or welcome me; if the attitude of these people had been different, it wouldn't have been so painful for me." (Female, Poland, Z8, FG 2)

5.4.2.5 Communicative proficiency of internationally trained pharmacists

European pharmacists

One of the questions posed to ITPs in stage one, was about their communicative proficiency when they initially arrived in GB and if they expected to face any problems communicating in a second language. Participants had a lot to say on this topic and different responses emerged from different EU pharmacists.

All the EU pharmacists (n=14) had to study a second language at school/university and they predominantly chose English as their second language. However, participants from Poland, Spain and Italy acknowledged the fact that what they were taught in school/university was insufficient to make them a competent English speaker:

"We learned English at school but it was with Spanish teachers. If you get a good teacher with a good accent maybe you can learn, but my personal experience is I never had a good English teacher." (Male, Spain, M5)

"The English you learn before coming here is just elementary...It is mainly reading and writing. You just learn at school, high school and the first year of college and then most people don't touch it anymore for years, until they get to the UK, and maybe they have never had a conversation in English before so they might know the basic grammar but they are not fluent." (Male, Poland, M2)

The majority of the Polish and Spanish (n=5) pharmacists and the Italian pharmacist talked about only knowing the basics of the English language when they initially came:

"When I came I only knew the basics." (Male, Italy, M6)

"My English didn't sound as good as it does now when I first came to England. Especially as the English that you are taught in school is different to what you experience when you are here...I didn't understand very much for the first month and I was constantly lost for words, so English at the beginning was a great barrier." (Male, Poland, M9)

One Spanish pharmacist described how he could not even speak a word of English on his arrival. He found this new experience shocking and used quite dramatic metaphors to describe his emotions:

"I didn't speak a word when I came over and I just hoped I could wake up one day and speak English perfectly, but I don't think that will ever happen." (Male, Spain, M4)

European pharmacists from Germany, Netherlands, Norway and Sweden seemed to have had a better grasp of English language on arrival:

"Before coming I didn't think I would have a language barrier because everybody speaks English in Norway." (Female, Iran/Norway, M10)

"We tend to have quite a lot of American and British TV ... so if you watch TV you kind of pick up a lot of English and you start learning English in school. I think I was ten when I started and you kind of continue on through school...My English was ok when I came." (Female, Sweden, M11)

"In university, we did have a course called English for Pharmacists which I joined. So language wise, it wasn't great but not too bad when I came." (Female, Germany, M8)

"I was eight when my mum and dad moved to Africa so I have never been to an English school but I had English friends and then, when we went back to Holland, I had quite a good education, including being taught English." (Female, Netherlands, M14)

Although participants from Scandinavian countries, Netherlands and Germany seemed to have had a greater level of communicative proficiency on arrival, the problems they experienced once they started work, were similar to the EU pharmacists from Poland, Spain and Italy. European pharmacists (n=12/14) described incidents when they had had difficulties understanding local phrases and, in some cases, medical terminologies used by patients:

"When I visited the ward, an old patient was saying, "Oh, he needs to spend a penny." I had no clue what that meant. I think that shocked me most and I was saying, "I have no idea what you

mean. I'll go and get the nurse," and the nurses had a big laugh about this." (Female, Poland, M1)

"I remember first time somebody asked me for something for piles, I had to go back and ask my technician what piles are. Because I knew haemorrhoids but I didn't know piles so there were these things that I didn't know." (Female, Iran/Norway, M10)

Medication names were another source of concern for EU participants. Being used to generic names of medications and having to use brand names in GB and also having to recognise combined formularies were some of the difficulties mentioned:

"I think, after six years here, I still sometimes find it difficult to get some drug names, especially when it's the brand name." (Male, Spain, M3)

"The drug names I knew most of them but one I didn't know...And then I kind of asked, "What's that drug?" and they just looked at me in disbelief and it was co-codamol which obviously I had never heard of and I thought, "What is it?" and they were looking at me in absolute disbelief because, obviously, if you're working here it's the most obvious drug that there can be, but of course it's a combination drug and how are you meant to know?" (Female, Germany, M8) [k]

All European participants also had problems understanding the different dialects:

"When I went to live and work in Liverpool initially, it was such a shock. I couldn't understand a word." (Female, Netherlands, M14)

"I thought England is England and if we watch English TV like, I don't know, BBC News or anything, it would be fine but then I ended up in Hull and that was a big shock because people were talking this difficult dialect with the Yorkshire accent and I didn't understand what they were saying." (Female, Sweden, M11)

They also talked about patients and colleagues having difficulties understanding them:

"To start with, when I came, it was really hard, especially when you have learned with BBC books and tapes and you come here and, obviously, you have an accent, which was difficult for the natives to understand." (Female, France, M13)

Some EU participants (n=7/14) had experienced problems because of the way they spoke, which had been interpreted as "being rude" by patients or colleagues in GB:

"The way you ask people in Spain, you do it in a polite way but you don't use "Please" and "May I," it's just the way you ask. Here you have to say "Please" and "May I" and I don't do it and it sounds very abrupt sometimes." (Male, Spain, M3)

"Culturally, in Norway, people are very direct and people here in England, they get easily offended; so at work I'm quite direct with my colleagues, not rude. They consider it rude because a culture of openness and honesty is not practised very much here. So yes, I have had problems at work with nurses, my colleagues and patients because I've said something and

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[k] Co-codamol is a combined, over the counter medication, containing paracetamol and codeine.

they've been offended, just because of the way I speak and the words I choose that maybe an English pharmacist might not use in their vocabulary." (Female, Iran/Norway, M10)

A few of the participants (n=6/14) blamed the language barrier for the isolation they experienced:

"It is hard to get in touch with colleagues…with British people... Sometimes you wonder what it is? Do they not like the way I speak English?" (Female, Germany, M8)

EU pharmacists' communicative proficiency and their expectations varied before coming to GB but, once they made the move and started practising as professionals, they mostly realised their level of communicative proficiency was nowhere near enough. They understood the importance of communicative proficiency and believed they had to be strong and determined to overcome the language barrier and not return to their home country:

"It was hard at the beginning. When I arrived my English was very poor, very, very poor and I sometimes thought, "What I am doing here in this country" because really you are not selling clothes where you only have to charge the money and I said you have to explain, you have to give explanations. I was thinking "My God!" It wasn't easy…I was so strong otherwise I would have returned home." (Female, Poland, M1)

Adjudication pharmacists

The question about communicative proficiency was also put to the adjudication pharmacists in stage one. Because adjudication pharmacists had been practising in the country for a longer period compared with their EU counterparts, they had difficulties recalling problems they had initially had with the language. The researcher had to use prompts such as, 'Did you experience problems with the different dialects?' or 'Was the language used by patients a problem for you?' to help the adjudication pharmacists remember their initial difficulties. That was not the case with EU pharmacists.

The majority of adjudication pharmacists were from ex-colonies and had been educated in English. Before migration, they believed communication would not be a big barrier for them:

"For myself, right from Pre-School it's been English language, the main language in Nigeria is English so I didn't actually expect to have any problems." (Female, Nigeria, M23)

However, once here, they had difficulties understanding the different dialects:

"Of course, when you come over, there are different dialects. It's difficult maybe to understand people, say, from Liverpool." (Male, Zimbabwe, M21)

"The only problem that I had was with some dialects, say for example, the Scottish accent in particular. It was very difficult for me but I got on well with other people." (Male, Sudan, M18)

Coming to GB and experiencing the different dialects and slang that was being used surprised some adjudication pharmacists. One believed only a small number of people in GB actually speak "proper" English:

"When I came to this country I thought the only people who spoke English were the news readers and a very few people at work." (Male, Ghana, M24)

One participant labelled the English that he knew as "textbook" English. This was different to the informal English being spoken in GB:

"We knew the textbook English but not the language which is commonly spoken. How we speak is quite different." (Male, Pakistan, M15)

Understanding the lay language used by patients to describe their minor conditions was difficult for adjudication pharmacists in the initial stages. However, they believed the pre-registration period very much prepared them linguistically for practising as independent pharmacists:

"You know the language because you were educated in English but all these lay terms used by patients, like nits and runs, were meaningless to me initially. But I must say I picked up those terms during the pre-reg. year." (Female, Nigeria, M23)

"I think one of the advantages of our pre-reg. year is that it helps us with the language. Not just the professional language, but the terms that patients use." (Male, Pakistan, M15)

Reciprocal pharmacists

All the reciprocal pharmacists referred to the English language as their mother tongue and labelled themselves as native English speakers. The four reciprocal interviewees could not recall any incident where they had problems with the English language.

5.5 Discussion

This chapter has described reasons for migration and early experiences of ITPs in registering, adaptation and settling in GB. To best explain the different reasons described for immigration of ITPs into GB, Buchan's 'mobile nurse' typology was

adapted and used.[77] This allowed the researcher to distinguish between permanent and temporary migrants.

ITPs' incentives to work in GB can best be explained as 'hope', both for their personal development and also their career development, the former stemming from the ambition of experiencing life in a different culture and gaining the confidence that living and practising abroad can offer.[59] Better remuneration and economic gain were not the central motives for migration, although they were of importance for some ITPs from developing countries and the 'New EU'. [1] Initially, the majority of 'Old EU' and reciprocal pharmacists came with some level of personal desire for travel and adventure; however; the data indicated that the three reciprocal pharmacists who initially came to London as working holidaymakers eventually settled in GB to pursue their desired careers.

Some EU and adjudication participants indicated the excitement of being exposed to more advanced pharmacy practice as one of the main migratory reason, while some hoped for greater opportunities for career recognition and progression compared to their home country. Learning the English language and experiencing life in a different country were also important motives for EU pharmacists, while providing better education for children played a part in adjudication pharmacists' decisions. The findings of this study confirmed that migration of ITPs was multifactorial. The five frequently articulated motives by ITPs for their migration (economic, career, working holiday, personal migrant and migrant partner) resonate with much of the existing literature on immigration motives of ITDs and IRNs.[53;54;55;58;60;62;67;68;70;136]

Similar to Austin's[138] research, this study also identified the prospect of providing better education and opportunities for children as one of the motives for immigration of adjudication pharmacists. Other motives for immigration of adjudication pharmacists included ensuring personal safety or joining friends or family members in GB. These described motives were not identified as a migrant type in the 'mobile nurses' typology literature. Consequently, a category called 'personal migrant' was created to cover these reasons described for immigration of ITPs into GB. Tapinos has explained how the first

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[1] In this part, the researcher interpreted the 'New EU' as those countries that joined the EU in 2004 and 2007. 'Old EU' refers to countries that were an EU member previous to 2004.

waves of migrants often serve as a catalyst for others to leave.[210] Before migration, six of the adjudication pharmacists knew at least one person from their home country who was already living in GB. For three, these individuals were family members or close friends. This purported 'friends and relatives' effect is described by the fact that first round migrants set up social networks that cut the cost and risks of migration for those who pursue trail.[64;211]

The speculations made by Schafheutle and Hassell,[27] in terms of EU pharmacists being short term migrants, were confirmed by this study. The majority of EU pharmacists interviewed expressed a desire to return to their home country and start a family there. However, this was not the case for EU pharmacists who had British partners. The possibility of staying in GB seemed more tangible for this group of pharmacists. Although the average length of stay in GB for the reciprocal pharmacists interviewed was 12 years, the three pharmacists from Australia and New Zealand explained how they initially had come for a working holiday before deciding to settle in GB for a longer period. This finding further confirmed the anecdotal evidence, which suggests the working holiday strategy was used by this group of pharmacists to experience leisure and travel before possibly settling or going back to their home country.[132] In Schafheutle and Hassell's[27] work, adjudication pharmacists appeared to retain a registered address in GB the longest compared with other groups of ITPs. This was confirmed by the findings from this study, where the majority of adjudication pharmacists considered the possibility of returning home only after retirement.

The literature has reported on how IRNs' experiences of working in the UK were shaped by their personal expectations.[54;55;58] The findings from this study also hinted at the importance of the ITPs' personal expectations before arrival and consequently the quality of life they experienced in GB. While ITPs' income provided financial security and gave them the desired luxuries some longed for, EU pharmacists' expectations for social relationships were not always matched. Some EU pharmacists spoke about the difficulties they had in making new friends and how they felt isolated, predominantly in the first few months. On the other hand, adjudication pharmacists did not state such experiences. The differences between these expressed views could be based on several factors. Adjudication interviewees were older and had been in GB for a longer period. The majority came with their families, while others migrated to join family or friends. It

could therefore be concluded that adjudication pharmacists had the social support of either a strong existing immigrant community and/or family living together with them.[211] They had come to improve their financial status, practice pharmacy at an advanced level and provide a better education for their children. The majority did not appear to have had any expectation socially from GB. According to Oberg's[125] initial formulation of the 'culture shock' hypothesis, in which initial difference in values, language, signs and symbols lead to insufficiency and irritation, most adjudication participants seemed to have coped with such difficulties by getting support from a primary network of co-national migrants. Immediate access to such networks was provided through existing family or friends. Even if they initially felt isolated, they either had forgotten the experience or the experiences were not significant enough for them to be talked about.

On the other hand, the European pharmacists were younger and had come for a variety of reasons, such as learning the English language and experiencing life in a new country. Unlike the adjudication pharmacists, they did not have the support of a close, tight-knit family. Most of them described wanting to be away from their fellow countrymen and having British friends to achieve their aims, but in some cases, unfortunately, professional social networks appeared to deliberately or unintentionally exclude them.[138] The literature on migration of nurses and doctors also mentions the isolation these health care professionals experienced on their arrival into GB.[54;89;110;111] In their study of the experiences of overseas nurses in the NHS, Alexis and Vydelingum[89] found that nurses were seen mainly as 'others' because their cultural identity was different from that of their predominantly British counterparts. Castles, Booth and Wallace[212] pointed out that migrants do not automatically become ethnic minorities. This, they argued, occurs through a process "*...whereby the dominant groups in society ascribe certain (real or imagined) characteristics to the newcomers, and use these to justify the assignment of specific economic, social and political roles*" (p.96).[212] They further argued that, as a result, migrants begin to see themselves as different and distinct from the dominant group. This is explored further in chapter 6 (see section 6.4.2).

Similar to IRNs,[54;66] the interviewed ITPs came to GB through different routes; some were actively recruited by recruitment agencies, while others came to join relatives or

friends. On arrival, EU pharmacists who had been actively recruited had a positive experience with logistical assistance, such as accommodation and transportation. This was different from the initial negative experiences IRNs had described in the literature.[54] Unlike IRNs, who were usually not totally aware of all the required information regarding registering before leaving the home country, ITPs seemed to have had enough information and no significant problem with registering with the RPSGB.[54,66]

Experiences were mixed regarding the adaptation programmes provided. In general, adjudication pharmacists were happy with the OSPAP course and the pre-registration training that they had received. While employers had no obligation to provide adaptation programmes for their newly recruited EU pharmacists, EU interviewees described that employers, did in fact, provide adaptation programmes for EU pharmacists. However, these individually designed programmes for EU pharmacists in the community sector were criticised. The criticisms made by EU pharmacists concerning their adaptation programmes in the community were similar to the literature on adaptation of IRNs in independent nursing homes.[52;54;66;89] Generally, these programmes were non-specific to EU pharmacists' unique needs and were inadequate in content and length.[54;66] EU pharmacists perceived that they would receive comprehensive adaptation programmes prior to arrival but felt disheartened when they started in their training posts because little training was on offer.[54;66;89;91] In some cases, pharmacists were kept in training for longer to cover for staff shortages[54;66] and prevented from attending English language classes because it was deemed to be disruptive during working hours. In general, European pharmacists felt there was inadequate support from colleagues and mentors in their adaptation period.[54;66;89] Some sensed that colleagues lacked patience in teaching and so felt disappointed and mistreated, which promoted feelings of being hurt and isolated.[52;54;66] Unlike the EU pharmacists in the community sector, EU pharmacists in the hospital sector described their adaptation programme as positive. This was in line with the positive experiences described by IRNs in the hospital sector, in Allan and Larsan's study.[54]

Similar to IRNs,[54;66] lack of support from designated mentors was a source of dissatisfaction with the adaptation programmes provided for the community recruited EU pharmacists. EU pharmacists in the community were generally assigned to mentors,

who were busy people and did not have the time, or were not willing to put aside time, for teaching and mentoring. Some of these EU pharmacists believed that their mentors lacked the necessary skills and knowledge to guide them through the adaptation programme and, in some cases, they were also insensitive in front of patients or colleagues. In a study conducted by Austin,[171] ITPs named a range of interpersonal issues, such as abruptness, lack of patience, arrogance and lack of interests, as specific qualities of mentors that were least helpful. These experiences and attributes could have adverse consequences on the mentees, for example, preventing them from asking for help or advice in the future.[54]

Ashcroft and Foreman–Peck[213] believe evaluation is an important component of education. From the interviews conducted, it seemed that EU pharmacists did not raise their dissatisfaction with their adaptation programme because there was no formal mechanism of evaluation in place. However, caution should be taken against generalising the findings from this study because of its small qualitative nature.

The general impression was that the adjudication and reciprocal pharmacists had a better experience with their adaptation programmes compared with their EU counterparts. However, the satisfaction described with their adaptation programmes by adjudication and reciprocal pharmacists should also be carefully looked at. All the adjudication and reciprocal respondents in this study had been practising in GB for a longer period compared to their European counterparts. Consequently, there was a possibility that, over time, they had forgotten some of the initial difficulties they had experienced in the process of registration and adaptation with the Society. In addition, for the adjudication pharmacists, the issue of registering and practising in GB was crucial because most of them had families to support and had taken out loans to pay for the OSPAP course. Similar to pharmacists in Austin's[138] study, returning home due to failure was considered costly and could have resulted in other issues such as loss of face as an unsuccessful immigrant. Subsequently, it could be that they concentrated all their energy on their training to avoid any failure and appreciated what they got in GB much more and therefore avoided talking about the 'little' problems they might have had during their training. Nevertheless, it should also be noted that OSPAP and the pre-registration training are both accredited by the regulatory body.[214] This accreditation and standardisation by the regulatory body was most likely to provide adjudication

pharmacists with an adaptation programme that was better organised, in terms of content and duration, compared to individually designed EU pharmacists' adaptation programmes. This could be why most adjudication pharmacists generally seemed satisfied with their training and adaptation programmes. Reciprocal pharmacists described how pharmacy practice in their home countries was similar to the way pharmacy was being practised in GB at the time. This proximity of practice could be the rationale behind reciprocal pharmacists' satisfaction with their adaptation programme.

Similar to other ITDs and IRNs, communication, in its widest sense, did cause nearly all interviewees some level of anxiety, not only because they took time to become accustomed to local dialects and colloquialisms, but also because problems encountered due to differences in medical terminology, jargon and medication names gave rise to some uncomfortable situations.[55;83;110;112;126;140;144;145] Some interviewees blamed the language barrier for the isolation they endured. In some cases colleagues and patients found it difficult to understand and accept ITPs' different accents and dialects.[54;108] Some had experienced cultural problems because of the way they interacted; their tone and word choice had been interpreted as "rude" by patients or colleagues. Similar to IRNs, no matter how well adjudication pharmacists thought they were equipped linguistically, they still found themselves not equipped enough to meet the communication demands in GB.[83;110;112;126;140] Recently, in the US and Canada, the potential impact of communication problems on quality of care and patient safety have been highlighted in the literature on IRNs.[153-155] Although the literature search was unable to find studies linking communication difficulty with patient safety, results from indirect research suggested that communication difficulty and breakdowns in some instances caused both real and potential risks in patient safety and quality of care.[106;107]

The findings on the communicative proficiency of ITPs in stage one and the lack of literature on this topic stimulated the researcher's interest in taking this forward to inform and shape the further stages in her programme of work. In addition, the data revealed by the Society's survey, where 63% of employers disclosed language testing of European job applicants was not routinely undertaken and more than a third had experienced problems with employees' grasp of English, was a further stimulus.[157;177;178] Consequently, the emphasis in the subsequent stages of this research programme concentrated on communicative proficiency of ITPs and its implication on

patient safety. The main findings from stage two and three are presented in chapters seven and eight respectively.

5.6 Chapter summary

In this chapter, ITPs' reasons for migration, future intentions, experiences of recruitment, arrival and adaptation in GB were presented. Buchan's 'mobile nurse' typology was adapted and used to best explain the different reasons for migration described.[77] Future intentions of participants varied by source country and individual circumstances. In general, EU pharmacists expressed a desire to return to their home country in the near future, while adjudication pharmacists indented to stay until retirement. Having arrived in GB, ITPs started to go through a process of adaptation. This experience of adaptation was mainly positive for reciprocal and adjudication pharmacists; however, that was not the case for the majority of the EU pharmacists in the community sector. The next chapter will describe the working experiences of ITPs as pharmacists in GB.

Chapter 6

Working experiences of internationally trained pharmacists in GB

6.1 Introduction

During data collection in stage one and two of this programme of work, participants described their work experiences as pharmacists in GB. In stage one, a greater breadth of work experiences were provided, as one of the objectives in this stage was to explore ITPs' working experiences in Britain. ITPs' description of their work experiences in this stage included accounts of their work experiences in their first and current jobs, work interactions with patients and colleagues, experiences of dealing with a new pharmacy practice system and experiences of discrimination and racism. In stage two, the dynamic nature of focus groups resulted in participants discussing specific aspects of their work experiences in GB. To provide the range of experiences described by ITPs, sections 6.2 and 6.3 draw upon the data collected in stage one of this programme of work and describe the work experiences of ITPs in their first and current jobs. This is followed by merged findings from stage one and two on ITPs' description of their work interaction with colleagues and patients in sections 6.4 and 6.5, their experiences of dealing with a new pharmacy practice system in section 6.6 and their experiences of discrimination and racism described in section 6.7.

6.2 Internationally trained pharmacists' first jobs

From the 14 European respondents who were interviewed in stage one, six were actively recruited. These six participants experienced difficulties once they started to work as pharmacists for the recruiting companies. As was noted in section 5.4.2.4, the majority of these actively recruited European pharmacists felt that the adaptation programme provided by the recruiting companies was inadequate and consequently two of them had problems when they started work due to lack of knowledge:

"When I started working, the first month, they put me in a branch were I had to take 13 patients with cassettes [trays] and I had never ever taken one before." (Male, Poland, M9)

However, most of these actively recruited respondents (n=5/6) talked about being placed in busy branches where companies had difficulties filling managerial gaps. They also explained how the support staff were minimal and they were expected to train newly employed dispensers:

"The main dispenser left two days after I arrived. It was in a not very nice area in Blackburn, a council estate. I went to an area that was rough, with quite a strong dialect. It was a busy shop, not ideal for a beginner, next to the surgery, the only surgery within the area. As I said, the main dispenser left and a new dispenser came who only knew as much as me, so I had to teach her as well. It was hell, it was hell the first three weeks. I didn't last long in that branch." (*Male, Spain, M3*)

To manage the situation they were in, some (n=3/6) had made a number of decisions that the companies were not happy about and, as a result, a few got verbal warnings or had to go through a disciplinary:

"I had to make a couple of decisions that the company didn't like so I could get through the day…. I had to close the shop early and explain to the people go to another chemist because we were too busy. There were probably a couple of complaints … but the company said I wasn't allowed to make such decisions." (Male, Spain, M5)

Most of these pharmacists (n=5/6) talked to their Area Manager about the situation they were in and raised their concerns; however, there was no immediate support. Some even felt that complaining made their situation worse:

"I complained again and that's why they were sending me to the worst branches with 400 items, 50 methadone prescriptions, because I complained twice." (Male, Poland, M9)

"When I complained ... they put me in a branch which was hell basically, like 800 items a day." (Male, Poland, M12)

Some of these pharmacists (n=3/6) considered the possibility of leaving. One pharmacist was so dissatisfied with the situation that he decided to leave and pay back the expenses to the recruiting company:

I signed a contract for two years and I had to stay with them for that period of time but I left before the two years were up. They paid for accommodation for the first month and the flight so I had to pay them back...I locumed for a while and I had to pay £1200 to xxx." (Male, Spain, M5)

European pharmacists (n=7/14) who came to GB and found work independently (not through recruitment agencies) had a variety of work experiences ranging from positive to very negative. However, it seemed that they had more freedom in negotiating with their employers because they were not bound in any way to their contracts (no flight/accommodation to pay back) and the employers seemed more vigilant in dealing with these pharmacists:

"The Spanish pharmacist I was sharing the flat with was recruited by an agency back in Spain. Although we both worked for the same company, I would say I got treated better. They would send him to very busy, disorganised branches everyday and no matter how much he complained, nothing was done about it...They treated me better because I could've just handed my notice in and left." (Female, Germany, M8)

The majority of the adjudication and reciprocal pharmacists interviewed in stage one had been practising in GB for nine years or more and when they were asked to talk about their initial experiences as pharmacists in GB they had difficulty remembering specific details. What became apparent during the interviews was the fact that, over the years, many had changed employers for personal or professional reasons:

"I stayed in my last position for eight years, eight years as an employee in community. I left because of the working conditions in that company. It wasn't good for me. I wasn't happy about it so I decided to change employer." (Male, Sudan, M18)

"I worked for different companies over the years. I left the last one because I was given no support." (Male, Pakistan, M19)

"I thought essentially you can't locum all your life because it was becoming more precarious.... I didn't want that instability.....So I took a full time job." (Male, Australia, M26)

6.3 Internationally trained pharmacists' current jobs

As noted in section 5.2.2, many of the ITPs came into GB so they could practise pharmacy in a new setting and experience what it means to be a pharmacist in a modern country. For EU pharmacists, once they passed the initial adaptation hurdle and with time (after six months to a year), became skilled at what they did, the majority had positive comments about pharmacy practice in GB. These pharmacists were excited to have a professional identity and to be able to use their knowledge in a productive manner:

"Once all the problems with the lack of training and lack of support were over, I could see why I was here. It was a whole new pharmacy experience." (Male, Poland, M9)

"Once I was working here, I could see the system is so different and the role of the pharmacist is so different. You get clinically involved much more with the patients here." (Female, Sweden, M11)

"It's much more patient focused here. I feel like a proper pharmacist," (Male, Spain, M3)

However, as time passed and pharmacists got over the initial excitement of living and working abroad and spent more time practising as pharmacists in GB, dissatisfactions began to emerge. ITPs practising in the community sector related their dissatisfaction with their heavy workload, long working hours and lack of support from their employers:

"I'm very stressed. The fact that you work for 10 hours, with just two hours cover with a second pharmacist, who leaves before the peak time, there is no point really. So physically, I have no time to sit down for just five minutes with my staff and discuss issues... I'm bored of getting promises from Head Office, you know, "we will get you someone so you'll have more time so you can spend time with your staff and get organised." That is never gonna happen." (Male, Spain, M7)

"Doing nine hours in a row without a lunch break is tiring....the workload is unbelievably high, prescriptions, MURs, needle exchange, supervised methadone and they [employers] are always pushing you to do more." (Female, Germany, M8)

"As a pharmacy manager you are responsible for each and everything and sometimes it's too much work." (Male, Pakistan, M16)

What demoralised these pharmacists even further was the fact that they were constantly under pressure by their employers to provide further services, not because it was useful to the local population, as one pharmacist described, but just to make more money:

"Everything has changed a lot in terms of pressure from your managers. It's all about figures and targets and MURs, those are more important than your own satisfaction...the way I feel now is that I'm just a money making machine and you don't get to feel that way in Poland at all." (Male, Poland, M2)

Although ITPs had come to practise modern pharmacy and were willing to take up new roles and responsibilities, they believed the system did not provide the time and the support needed by the pharmacist to provide such services to the entitled patients:

"Sometimes I think that everything in England about pharmacy is wrong; I like what they talk about and what they want to do but it's not happening. The thing is, most of the pharmacies are owned by the big companies, who don't really care about the patients at all and it's just about money. You can't compromise on the patients' safety, but they do that, they don't care about the patients' safety. In some places, you work for 11 hours in busy shops. They call you every day and threaten to suspend you if you don't do the MURs, even though there's no chance to do the MURs because there are requirements about doing them and so you can't just do it on just any patient and if you do, it's absolutely wrong. Most of the pharmacists are permanently stressed, I don't even know one pharmacist who's enjoying what they do and the only thing that keeps us doing what we're doing is money because, compared to other professions that we could swap with, we earn much more and that's why we're doing that. Don't get me wrong I'm trying my best to never, ever make a mistake or have any problems or be suspended but if that happens, I wouldn't cry." (Male, Poland, M12)

A few pharmacists mentioned that the pressure from their employers to meet financial targets was so high that sometimes they did MURs against their own professional judgment:

"The MUR is a problem because they ask you to do so many MURs. If a person comes in and you believe that this person will not benefit from a MUR, you do it anyway because of your figures. It is suitable for you but no benefit to him, you just do it and sometimes if a person comes in who will benefit from a MUR, because he is on so many medications, but it is not good for you because it will take so much of your time, you skip him." (Male, Ghana, M24)

It seemed that the participants lacked the necessary skills and strategies to deal with the demands of their employers effectively:

"We don't know how to handle them [employers] initially. You can't just turn around and say "no". But as your confidence grows and you get to know other pharmacists you learn the politics, you learn how to say "no". "I can't do more than the eight MUR I'm doing in a week." It comes with time." (Male, Italy, M6)

"Back at home, there is this culture of mutual respect. Employers treat you as professionals. You make the decisions. But here when they phone and say, "you have to do this many MURs," you don't really know what to say because you've never been treated in this way." (Female, Nigeria, M20)

ITPs mentioned that there is a shortage of qualified staff in their work place and this shortage puts them under a lot of stress:

"So you have the constant pressure from your managers about figures, targets, questionnaires and MURs and other things, accreditation for the morning after pill and then you have internal audits things that you have to do, SOPs, but you don't get any help. You are on your own, it's impossible…they don't want to spend money, they don't want to even spend money on an ACT, Accuracy Checking Technician, so they are not giving me more time to do my job properly but you get constantly, on a daily basis, emails asking for more MURs etc." (Male, Spain, M7)

A high workload, lack of support from the employers and working with skeleton staff caused many of these pharmacists a lot of anxiety, to the extent were their day-to-day life was affected:

"I worked, really, with a skeleton staff...I had to work on my own in the dispensary for two months and ended up exhausted. I woke up one morning crying which is very stupid, isn't it, because no money is worth it. My partner bought me coffee in bed and I said "I don't think I'm going to work today" and he said "what's wrong?" I said "I can't, I wish I had more hands than I do, I wish I had a second head that I could think more with."" (Male, Poland, M9)

ITPs' dissatisfaction with their work certainly had a negative effect on their attitude towards the length of their stay in GB. One Spanish pharmacist's experience was so bad that he decided to have a career break:

"I had enough of xxx, being a pharmacist, being here. I just had enough and I was also very disappointed with the company ....I was really stressed and disappointed with my job here, in xxx, and I said, "Listen, now what I want is to be with my family and that's it," and eventually I went back to Spain for nine months."" (Male, Spain, M3)

The level of frustration was so high for some pharmacists that they saw no option but to leave their current job:

"I wouldn't say I enjoy pharmacy...I'm dispensing prescriptions and there are a lot of prescriptions to check and when I go to less busy pharmacies, I still try to get that interaction with patients. But it's hard to find that time to chat with customers because you are very busy and when you come out to talk to them you don't want to spend more than two minutes with them...Pharmacy is just getting boring. Pharmacists are stressed and if you read the journal someone makes this one little mistake and that's it, their job is gone, their future is shattered, so you wouldn't want to keep a job like that." (Male, Zimbabwe, M21)

Unlike the majority of the European and a few adjudication pharmacists, all four reciprocal pharmacists seemed satisfied with their current working conditions as lead pharmacists in the hospital sector:

"I'm very happy with work. Yeah, I've got, you know, a good job in a clinical lead position." (Male, Australia, M26)

"I consider myself very lucky to have got the job in xxx... You see, private medicine [private hospital] is much more patient focused or patient orientated.....It has a good work load." (Male, Northern Ireland, M29)

"I really enjoy what I do here and I love working here in an area of pharmacy that I'm really interested in." (Female, New Zealand, M28)

"Every job has its stresses but it is what you make of it. Yeah, I don't think it has been too bad for me. I enjoy being a hospital pharmacist." (Male, New Zealand, M27)

The quotes from the reciprocal pharmacists raised the question as to whether the dissatisfaction described was unique to community pharmacy and did not apply to the hospital sector. However, the four individually interviewed European pharmacists who were working in the hospital sector at the time of data collection were also dissatisfied with their working conditions:

"I love my job in terms of what I expected. I have patient contact but there is too much stress. The workload and the stress are too high for me to sustain the job in xxx. We don't have enough staff. People are getting like, "I don't care about if you're staying late, I'm going." So everybody does their own thing. It's not really team work." (Female, Iran/Norway, M10)

"I think there is a bigger pressure now because it's all about saving money. They know I've got experience in different areas now, they can send me to a ward and instead of an hour and a half

they just give me an hour, but that's not fair. They are obviously trying to save money and they're not employing more people because we are saving money for our trust; the quality is not as it used to be." (Female, Poland, M1)

"A few years ago I was proud to work for the NHS hospital and then I worked at xxx and I lost that pride. Basically you get so little thanks for what you're doing, so little job satisfaction." (Female, Netherlands, M14)

"I had to leave xxx hospital because the staffing situation wasn't getting better, it was getting worse as people were leaving. The three pharmacists, who I had mostly been friends with, had left for other jobs, so I had to leave too." (Female, Sweden, M11)

In stage one, there was only one adjudication pharmacist who was working in the hospital sector. She was locuming in the hospital sector and she seemed more satisfied with her working conditions:

"I've enjoyed it so far [locuming in the hospital]. Being a locum in the hospital, the pay is very good compared to community locuming. The hours in a day is 7.5 hours instead of 10 hours that you usually do in the community and I get three breaks in a day, a lunch break and coffee breaks, one in the morning and one in the afternoon. Also I earn more money doing 37.5 hours a week in the hospital compared to when I was doing 50 hours a week in the community." (Female, Nigeria, M22)

6.4 Interaction with colleagues

As described previously (see section 6.1) the rest of this chapter describes the merged findings from the semi-structured interviews and focus groups on ITPs' descriptions of their work experiences in GB, starting with their interaction with colleagues in Britain.

6.4.1 Proving themselves

Thirty two of the 45 EU pharmacists who participated in stage one and two of this programme described their working relationships with colleagues as difficult early on, in the job. EU pharmacists (n=32/45) felt that colleagues lacked trust in them and they believed they had to work harder compared to their British colleagues to prove themselves as 'proper' pharmacists:

"I think you have to work harder to prove yourself than if you were English, that's my experience." (Female, Poland, Z4, FG 1)

"Although the Society had accepted our qualification, the way we got treated felt like we were not proper pharmacists. We had to prove our competency." (Male, Poland, M12)

EU participants had to prove themselves as 'proper' pharmacists not only to more senior figures, that is, Area Managers, but also to other doctors, pharmacists, dispensers and technicians:

"I had to take double exams for everything, double, double, double. I know more than other colleagues do but in my case I had to show, I had to show all the time. I think in the beginning they even wanted to see if I was able to deal with the labels in the computer and I am so good at software and computers. I just said, "Okay, there's your label." So I had to start by proving myself to everyone, even the technicians." (Female, Portugal, Z24, FG 5)

Suspicion and lack of trust from seniors were particularly hurtful, especially when one manager ignored the previous experiences of a Maltese pharmacist and said to him that he has to start all over again:

"The knowledge that I had, I was working for more than four years in Malta, didn't count, that didn't count and whenever I said something like, "why don't you do this?" The pharmacy manger said, "You are in England now, forget Malta." These were her exact words; it is like those four years counted for nothing so I had to start from scratch. That was a bit hard." (Male, Malta, Z12, FG 3)

In stage two, this 'proving' phase was experienced by all EU and the one adjudication pharmacist practising in the hospital sector. Although the eight EU pharmacists in the community also experienced this, the problem did not seem to be as pronounced as in the hospital sector. A possible explanation for this could be the fact that the majority of ITPs in the community sector worked as pharmacy managers and they had full authority over staff:

"With my first job I was a pharmacy manager. There was no problem with the staff because from day one I was in charge of the pharmacy, so you tell people what to do, not the other way round" (Male, Nigeria, Z10, FG 2)

6.4.2 Being a 'stranger'

As noted in section 5.4.2.4, EU pharmacists experienced lack of assistance from colleagues during adaptation. They described how colleagues were impatient and intolerant about teaching the same material twice. In addition, descriptions of loneliness and isolation were also common. Once the adaptation period was over, EU pharmacists' experiences of isolation continued. Having been natives in their home countries, EU pharmacists (n=29/45) in stage one and two experienced what it felt like to be an "outsider", not accepted and not belonging:

"I felt very lonely in the beginning. It's difficult to describe it. You know, I'd just finished university, more or less, and my feeling was to, you know, invite people back to my home and you can just have a video evening or something like that. And over here, it was really difficult trying to socialise during or after work with people and if we did, it was not a case of, "We're cooking something together," we just went to the pub. And it was...that gave such a cold and distant impression, you know, trying to keep you at a distance and you know, I later learned, "My home is my castle" so I felt singled out really." (Female, Germany, Z30, FG 6)

"I felt alone when I was working in the hospital. That is why I left. I was working in the hospital pharmacy for 6 months in Scotland and I felt like that. The work was great, going to wards but the people weren't nice, I was the foreigner who was always alone. There were 32 pharmacists, it was a huge hospital and I didn't feel welcomed. I know it takes time but I felt not welcome because I was a foreigner." (Male, Spain, Z14, FG 3)

In the new working environment, EU pharmacists (n=29/45) largely felt ignored by their co-workers:

"At the hospital, they [colleagues] all used to go out for their lunch breaks but nobody asked me to go. I was always alone, nobody asked me to join in." (Female, Spain, Z23, FG 5)

"When I started, I remember that you walked into the tea room, there are eight people that work with you, nobody talks to you and you think "They don't like me, they hate me!"" (Female, Spain, Z27, FG 5)

"Sometime, you pass two people in a corridor and you say, "hi" and you make eye contact but they don't even look at you. They just turned around...their eyes. It was so strange. In the first month after I started it made me feel all upset. I kept asking myself "why do I get treated this way." (Female, Iran/Norway, M10)

EU pharmacists (n=16/45) talked about their unmet desire for close friendship with British colleagues and so, to compensate, some established friendship with other internationally trained healthcare professionals in the workplace:

"It's not easy to make friends here with the British. In Southampton, where I started, I always found it easier to make friends with the other nurses and doctors who were in the same position as me, obviously away from home, usually from a foreign country...I mean it's still the case that the majority of my friends are foreigners." (Female, Germany, Z30, FG 6)

One Polish pharmacist tried to understand why she was ignored by her British colleagues:

"I haven't got many English friends up to this day...I've got lots of acquaintances through clubs that I've joined but apart from that I haven't got really close contacts, but then again sometimes I think people here have got their own families. If I look at myself back at home thinking, "Okay I've got my circle of friends" and I don't know if I've always been very welcoming and making an effort really and pulling out my leg to say, "Hey new person, come along and join

us." So I think, you know, to a certain level I can understand this but it's not nice." (Male, Poland, M9)

One participant perceived they were not being trusted and that was the reason for not being let into the 'inner circle':

"There is a question of trust really. Yeah, they hardly trust someone, so I always say to myself, I have to just do my best really. But once they get to know you, once they trust you really, then they talk to you." (Female, Spain, Z23, FG 5)

6.5 Interaction with patients

6.5.1 Encouraging vs. discouraging patients

The participants had varied experiences with their interactions with patients. All four reciprocal pharmacists in stage one and the majority of the European pharmacists (n=30/45) in stages one and two, believed the fact that they were from overseas opened up avenues for them to have a better relationship with patients:

"People have always been lovely to me. I mean they love Australia. So you get this lovely reaction when they [patients] find out that you are from Australia."(Male, Australia, M26)

"Being Spanish was a thing that eased my situation with the customers because they were like "I've been to Spain I've been to the south"...it has helped my relationships with the customers because you've got something interesting to talk about, it has been a thing to connect more than disconnect." (Female, Spain, Z19, FG 4)

"When I say I'm Italian the reaction of people is good it's positive...they say, "how long are you staying here? Could we come and see you in Italy?"" (Male, Italy, M6)

"Everybody always says, "Sweden, that's nice," I've always been very well received." (Female, Sweden, M11)

However, this was not the case for others:

"You know, they haven't said anything but you can sometimes pick up on the vibe that they don't want us here. It is strange, I can't explain it really." (Male, Zimbabwe, M21)

"Once, this old lady said to me, "you come and take all the jobs." She didn't say it seriously but she did mean it." (Male, Egypt, Z11, FG 2)

"I think, they [patients] think we are here for the money. They don't see the whole picture." (Female, Poland, Z26, FG 5)

When patients were refused sale of an over the counter product, EU pharmacists (n=17/45) perceived patients associated this rejection with what they believed was the lack of knowledge of the non-English pharmacists:

"If you refuse to sell a product because it is not licensed or because legally you can't, they think like "she is from another country, a foreigner, she doesn't know. I'm gone get it from somewhere else."" (Female, Poland, Z8, FG 2)

At times, European pharmacists (n=15/45) felt demoralised when patients refused to accept foreign branded medications and only wanted the British brand. They made the assumption that if patients are refusing the foreign brands, then they must also be dissatisfied with foreign pharmacists:

"Another problem is, when they don't want any product that is not from the UK, they just want a British brand and if that brand is not available and you try and explain they wouldn't have it. And so when they complain about foreign manufacturers and foreign medicines and you are a foreigner, it's just, what can you do? Iit is a tough situation and very uncomfortable and sometimes you just have to laugh, what can you do otherwise? But it's shocking when people refuse to have medication that is not from the UK, I just don't get it. If that medication was from US then they would have it." (Male, Spain, M7)

Such incidents were painful and humiliating but made the EU pharmacists more determined to win back the trust and respect of the patients:

"I think there are not many people that are negative about foreign pharmacists but you can find some and, well, it's not very nice thing to experience. Most of them, even if they are not 100% happy that non-English pharmacist is dealing with them, you can win them over by being nice and polite and explaining things slowly and I think you can gain their respect." (Female, Poland, Z7, FG 2)

On the contrary, some EU pharmacists (n=17/45) were genuinely surprised over how supportive and understanding some patients were:

"In fact I think they (patients) are quite understanding and supportive. I must say customers that you don't know at all. I was actually surprised in a good way that they were quite understanding." (Male, Spain, Z3, FG 1)

"They [customer] are so nice. I never had a bad experience with them." (Female, Sweden, Z40, FG 8)

"Customers are so sweet sometimes. They tell you nice things, make you feel at home." (Female, Netherlands, Z25, FG 5)

6.5.2 Demanding patients

Adjudication and EU pharmacists' descriptions of their interactions with patients in GB contrasted to what they had experienced back in their home countries. In stages one and two, many of these pharmacists (n=50) reported that patients in GB were more

demanding in terms of the services they wanted from their pharmacist and how sometimes these demands or requests were made with no patience. Some participants went further to add that customers in GB are 'never wrong'; a notion that they believed was introduced by companies:

"The system is completely different here. Patients or customers here are more demanding, much much more demanding. Sometimes unfairly really, and in doing so sometimes they forget that I'm a professional; so at some point, you have to draw a line. So yeah, the system is completely different here, I think because it's just companies. You are a pharmacist but you work for a company so your customers are always right whatever they say and they [employers] forget that we are dealing with medicines and patients so that is why you feel more pressure here... I would say nowadays, here, you have to look after the business side more than the professional side."
(Female, Poland, Z26, FG 5)

ITPs (n=38/50) believed that this patient-orientated culture, granted patients the right to complain, if the pharmacist did not meet their expectations and demands:

"When they changed the rule about the cough medicine for children over six, they [patients] were like, "Why not? Why can't I buy it? Do I have to go to the doctor? Why? I'll complain." And I was like, "here there is the leaflet you can see that I'm not making this up."" (Male, Poland, M2)

A few pharmacists (n=10/50) believed that this patient orientated view of patient care and the freedom of choice was simply wrong:

"In Spain you tell the patient, "You take this," and they don't even question what's written in the drug chart....Whereas here it's like, "oh, the patient refused the IV antibiotic, we have to put him on this other antibiotic." What do you mean? It is just wrong. If this antibiotic works then they should take it." (Female, Spain, Z29, FG 6)

Some participants (n=25/50) described patients in GB as being over educated, which, in words of this Spanish participant, required pharmacists to be extra vigilant when dealing with them:

"If you go to the doctor in Spain and he says, "oh you've got, I don't know anything simple, like a hernia" they go home, "Yeah, the doctor told me I've got this and I have to take this." Whereas here, I mean 90% of the people go on Google, find out what it is and there's so many websites, so they know a lot. And they come into the pharmacy and say, "oh, I read here that this interacts with that" and you think, "Jesus, I have to be careful." (Female, Spain, Z27, FG 5)

In fact, a few pharmacists (n=7/50) described being caught off-guard by the assertiveness of their patients in GB when they started asking specific questions about the medications they were given:

"They are like "So why am I taking this, what's the side effects, why am I taking it like this, why, why, why?" I feel like saying, "Shut up and just take it." And then on top of everything, like, you go through the medication reconciliation and the patient's like, "I take this for this, I take it like this and it has this side effect." I'm like, "my God, you know more than me." (Female, Spain, Z28, FG 5)

Adjudication pharmacists from developing countries described a different power dynamic in the pharmacist-patient relationship back at their home country. They were regarded with a great deal of respect and they usually had the authority in the relationship and made the decisions:

"Patients are very respectful back at home. You tell them what to do and they do it, no questions asked." (Male, Pakistan, M19)

6.6 Dealing with a new system of pharmacy practice

For adjudication pharmacists, a surprising aspect of pharmacy practice in GB was the legal framework to which British pharmacists had to adhere. Pharmacists recognised the fact that, as professionals in GB, they were accountable for every action, which was not the case back in their home countries:

"There's a world of difference in the culture of work here compared to where I used to work before. Here everything is done according to the law... And also with the pharmacists you've got to be accountable for all the actions. Here if you don't do something properly then you have to face the consequences but back where I was, pharmacists they would get away with a load of things." (Male, Nigeria, Z10, FG 2)

However, some of the EU respondents believed all the protocols and guidelines that had to be followed, made the scope of pharmacy practice in GB narrower compared to their home country:

"All these SOPs [Standard Operating Procedures] *here, it looks like you are working in the industry; they need to follow protocols to manufacture tablets but in a chemist, they box you in basically. So really you haven't got any freedom to use your own initiative." (Male, Spain, M3,FG1)*

"In terms of issuing what it says on the prescription, I have to say I think it's pathetic here. If it says 120 tablets and you have 119 then you actually have to owe them one tablet or if it comes in a box of 112 you have to add the extra eight. In Holland, you just put a line through it and say look it comes in a box of 112, no messing about, that's what you're going to get. I think it's mad here with all these brands and generics." (Female, Netherlands, Z25, FG 5)

While some level of documentation was generally acknowledged to be necessary, a few criticised it for moving attention away from patients:

"I do understand that there needs to be some paper work but all this bureaucracy ...you don't actually get a chance to do your job, which is patient care." (Female, Spain, Z28, FG 5)

6.7 Discrimination and racism

Some of the European and adjudication pharmacists in stages one and two of this programme of work described unpleasant incidents with colleagues and patients, which they put down to discrimination and racism and these are described in this section. As described previously (see sections 1.10.3 and 1.11), discrimination and racism were identified as a frequent theme in the literature on IRNs and ITDs.[54;66;89;112;113;118;119;130;131;134] Discrimination is referred to as *"differential treatment of otherwise equally qualified persons"* (pg.16).[89] While racism has been described as *"any form of discrimination on the basis of race or ethnicity"* (pg.12).[69]

In stage one, during the first seven interviews, when asked about their experiences in GB, occasionally words such as 'prejudice', 'discriminate', 'fair' and 'biased' were used by the ITPs interviewed to describe episodes of their experiences in GB. This made the researcher think that such experiences might be more widespread amongst ITPs. Consequently, in the following interviews, if this sensitive topic was not directly approached by the participants, the researcher asked a direct question "have you experienced discrimination or racism since migrating to Britain?" This was to ensure all participants' views on this subject were collected. From the 29 interviews conducted in stage one, 18 participants talked about this topic unprompted, while the other 11 had to be asked directly to talk about the topic.

In stage two, participants were not directly asked if they experienced discrimination or racism in GB. Nonetheless, the dynamic nature of the focus groups resulted in the topics being raised and discussed in six focus groups. In the other two focus groups, on the other hand, these topics were not addressed directly but emerged as 'emic' [m] concepts

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[m] An anthropological term which means understanding reality from the view of the insider in a culture, as opposed to an outsider view.

during the discussions. The discussions in the ethnically mixed focus groups resulted in productive exploration of language, colour and foreignness as root causes for the discrimination experienced. Discussion around this sensitive topic caused laughter and empathy between ITPs and this friendly and safe environment allowed the shyer members of the group to also open up and describe their experiences. Nevertheless, due to the sensitivity of these topics, the degree to which ITPs were able to be honest and open is unknown. Consequently, denial or rejection of speaking about these topics did not automatically rule out the existence of such incidents.

Although this was a theme that arose from the data, of the 71 participants in stages one and two of this programme of work, 21 only talked about experiencing positive attitudes from British colleagues and patients. The researcher did not intend to diminish ITPs' positive experiences.

The researcher used the definitions of discrimination and racism described earlier during data analysis to decide if experiences of discrimination and racism were presented in the data collected. ITPs discussed discrimination in terms of colour, language and foreignness and reported colleagues, employers and patients as the people responsible for imposing discrimination. Table 19 was composed to provide an overview of the ITPs' experiences of discrimination and racism in stage one of this programme of work. As can be seen from this table, in most cases, the people responsible for imposing discrimination on EU pharmacists were colleagues and employers. On the other hand, the adjudication pharmacists, in most cases, reported having experienced racial harassment from patients.

	ID Number	Experiences of discrimination at work with colleagues	Experiences of discrimination with employers	Experiences of racism at work with patients
EU pharmacists (n=14)	M1	No	No	No
	M2	No	No	No
	M3	No	Yes	No
	M4	Yes	Yes	No
	M5	No	Yes	No
	M6	No	No	No
	M7	Yes	Yes	Yes
	M8	Yes	Yes	No

	M9	Yes	Yes	No
	M10	Yes	Yes	No
	M11	No	No	No
	M12	Yes	Yes	No
	M13	No	No	No
	M14	No	No	No
Adjudication pharmacists (n=14)	M15	No	No	Yes
	M16	No	No	No
	M17	No	No	No
	M18	No	No	Yes
	M19	No	No	No
	M20	No	No	No
	M21	No	No	Yes
	M22	Yes	No	No
	M23	No	No	Yes
	M24	Yes	Yes	Yes
	M25	No	No	No
Reciprocal pharmacists (n=5)	M26	No	No	No
	M27	No	No	No
	M28	No	No	No
	M29	No	No	No

Table 19 – Experiences of discrimination and racism from the one to one interviews conducted with ITPs in stage one of this programme of work

Some ITPs felt their 'difference' acted as a social marker[113] or a determinant for racial harassment,[122] which affected their affiliations with British colleagues, employers or patients before their personal and professional characteristics were evaluated.[54] Their 'difference' was colour, language or foreignness and, at times, it made their interactions with patients and colleagues unpleasant affairs:

"They think I'm black and therefore whatever I'm saying is basically crap. It's annoying and demoralising. I don't want to take it seriously otherwise I would break. I'm human after all." (Male, Ghana, M24)

Some participants described situations when they felt discrimination blighted their experience. Most experiences of overt discrimination appeared to have occurred earlier in the pharmacists' career:

"I remember in the beginning, when I had just started, one of the senior pharmacists came in with one prescription and she said, "can you tell me how you would screen this prescription," but in front of all the technicians, which I consider as very rude and unprofessional…You know they had this manner and attitude like, "Does she 'know' what she's doing," and I remember that attitude and I said, "well, it's gonna be hard but so far you know, I've never had any major issues with hundreds of prescriptions that I screened." Yeah prejudice, the environment, I think

the culture in that place… too much prejudice I've found." (Female, Argentina, Z39, FG 8)

However, a number of accounts were of more recent origin:

"Not long ago, one of my managers who was in charge of the dispensary...she didn't have any patience for me at all…I didn't know what the issue was but she started, like, actually bullying me a little bit, just kept ignoring me, she didn't trust me to do anything and she showed it in front of everyone and my friends at work or my colleagues, they could see it too...To be honest, she was actually a bit biased" (Female, Sweden, Z40, FG 8)

Some of the experiences describing discrimination were explained by racism. For example, a Nigerian pharmacist said:

"I can remember once I was locuming for xxx and something didn't go quite right and it had nothing to do with me and I think the lady [patients], she said some racist things. I think she said, "go back to where you came from," something like that." (Female, Nigeria, M23)

Indeed, racism was not just happening at work. This European pharmacist, originally from the Middle East and married to a British man, explained how her foreignness still caused her problems, even with her in-laws:

"My mother-in-law says that all these foreigners come here and ruin this country and then I say "I'm a foreigner too" but she says" no, you are English" and I say "no, I'm not" and then she says "I think you should be then otherwise you'll have to leave the country" and I say "how about your grandchild"…" (Female, Iran/Norway, M10)

Most of the adjudication pharmacists put these incidents down to their colour, while the white European pharmacists believed their foreignness and their inadequate proficiency in the English language were the issue. ITPs were grouped together according to their route of entry to best describe their perceptions for their differential treatment by colleagues, employers and patients. These are described under the following subheadings:

6.7.1 EU pharmacists' perceptions

As seen from table 19, in most cases, the people responsible for imposing discrimination on EU pharmacists were colleagues and employers. ITPs' discussions of the meaning of discrimination experienced from employers eventually led to a sharing of experiences of exploitation. This is described next.

6.7.1.1 Imposed discrimination by employers

In stages one and two, there was a general feeling amongst some of the European pharmacists (n=16/45) that they were treated unfairly and recruiting companies would not have treated a British pharmacist in the same way.

"What happened to me couldn't happen to an English pharmacist. I don't think so." (Male, Spain, M5)

These perceived differences in treatments were generally described through exploitational experiences:

"Working with minimum staff is wrong. It is against the law. British pharmacists certainly wouldn't accept it, but somehow with us foreign pharmacists, it's not against the law and acceptable." (Male, Poland, M9)

"To be honest, you can say it is modern slavery. I guess we have a choice and we can leave. But once you're here, you want to give it a go and you hope that all these problems will go away, but I am still suffering." (Female, Poland, Z8, FG2)

As noted in section 5.4.2.4, two EU pharmacists believed that the recruiting companies prolonged their training periods so they could cover the shortage that already existed without having to pay them appropriately:

"I was not getting paid right because after a year I was still on training, that's why I complained. I kept saying "what training are you talking about, you haven't given me any training so how can I pass a training that I haven't done at all?" I'm working as a pharmacist, covering shortages, checking prescriptions and I have all the responsibilities but I'm not getting paid as a pharmacist." (Male, Spain, M7)

This exploitation described during adaptation seemed to have carried on, even once the EU interviewees started to practise as pharmacists for their companies:

"After finishing training, they still used us in the wrong way. You know, having us going to busy, disorganised shops, doing long hour, changing our schedule at the last minute...it basically wasn't fair." (Female, Spain, M3)

As noted in section 6.2, these undesirable working conditions prompted some of the EU pharmacists to complain. However, complaining only seemed to have made the situation worse.

A few pharmacists (n=5/16) talked about doing shifts and not being paid for them at all:

"I'm contracted for 45 hours a week but the reality is I work 50 hours a week and only get paid for 45 hours." (Male, Poland, M12)

Other pharmacists (n=4/16) talked about the problems they had asking for a pay rise:

"I wanted a pay rise like every other pharmacist and I got to know that there are few people that actually managed to get a pay rise, but I got some information that overseas pharmacists actually don't get a pay rise. I don't know how much that applied in the end but I heard something like that. I was quite shocked by that, whether that is right, I'm not sure." (*Female, Poland, Z8, FG 2)*

These European pharmacists (n=16/45) based their perceptions of being exploited by their employers on several reasons:

"To be honest in xxxs we had the feeling that they think about us as pharmacists from poor, foreign countries. The feeling is that, "look at me I'm an Area Manager and have money and you're definitely here for money." And there is a shortage of pharmacists in England so they always tried to fill Saturdays with us and we weren't happy about it and wanted to have time off and it was like, come on, we're going to pay you money." (Male, Poland, M12)

"They see us as foreigners. You know, both employers and colleagues. Employers want to fill the gaps with us while the staff think, "Why are you taking our jobs?" so we can never win." (Female, Poland, Z8, FG 2)

"I think they [company] had this feeling with overseas pharmacists that, because of the language barrier they can take advantage but it just depends on the company as well." (Female, Spain, Z13, FG 3)

6.7.1.2 Imposed discrimination by colleagues

In addition to feeling isolated and lonely (n=29/45), the majority of EU pharmacists (n=32/45) described how colleagues lacked trust in them. They believed they had to work harder compared to their British colleagues to prove themselves as 'proper' pharmacists. Some EU pharmacists believed their 'foreignness' was the root cause for their different treatment:

"They probably think, "Oh, you're from somewhere and you probably don't have such advanced science like we do in here."" (Female, Poland, Z26, FG 5)

While others believed that inadequate proficiency in English was the issue:

"To me, all these negative experiences are to do with the language. That is why we are not liked." (Female, Poland, Z8, FG 2)

Some EU pharmacists believed that communicating with staff was sometimes a bigger hurdle than communicating with patients. They explained that some of the staff had reached the conclusion that ITPs cannot communicate in English and this gave them a legitimate excuse for not trying to understand them:

"Sometimes they don't understand you because they have their own mindset and unless you say the things in their own words, they can't understand. That is when I think that staff don't really make the effort. I mean, what I am saying can be understood, it means something, it makes sense but I'm not using their standard sentences that they're used to saying. That's when they will say like "What, what?" But, I'm sorry, I am expressing it in a different way but what I am saying is clear." (Female, Spain, Z23, FG 5)

These participants believed that reluctance to understand, led to ignoring the pharmacist as the responsible professional and created tension within the pharmacy:

"Patients are more willing to make an effort to understand you than the staff. The staff are sometimes reluctant to do so. I was doing a locum work last week in Bury and they had problems in understanding me and they kept ignoring me and I was like "fine you're ignoring me, I'll just do my job so if you need me come and find me" But you know it creates this situation of tension which is not good." (Female, Spain, Z2, FG 1)

Similar to the employers, the communication inadequacy gave the staff the ultimate excuse to undermine the pharmacist:

"The dispensers sometimes undermine us because of the language problems. The dispenser or the ACT knows that our English is not perfect and sometimes they abuse that situation. This is not just my experience, but the experiences of my friends also." (Male, Spain, M4)

Communication inadequacy also unjustly provided the grounds for discrimination, as described by this Spanish pharmacist:

"One of the girls took advantage of the fact that my English wasn't so good and called me a "scruffy bugger," and I didn't know what it meant at the time. But as I locumed and moved to other shops I asked and said, "she called me a scruffy bugger," and the reaction of the girls was not the same as the explanation I got in the shop. So the problem could be when somebody tells you something and then they don't explain the proper meaning of the words and so sometimes people take advantage of this and lie. If you are the manager there or you are there all the time, the other people are not going to tell you anything but when you locum and move, you might hear insulting things that you don't even know the meaning of and find out later. I remember when she called me a "scruffy bugger," there was nobody else in the dispensary. She was the only one with me and later, when I found out the meaning of the words and the situation, I thought that was cheeky and quite offensive." (Female, Spain, Z6, FG 2)

6.7.2 Adjudication pharmacists' perceptions

Some black adjudication pharmacists (n=6) had experienced negative attitudes from patients that included their authority as a pharmacist being questioned. For example, asking a white counter assistant, who was unqualified, for information rather than accepting it from the adjudication pharmacist:

"For example, they say, "can I speak to the pharmacist?" I will go out to speak to them right away, but when I start talking, say a colleague is standing there and [pointing to a meter away] and I'm here, I'm talking right, the patient who asked to speak to me starts to look at the counter assistants instead of me. To me, that means, he or she is not taking what I'm saying seriously. He or she thinks the assistant is better than me right? I experience this every day, every day...Some of them do it subconsciously, right; they think "she is white so she knows better than what this man is saying"...they think that I'm black and frankly don't know much." (Male, Sudan, M18)

Black adjudication pharmacists (n=4/6) believed that racial discrimination was expressed covertly or openly and it made these pharmacists feel that their skin colour determined what their patients thought of them. The following quotes show the extent to which adjudication pharmacists experienced problems that were interpreted as racism:

"Maybe once or twice I've heard somebody say, "Are you really the pharmacist? Is there nobody else I can talk to?"" (Male, Ghana, M24)

"If a mistake is made, the patient automatically blames the black pharmacist." (Female, Nigeria, M23)

Adjudication pharmacists had not shared their experiences of racism with their superiors because they had difficulties quantifying racism in real life:

"The thing is, it happens and you feel like it might be racism but it's not confirmed that it is racism, because there are definitions of racism. You can't just pick on anyone saying she's been racist or he's been racist even if they pass racist comments. It might be a personality clash, it might not be a personality clash, it might just be to do with colour of my skin but it's, like, something which is not confirmed." (Male, Pakistan, M15)

"Inside of work, it's very difficult quantifying these things [racism]." (Male, Ghana, M24)

Reciprocal pharmacists had not come across racism themselves but perceived other ITPs could have been discriminated against because they believed British society tends to stereotype:

"Britain still loves Australia and often everyone was like "why the hell did you come here?" And so I haven't had any problems. I guess with Eastern European it is different. If you're seen

as a Polish pharmacist you get painted in a different way. You know, as an ex con." (Male, Australia, M26)

6.7.3 Dealing with discrimination and racism

ITPs described different ways of dealing with discrimination and racism. In situations where unequal power exists subordinate groups are reluctant to challenge the status quo[215] and are more likely to choose coping strategies that are non-confrontational.[216] The majority of the interviewees who talked about discrimination and racism opted not to directly confront the member of staff/patient concerned; they mostly ignored the comments and convinced themselves that they were here to work and not to socialise:

"If I feel if somebody made a comment that I felt that it was a bit funny...I would ignore the person and tell myself that I came to work not to make friends because, personally, I'm a very quiet person and I mind my own business anyway. So I tell myself that I'm minding my own business and at the close of day I need to go home." (Male, Ghana, M24)

A few of the participants talked about racism that happens on a daily basis. One recognised that to be able to survive he had to forget the incidents:

"I feel so bitter, but because of being the pharmacist and in charge, I control my emotions. When it's happening, you get frustrated but to survive you have to forget about it...I guess this is something an overseas pharmacist has to accept to work in this country; you have got to live with it. If you don't accept it you're not gonna be able to work in this country. It happens nearly every day, nearly every day." (Male, Sudan, Z21, FG 4)

A coping strategy used by a few of the ITPs was actually putting themselves in the shoes of the British person:

"It's only because they don't understand where you're coming from and if you're here you have to think I'm here and this is the way things are done and how can I fit into that system but you don't have to change who you are, you just have to understand things from their point of view." (Female, Nigeria, M22)

A number of adjudication participants (n=7) believed individuals sometimes use claims of racism as an excuse to cover their own incompetence:

"Some people when they feel inadequate, when they are not doing their job properly and they are for example, asked to account for it, they tend to say, " oh you are saying this because I'm black or I'm dark or that. To me that's not right."" (Male, Pakistan, M16)

These ITPs believed if the job is done properly then that would leave no room for any complaints or claims:

"Fitting into the society depends on how the person carries themselves. Even people talking about racism, if you believe in reciprocal respect people will respect you but if you give people the impression that you not equal to the task or not suitable for the profession, then they look down on you. Then you think they're being racist but if you can prove to them that you're being competent you get respect." (Female, Nigeria, M20)

6.8 Discussion

The findings from the one-to-one interviews and the focus groups provided an insight into the working experiences of ITPs in GB. The majority of the European, and a few of the adjudication pharmacists described how, after some years, their experiences of GB were going "down hill" and the initial excitement of living and working in a different country was wearing off. Similar to the IRNs[54;55;70;78] who came to GB for professional development and exposure to a high level of nursing practice, one of the main reasons for pharmacists' migration to GB was so they could practise pharmacy in a new setting and experience what it means to be a pharmacist in a first world country (see section 5.2.2). Initially, the ITPs interviewed were excited about having a professional identity and being able to use their knowledge in a productive manner and having a direct influence on patient care. However, as time passed and these pharmacists spent more time practising as pharmacists in GB, their dissatisfactions emerged. Many related their dissatisfaction with their heavy workloads, long working hours and lack of support from their employers. The complaints made by the majority of the European, and a few of the adjudication pharmacists about their current jobs seemed similar to complaints made by British-trained pharmacists in other studies.[217-219] For example, Gidman *et al.*[218] conducted interviews with 30 female community pharmacists in the UK to find out their perceptions of their working conditions, positive and negative aspects of community pharmacy working and their future career plans. Findings suggested that the community pharmacists' work environment has become increasingly pressurised, resulting in decreased job satisfaction. Additionally, the evidence from this study highlighted that increasing workloads resulted in decreased health and well-being. In another study, McCann *et al.*[219] used a survey in Northern Ireland to look at the levels of job satisfaction and stress in all the community and hospital pharmacists. Pharmacists from both sectors (n=766) found excessive workloads, inadequate staffing and interruptions to be the most stressful aspects of their employment.

Due to the growth of prescription volume and lack of support staff, the majority of EU, and a few of adjudication pharmacists, felt that they were unable to utilise their clinical skills to provide extended services such as MUR, to eligible patients, in an accurate manner. This disheartened this group of pharmacists because practising modern pharmacy and role extension was the very reason for their migration to GB. Eden *et al.*[217] looked at workload pressure among recently qualified pharmacists. One of the key findings was that, regardless of the sector in which early career pharmacists had gained work experience, there was a common occurrence of workload pressures. In his study, the pressure to do a certain number of MURs in the community had a detrimental effect on morale and performance in busy stores. Besides the resentment described in the literature with regards to pressure from employers to deliver new services and meet financial targets,[220-223] this study provides a new perspective on the level of discomfort ITPs felt in these cases. A few ITPs reported that the continuous demands from their employers put them in such an awkward and tongue-tied position, where they had to provide unnecessary clinical services such as MURs to unqualified patients, just to be able to meet their financial targets. It seemed that the ITPs lacked the necessary strategies or assertiveness to deal with the pressure from employers and ended up conforming to their employers' demands. Literature on IRNs also reported that nurses had to change their personality, becoming more assertive. They requested that their cultural background should be acknowledged and respected.[54;120;232]

This target driven culture, the heavy workload and lack of qualified staff put the majority of EU, and a few of the adjudication pharmacists, under enormous stress. This anxiety and stress had a negative impact on some ITPs to an extent where their day-to-day life was affected. This is consistent with evidence from other labour markets that increased workloads are directly linked with increased levels of stress, decreased health and well-being and decreased job satisfaction.[218;224] As a matter of fact, data indicate that pharmacists' mental health is directly affected by stress in the workplace [225]and job turnover is increasingly being associated with stress.[218;220;226]

Although there seemed to be similarities between the views expressed by British-trained pharmacists and some ITPs with regards to unsatisfactory working conditions,[217-223] there was also a general feeling amongst some of the EU pharmacists that employers

had exploited them. Similar to IRNs,[54;120] factors that led to feeling of exploitation included: a high rate of weekend shifts, deployment in undesirable areas that were difficult to recruit for, lack of pay rise opportunities, heavy workload and working with a shortage of support staff. EU pharmacists based their perceptions of being exploited on their foreign nationality, inadequate English language proficiency and an inaccurate but common perception of EU pharmacists and their supposed motivation for choosing to work in GB. Although the evidence presented from this study would support the claim of exploitation, the lack of empirical evidence and comparison with experiences of British-trained pharmacists limits the validity of this particular finding.

While the majority of EU pharmacists were dissatisfied with their current working conditions in GB, only a few adjudication pharmacists described similar dissatisfactions. This overall sense of contentment could be based on several reasons; adjudication pharmacists' age could be one explanation. A survey of Filipino American nurses (n = 327) showed that job satisfaction was positively associated with age, that is, the greater age was associated with greater job satisfaction. Similarly, job satisfaction was inversely associated with the number of years to retirement, with those with fewer years to retirement reporting greater job satisfaction.[227] Research indicates that adults experience life in stages and these stages may influence what one looks for in work.[228] What may be important in one stage may not be as important in another stage. Younger EU pharmacists may be looking for certain things within their career and life that may be very different from an older adjudication pharmacist who has been in the profession for over 10 years. What was apparent from the data was the fact that young European pharmacists expressed a stronger desire to change employers or return to their home country when compared with adjudication pharmacists, who were older and had been in the profession for longer.

Another reason for the overall sense of satisfaction of adjudication pharmacists could be related to their position in the community sector. In stage one, seven of the adjudication interviewees worked in the community as managers, while seven of the EU pharmacists worked in the community sector as locums or reliefs. A study of locum pharmacists found that locums experienced lower levels of job satisfaction. This was related to lack of established links with a pharmacy and its patients, essentially a general lack of continuity.[229] This problem could be considered more pronounced for locum ITPs who

may also need to prove their knowledge and communicative proficiency, both to staff and to patients, on a daily basis.

From the interviews conducted it seemed that all the four reciprocal pharmacists were working in higher-ranking positions, that is, as lead pharmacists compared to their European counterparts, who were working mainly as junior pharmacists in the hospital sector. All four reciprocal pharmacists seemed satisfied with their work, unlike their EU counterparts. Reciprocal interviewees had been in GB for a longer period and were native English speakers. This could possibly explain their higher ranking positions. Their described job satisfaction is consistent with the findings from a study conducted by Dowell *et al.*[230] into New Zealand healthcare professionals, whereby the overall mean stress scores were considerably higher for lower grade (Grade A-D) hospital pharmacists than higher grade ones (Grade E and above). Other studies have also shown that that those in lower grade jobs tend to be less satisfied with their role.[219;231]

Loneliness was a constant theme described by the majority of EU pharmacists. As described in chapter five (see section 5.4.2.4), the initial settling down period following immigration, and having no family or friends to rely on during adaptation, was harsh for this group of participants. However, the sense of being a 'stranger' did not disappear after this group of pharmacists finished their training and started to work as pharmacists in the hospital sector, or as locums/reliefs in the community. Some still felt excluded, alienated and were seen as 'foreigners' in the workplace by their British colleagues. This was further compounded by the difficulties participants had in communicating fluently (see chapter seven). IRNs have also reported feeling lonely and excluded.[54;66] IRNs in Allen and Larsan's[54] study found themselves in a foreign and often unfriendly working environment. Nurses gave reports of being excluded from the solidarity of their UK colleagues. They felt the stigma of exclusion. Lack of recognition of skills and a constant pressure to prove competency was another common feeling among most of the European pharmacists. This lack of recognition of skills resulted in a sense of injustice and the feeling that their experience and skills were not being appreciated. Literature on IRNs has also described the frustration nurses experienced when their previous experience, knowledge, skills and qualifications did not appear to be accepted or appreciated by UK employers.[54;66;70;90;93;121]

Not surprisingly, isolation at work gave rise to feelings of being marginalised and not liked. To compensate for their unmet desire for close friendship with British colleagues, some EU pharmacists established friendships with other internationally trained healthcare professionals, such as nurses and doctors. In his study of ITPs in Ontario, Canada, Austin[138] reported that the lack of identification with the professional community early on in the job may lead to marginalisation or separation from professional practice and the professional community.[138] What is apparent from this study is that, in some cases, EU pharmacists could not find friendship with their British colleagues and, to compensate, they made acquaintance with other internationally trained health care professionals, which magnified the feeling of 'otherness' and marginalisation.

According to Austin,[138] pharmacists attempt to resolve lack of appreciation and feelings of marginalisation by a variety of psycho-adaptive responses. These include devaluing and dissociating from professional culture and professional practice of the host country and defensiveness regarding professional culture and practice in the home country. Similar to pharmacists in Austin's[138] study, some of the EU pharmacists believed that British pharmacists were 'boxed in', more rule-bound and procedure-driven. While they readily acknowledged the extended role of pharmacists in GB and the value of 'pharmaceutical care' services, they believed there was lack of support for pharmacists in performing these tasks and the employing companies only used these services as a means to make money.

Participants had varied experiences with their interactions with patients. Some of the European pharmacists believed that the fact that they were from overseas opened up avenues for them to have a better relationship with patients. However, that was not the case for other EU pharmacists. From the data collected, the researcher sensed that some Polish pharmacists had to deal with a level of hostility from patients. It seemed that patients reacted to pharmacists from the 'New EU' [n] and the 'Old EU' differently. The pharmacists from the 'New EU' were stigmatised as 'economic migrants' and this certainly had a negative connotation in the British context. On the other hand, pharmacists from the 'Old EU' were seen as 'temporary migrants', motivated to come to

[n] In this part, the research interpreted the 'New EU' as those countries that joined the EU in 2004 and 2007. 'Old EU' refers to countries who were an EU member previous to 2004.

GB for travel and adventure. Their better knowledge of the English language (particularly pharmacists from the Scandinavian countries, Netherlands and Germany) made their interaction with British patients much easier. To best describe the ITPs' relationship with patients, pharmacists from Australia, New Zealand and the 'Old EU' should be stratified together. This is because their interactions with patients were mainly a positive one. On the other hand, pharmacists from Africa, Asia, South America and the 'New EU should be grouped together as they were seen as economic migrants and their interaction with patients was not as pleasant as the others. Non-EU IRNs have also described in the literature how they felt labelled in the UK as economic migrants and how this biased perception of them led to abuse and mistreatment.[54]

Many EU and adjudication pharmacists labelled GB patients as demanding. The centrality of patients in the US care system had also been identified by ITDs.[148] In a study by Dorgan et al.[148], ITDs highlighted a change of power dynamics in their descriptions of interactions with patients in the new host country. This was completely different from what they had experienced in their culture of origin. For example, ITDs in this study reported involving US patients in the decision-making process and providing them with a greater amount of information than they would usually do in their home countries. For several ITDs, this horizontal physician-patient relationship, in which the physician shared responsibility, power, decision-making and even talk-time with their patients, was a source of struggle.

Allegation of discrimination experienced by IRNs in the UK has been well documented. Research has focused on the working environment and particularly on relationships with colleagues and managers and with patients. [54;66;89;110;112;115;117-120;122] Similar to IRNs, ITPs discussed discrimination in terms of colour, language and foreignness and reported colleagues, employers and patients as people responsible for imposing discrimination.[54;66;89;110;112;115;117-120;122] What was novel about the findings in this study was the difference in discriminatory experiences between European and adjudication pharmacists. When EU pharmacists talked about discrimination, most of their accounts seemed to focus on experiences concerning colleagues and employers. Yet, for adjudication pharmacists their main accounts of discrimination were concentrated on patients. The differences between the experiences described could be based on the sector of employment and the position of pharmacists at work. The majority of

adjudication pharmacists worked as Pharmacy Managers in the community sector. Interestingly, adjudication pharmacists who only locumed, or used to locum, in the community, described experiencing racist behaviours from patients. Being in charge of a community pharmacy and having established links with its staff and patients could perhaps explain why adjudication pharmacists who were the permanent pharmacist in a store did not have negative experiences with staff and patients. What became clear through the course of the data analysis was the fact that adjudication pharmacists had changed employers several times over the years for professional and personal reasons. The professional reasons, in some cases, could be best described as professional dissatisfaction. What seems to have happened is that the adjudication pharmacists practised in different working environments in GB and they eventually settled in a position with which they seemed most satisfied, a process which EU pharmacists may possibly still need to go through. It is also important to say that years of experience could have influenced adjudication pharmacists' perception of exploitation and discrimination.[112]

The RCN warned the government in 1998 that working experiences of ethnic minority nurses have been sufficiently negative to have an impact on future labour supply.[232] Indeed, some EU pharmacists expressed that their dissatisfaction with their work certainly had negative impact on their attitude about the length of their stay in GB. Once ITPs have been trained and start to practise as pharmacists in GB, retaining them could depend on managing their work environment so they can use and develop their skills, and feel valued and respected in their work.

6.9 Chapter summary

In this chapter ITPs' working experiences as pharmacists in GB were described. While there were descriptions of positive work experiences, the majority of EU and a few adjudication pharmacists described their work experiences as dissatisfactory. Some EU participants felt alienated and believed colleagues saw them as 'foreigners'. Others reported that their skills and expertise were not fully recognised and they felt under pressure to prove competency. There were also reports of experiencing discrimination and racism by EU and adjudication pharmacists.

Chapter 7

Communicative proficiency of internationally trained pharmacists

7.1 Introduction

In stage one of this programme of work, communication difficulty was identified as a source of anxiety for ITPs when they initially started to practice in the GB healthcare setting. This finding, in addition to the restriction imposed on UK regulators, including the RPSGB and the new GPhC, with regards to language testing of EU candidates stimulated the researcher's interest to take this forward to inform and shape the further stages in her programme of work.[157] Further stimuli was provided by the data revealed by the Society's survey, where 63% of employers disclosed that language testing of European job applicants was not routinely undertaken and more than a third had experienced problems with employees' grasp of English.[157;177;178] Consequently, the emphasis in stage two and three of this research programme concentrated on communicative proficiency of ITPs and its potential implication on patient safety. The bulk of the findings from stage two of this programme of work, the focus groups with ITPs, are presented in this chapter.

The decision made to only use focus groups as a method of data collection for stage two of this programme of work proved to be a success. The discussions in the ethnically mixed focus groups covered a wide selection of topics spanning a breadth of fields. Topics such as ITPs' training, their relationships with patients and colleagues, experiences of discrimination and racism and ITPs' communicative competence were explored and discussed. In stage one of this programme of work, adjudication pharmacists who had been on the Register for a longer period, clearly struggled to remember the initial difficulties they had experienced with the language. Although the researcher used prompts during the interviews, these pharmacists could still not remember specific incidents. This was not the case in the focus groups. Many EU pharmacists described the initial difficulties they had with the language and this prompted the memories of the adjudication pharmacists, who had been in GB for a longer period, into also remembering and commenting on their problems, as well as their coping strategies. Discussion in the focus groups caused laughter and empathy between ITPs and this friendly and safe environment also allowed the shyer members of the group to also open up and describe some potentially upsetting experiences such as their experiences of bullying and marginalisation.

In this chapter section 7.2 begins by defining what communicative proficiency is, before moving on to describe the model that was used by the researcher as a way to understand and explain the data obtained from the focus groups. Sections 7.3 to 7.6 describe the findings from the focus groups based on this model. Section 7.7 describes a part of findings that did not fit into the chosen model. This is followed by the emotions ITPs experienced due to the communication barrier and their perceptions on whether practising in a second language had negative implications for patient safety in section 7.8.

7.2 What is Communicative proficiency?

Communicative proficiency is the ability to use the language in real communicative situations. "*It is the ability to communicate: to interact, to express, to interpret and to negotiate meaning, and to create discourse in a variety of social contexts and situations*"(p.5).[233] Communicative proficiency stems from Dell Hymes' original idea.[234] Hymes' proposal was that effective communication in a language requires more than grammatical competence, a speaker of a language also needs to how language is used by members of a speech community to accomplish their purposes.[234] In other words, in addition to the ability to form grammatically correct sentences by applying the grammatical rules of a language, they must also know when and where to use these sentences and to whom.[235] Research has also suggested mastery of linguistic skills is essential but not sufficient to ensure communicative effectiveness because communication is essentially linked to culture.[148;149;162;236;240] For example, unfamiliarity with slang, idioms and jargon caused major obstacles for IRNs.[55;83;110;112;126;140] In other words, there was a gap between the formal 'BBC English' that most IRNs knew and the informal 'Street English' that was used by patients.[54] Data collected in stage one of this programme of work also confirmed these communication challenges identified. In addition, some EU pharmacists had experienced cultural problems because of the way they interacted; their tone and word choice had been interpreted as "rude" by patients or colleagues. Such experiences highlighted the discrepancy that existed between the perception of patients and colleagues and that of the ITPs.

In the early 1990s, the Department of Citizenship and Immigration in Canada established the Centre for Canadian Language Benchmarks (CCLB). Later on, in 1996,

the Canadian Language Benchmarks (CLB) were introduced. The rationale behind the CLB design was to develop a system that would act as standards for describing, measuring and recognising the second language proficiency of immigrants in Canada. It was mainly intended to focus on education for migrants settling in Canada and to offer a practical curriculum guide.[173] In 2002, Pawlikowska-Smith developed the Model of Communicative Proficiency (MCP) for the CCLB.[233] Based on the MCP and further research carried out,[237] the CCLB was successful in designing the Canadian English Language Benchmark Assessment for Nurses (CELBAN). The CELBAN was the first nationally validated, occupation-specific language assessment tool designed to assess the language proficiency of IRNs seeking licensure in Canada.[238] At the moment, the CCLB is in the process of designing a pharmacy specific language assessment tool for ITPs in Canada.[239]

Pawlikowska-Smith's[233] MCP model has five distinct components (p.6):[233]

1) **Linguistic competence** *is the knowledge of grammar and vocabulary at a sentence level. It enables the building and recognition of well-formed, grammatically accurate utterances.*

2) **Textual competence** *is the knowledge and application of cohesion and coherence rules and devices in building larger texts. It enables the connection of utterances and sentences into cohesive, logical and functionally coherent texts.*

3) **Socio-cultural competence** *focuses on appropriateness in producing and understanding utterances. These include rules of politeness; sensitivity to register, dialect or variety; norms of stylistic appropriateness; sensitivity to naturalness; knowledge of idioms and figurative language; knowledge of culture, custom and institutions; knowledge of cultural references; and uses of language through interactional skills to establish and maintain social relationships.*

4) **Functional competence** *is competence to convey and interpret communicative intent (or function) behind a sentence, utterance or text.*

5) **Strategic competence** *manages the integration and application of all the other language competence components to the specific context and situation of language use. It involves planning and assessing communication, avoiding potential or repairing actual difficulties in communication, coping with communication breakdown, and using affective devices.*

The MCP has recently been used in the literature to present the communicative proficiency of IRNs in the US.[240-242] For example, Xu[241] believes that the communicative deficiency of IRNs comes from two main sources, their linguistic and their socio-cultural competence, as defined by Pawlikowska-Smith. Consequently, Xu *et al.*[240;242] conducted a study to investigate these two sources. A total of 79 IRNs participated in this two-phase study, which included two interventions. The Phase I intervention was a 10-week linguistic training course offered by a certified speech language pathologist, with expertise in accent reduction. The Phase II intervention included four workshops addressing socio-cultural aspects of communication (that is, establishing rapport, non-verbal communication). This study indicated that the Phase I intervention was successful in reducing pronunciation errors by IRNs regardless of gender, age, country of origin, or length of residency in the US. For Phase II intervention, despite improvement for some communication variables, there were no significant changes. Xu *et al.*[240;242] believes this was due to the fact that the IRNs who participated in this study had already adapted to the US culture as a result of living and working there for a long period of time.

Little research on communicative proficiency of internationally trained healthcare professionals has been theoretically grounded.[240-242] The MCP model was selected by Xu and other scholars to describe IRNs' communicative proficiency because the characteristics of the model make it especially relevant to the healthcare professionals-patient context.[244] The limited literature, the relevance of MCP to the healthcare context and the use of this model by Xu and colleagues to describe communicative proficiency of IRNs in the US led to a decision by the researcher to use the MCP as a tool to handle and explain the data obtained from the focus groups. The model was in no way utilised to design the data collection but was rather used as a simple instrument to understand the findings. Using the model in this way allowed the researcher to offer suggestions for change, or how, or where to concentrate efforts for improvement and/or training (see chapter nine).

As will be seen in this chapter, the focus group data are presented under the linguistic, functional, socio-cultural and strategic components of the MCP. However, there was no evidence in the findings for the textual component of the model. As the MCP was not used to design the data collection, the participants were not probed further to see if data

on this specific component will actually arise. Nevertheless, Pawlikowska-Smith states, "*communicative proficiency is not an abstract concept of "absolute" language ability. Rather, it depends on situations of language use. It is described as adequate control over language skills for a specific purpose (e.g. for studying, performing a job, functioning independently in a community). Depending on what communication tasks will be required, certain components may be given priority in a description of communicative proficiency, and others may not be included at all*" (p.5).[233] Based on this statement, it seemed that the four components of linguistic, functional, socio-cultural and strategic competence were given priority by ITPs in their description of their communicative proficiency. Perhaps the textual component was not described because it was not a main concern when ITPs discussed effective language use while performing the role of responsible pharmacists; this, however, requires further investigation.

In the following section, data from the focus groups are structured, using the MCP model's four distinct components.

7.3 Linguistic competence

As described previously, linguistic competence "*is the knowledge of the formal code of language on how to combine the elements of grammar, vocabulary, and pronunciation to produce well-formed sentences*" (p.9).[233] The components of linguistic competence, as suggested by Pawlikowska-Smith, are presented in textbox 6.

Textbox 6: Components of linguistic competence

Pronunciation**:** "*the way in which a word is pronounced*"
Vocabulary: "*the body of words used in a particular language*"
Grammar**:** "*the whole system and structure of a language*"

One would assume that linguistic competence is essential for ITPs because of their day-to-day contact with patients. However, from the data collected, it was clear that this initially proved to be a problematic area for many ITPs. Participants explicitly discussed the pronunciation and the vocabulary components of linguistic competence; however,

they did not speak about the grammar component. Nevertheless, participants' relevant mastery of the grammar component was demonstrated by their communication skills during the focus groups. Whether the grammar component of the language was a problem immediately after arrival requires further investigation.

7.3.1 Pronunciation

The theme of 'pronunciation' was raised by ITPs and was recurrent throughout the focus groups. This issue emerged unprompted and went on at some length. Data analysis suggested that, initially, the majority of ITPs (n=37) perceived that their pronunciation was different from that of native speakers:

"Every single word that you say is different from the English people. Their pronunciation is different. I would say it takes years for us to correct our pronunciation." (Female, Portugal, Z24, FG 5)

The 15 Spanish pharmacists who participated in the focus groups explained how they had difficulties in pronouncing vowels:

"It's not your first language so there are always going to be words that, you know, you're not going to pronounce properly. I mean, one of the main problems that I have is with vowels." (Female, Spain, Z20, FG 4)

 EU pharmacists (n=10) went on to describe how their different pronunciation had led to some "embarrassing" situations within the practice setting:

"Once I was talking to a patient, I asked her, "how are your parents?" because her parents come to my pharmacy but she understood "piles" instead of "parents" and she started talking about her piles. She said, "how did you know I had piles?" and I had to go under the counter because I was going to explode...There is a big difference between "parents" and "piles" but I don't know if it was the way I said it." (Female, Poland, Z26, FG 5)

Pronouncing patients' and medication names in the correct British manner was also a challenge for the ITPs (n=28):

"Pronunciation of drugs in Dutch is quite different and every time I get a student over from Holland I can see where I said them wrong when I started, you can just…you recognise it, it's just a different way of saying it." (Female, Netherlands, Z25, FG 5)

"Just because I said Athenolol instead of Atenolol or, Omaprazol instead of Omeprazole… they [colleagues] didn't understand what I said." (Female, Kenya, Z38, FG 8)

"Dealing with drugs was hard. You are used to the names but are you used to pronouncing it in your own language so when they said it in English I had no idea." (Female, Sweden, Z1, FG 1)

"I really get embarrassed sometimes cos they tell me, "No, it's not like this. You have to say it [name] like that." (Female, Iraq/Netherlands, Z34, FG 7)

ITPs (n=30) went on to describe how their accent made understanding difficult for both patients and colleagues:

"To be honest, it's not just the patients' or medication names. I think the way we speak, our overall accent is just different and that sometimes makes understanding difficult for everyone, patients and colleagues." (Male, Nigeria, Z10, FG 2)

The online Oxford dictionary defines 'accent' as "a *distinctive way of pronouncing a language, especially one associated with a particular country, area, or social class.*"[243] Pawlikowska-Smith[233] drew on Derwing and Munro's[244] work to describe "accentedness". This term describes "*a subjective judgement by a listener on the 'heaviness' of the speaker's accent, that is, the extent to which a second language speaker's spoken productions are judged to differ from the accent of the community. A subjective judgement by a listener of the relative difficulty or ease in understanding a speaker's accented speech is termed comprehensibility*" (p.29).[233] In the focus groups, ITPs described how patients and colleagues had difficulties understanding their accented speech. They perceived that their accent made their speech incomprehensible on occasions when they initially started practising:

"At the beginning, sometimes people didn't understand you although you spoke good English and you couldn't really figure out why there was this problem. It was probably the accent, they just didn't understand it." (Female, Poland, Z26, FG 5)

"Initially, sometimes patients or even colleagues didn't understand me and I bet it was my accent." (Female, Italy, Z22, FG 4)

7.3.2 Vocabulary

Apart from difficulties caused by their pronunciation, not having an extensive knowledge of the vocabulary was another major barrier for EU pharmacists (n=18):

"With me, I was missing the vocabulary so I did have to learn to express myself." (Male, Poland, Z33, FG 7)

"Your vocabulary is not as rich as it should be when you come and of course you learn when you get here but it's difficult." (Female, Poland, Z8, FG 2)

A few EU pharmacists (n=7) went further, to say how their limited vocabulary

compounded their sense of insufficiency in providing care for very ill patients:

"I think probably if it's cytotoxic drugs and you had to explain them in Spanish, I could find really a sweeter way of explaining them, just because I could use other words to maybe make a very ill patient feel better, whereas in English I would stick to, you know, the words I know."
(Female, Spain, Z29, FG 6)

"Providing care for patients who are dying is not easy. You feel imprisoned because you can't show you care by the way you speak." (Female, Spain, Z23, FG 5)

Initially, the technical vocabulary and the pharmaceutical terms that are used within the pharmacy system in GB were generally unknown to most of the EU pharmacists (n=25):

"Obviously you know some of the terminology, like hypertension, but you don't know everything." (Female, Spain, Z130, FG 3)

Some EU pharmacists (n=13) managed to master the more technical terminology by studying relevant textbooks:

"When I just started working, I read a book. I think you might be familiar with the book, it's called "Symptoms in the Pharmacy" by Alison Blenkinsopp. Suddenly my eyes just opened to a whole new world; that was the first time that I got in touch with the technical vocabulary and I started, you know, getting more and more confident when talking to people." (Female, Germany, Z30, FG 6)

Early in the job pharmacists realised that, as well as knowing the technical vocabulary, that is, 'pharmaceutical terms', they should also learn the common 'lay terms' to be able to give advice to the general public on minor ailments. This is discussed further under the socio-cultural competence (see section 7.4).

7.4 Socio-cultural competence

Command of linguistic skills is essential but insufficient to guarantee communicative effectiveness because communication is essentially linked to culture, contexts, and non-verbal behaviours. Socio-cultural competence is the knowledge of appropriate use of language, given the setting, the topic and the associations between the people communicating.[233] The components of socio-cultural competence as suggested by Pawlikowska-Smith, [233] are presented in textbox 7.

Textbox 7: Components of socio-cultural competence

Sensitivity to naturalness
Adapting language to audience
Knowledge of idioms and figurative language
Sensitivity to dialect and its variety
Knowledge of culture and customs
Knowledge of non-verbal communication

7.4.1 Sensitivity to Naturalness

This is defined as a 'native-like way' of talking. It is a style of speaking that sounds natural, and not strange, foreign or bookish.[233] All but three adjudication pharmacists and a few of the EU pharmacists (n=5) were taught and knew what they defined as "BBC, Textbook or Queens English" (formal English) and subsequently had problems with "Street English" (informal English):

"I realised the English that I thought I knew was more like BBC type English and what people actually say in reality is different." (Female, Sweden, Z1, FG 1)

"Initially, when you listened to the news you didn't have to make any effort to understand it but when you were talking to the local people you had to put in extra effort and be very, very careful and look at their mouths to understand. I got there in the end but it took time." (Male, Sudan, Z21, FG 4)

A few ITPs (n=4) recognised that initially it was not just them having difficulty understanding patients/the general public's "Street English" but the British/native speakers also had problems understanding the participants' "BBC English":

"Sometimes you speak with your BBC English and then they don't understand you, so it works both ways." (Male, Nigeria, Z10, FG 2)

7.4.2 Adapting language to audience

As explained previously, early on in the job pharmacists realised that, as well as knowing the technical vocabulary, that is, the 'pharmaceutical terms', they also needed to learn the common 'lay terms' ° to be able to give advice to the general public on minor ailments:

° "Lay terms" are non-technical terms, easy to understand language for the average person without advanced medical or pharmaceutical knowledge.

"You can't really use terms like hypertension or hyperglycaemia in front of patients. So we [the ITPs] had to lean all these common lay terms so that we could communicate with patients." (Female, Sweden, Z40, FG 8)

The majority of ITPs (n=34) gave particular examples of 'lay terms' which they initially found confusing:

"It was strange hearing "water tablets" for the first time. I was like "what are they talking about,"...we didn't have that term back at home. So as well as getting used to the pharmaceutical way of describing something you get used to the common way that people talk. Well, things like..."drawing ointment", later on, I realised they were talking about Magnesium Sulphate. Or terms like I'm all "bunged up" that means they are congested." (Female, Nigeria, Z41, Interview 1-stage 2)

"The first time I heard someone say "Could I have something soothing," "soothing" was the word I didn't understand." (Female, Sweden, Z40, FG 8)

"For me, when I heard the term "painkiller" for the first time I was like "what?" For me it was more like analgesic, then you realise it is killing pain, which is same as analgesic." (Male, Spain, Z3, FG 1)

""Athlete's foot" I didn't know what it was initially. It was a bit confusing." (Male, Iran, Z32, FG 5)

"Things like "nits, lightheaded, stye" were all new to me." (Male, Spain, Z14, FG 3)

""Flu" for me was a word I didn't know. I knew "fever"." (Female, Netherlands, Z25, FG 5)

"I think "congestion", that someone is congested, that was new for me, because congestion as I learnt initially meant traffic." (Female, Poland, Z26, FG 5)

Occasionally to describe conditions, different terms are used in other languages and direct translation does not communicate it. For example, one pharmacist said:

"In my country constipation or being constipated is like having flu; here constipation means, you have to give a laxative so sometimes, when I'm counselling a patient and they tell me that they were on a medication for flu I automatically say to them "Oh, were you constipated?"" (Female, Portugal, Z24, FG 5)

However, adjudication pharmacists believed the pre-registration period very much prepared them linguistically for practising as independent pharmacists:

"Pre-reg wasn't just about knowledge. It taught us all these common terms." (Male, Nigeria, Z10, FG 2)

7.4.3 Knowledge of idioms and figurative language

All EU and adjudication pharmacists highlighted colloquial terms, idioms and slang as a source of difficulty when they started practising in GB. Even pharmacists from Sweden, Germany, Netherlands, Kenya, Nigeria, Pakistan and Sudan, who appeared more competent in communication during data collection, described incidents when colloquial terms, idioms and slang limited their understanding. The participants had a lot to say on this topic and this caused major discussion among the ITPs.

The online Oxford dictionary[243] defines:

Idiom: "*as a group of words established by usage as having a meaning not deducible from those of the individual words (e.g. over the moon, see the light).*"
Colloquialism: "*as a word or phrase that is not formal or literary and is used in ordinary or familiar conversation.*"
Slang: "*as a type of language consisting of words and phrases that are regarded as very informal, are more common in speech than writing, and are typically restricted to a particular context or group of people.*"

Colloquial terms used by the native speakers were sometimes a major source of difficulty:

"*I remember the…"innit". It took me a few days to realise that what they were saying was "isn't it.""* (Female, Netherlands, Z25, FG 5)*

Idioms and slang used by native speakers were totally unknown to both EU and adjudication pharmacists:

"*Yeah, phrases like "I'm so over the moon" or "over my dead body" or I heard a shop assistant say, "I'm not coming out tonight because I'm skint." These phrases were totally new to me." (Female, Spain, Z6, FG 2)*

"*They simply speak differently. They have this 'slangish' way of speaking which is totally different to what we know." (Male, Spain, Z15, FG 3)*

Participants described incidents where they took offence because they simply did not understand the cultural connotation of expressions used by the patient/colleagues:

"*Here in the North they sometimes say, "Are you ok, cock?" and the first time when somebody said to me in a pharmacy "Are you alright, cock?" I went bright red and turned around looking*

for help from my dispensers. I thought it meant something else. I thought it was rude." (Male, Spain, Z3, FG 1)

"I didn't like, for example, at the beginning when they said "love" or "honey" and I was getting really upset because I didn't know it was a normal thing to call someone "honey." I was thinking, I'm the pharmacist why is he talking to me like that?"" (Female, Spain, Z5, FG 1)

Other participants gave example of incidents where not understanding the cultural context of the conversation had led to what they described as a "funny "situation:

"I had a nice, funny situation with a colleague. When she said "I want a fit guy," I said to her, "But you only go to the gym twice a week." We still laugh about it." (Female, Netherlands, Z25, FG 5)

7.4.4 Sensitivity to dialect and its variety

The online Oxford dictionary[243] defines dialect as: "*a particular form of a language which is peculiar to a specific region or social group.*" Sensitivity to dialect and its variety therefore refers to recognising differences in language use in different regions, or by different social groups.

The difficulties experienced due to the use of idioms, slang and colloquial language, seemed to have been amplified by the regional dialects of patients. Initially, the simplest words spoken by the native speaker caused confusion for the majority of ITPs (n=32):

"You feel like you are someone from out of this world. It is because the English you learn is like "BBC English" and ... when you come over, because you are not used to that sound, even hello or hi, was like "what", did he say hello? You are not used to the sound, not the way they pronounce it and it is really difficult... The way they pronounce U, "I'm on the boos (bus) with my moom (mum)." So yeah, that is the way they pronounce it and if you say, "I'm on the bus with my mum," they probably say "What?"" (Male, Spain, Z3, FG 1)

As expected, ITPs who took part in the Manchester, Liverpool and Glasgow focus groups seemed to have had a bigger challenge in terms of dealing with natives' spoken dialects than pharmacists who went to London:

"I came straight to Manchester and I started in Atherton, then moved to Salford and then Eccles, so for me at some point in my first year I said "please tell me that there is another England than this?" I really thought this can't be it. This is not what we think when we think about England back at home...Obviously, you don't learn Yorkshire accented English or Mancunian accented English back at home. You don't, and that's why we struggle and you just have to put up with it and get used to it, but it's a big, big barrier even if your English is brilliant grammatically, you speak perfectly, you read perfectly and your English is at a very good standard, you still struggle." (Male, Spain, Z3, FG 1)

"I was shocked with the Scouse dialect. It was totally, totally a different language and I was getting depressed initially thinking I can't learn this." (Male, Spain, Z16, FG 3)

"The dialect, like some of them say "water" the others say "wa-er" and I couldn't understand that in the beginning. Like "Nytol" or "Ny-ol." So yes, it's difficult." (Female, Germany, Z37, FG 8)

London was described as a multicultural city, with foreigners from a variety of countries with different accents:

"I think you meet people from everywhere here in London, with different backgrounds and different accents. I've got overseas colleagues for whom English is not their first language and others who speak English as their first language, I've got Australian colleagues, New Zealand, Scottish and Irish colleagues." (Female, Germany, Z30, FG 6)

The majority of ITPs in London (n=10) believed it was more difficult to understand foreigners' English accents than the native speakers' dialect, a problem that was not highlighted by participants in other cities:

"I find, not the accent from the English people, but the accent from foreign people, I find that difficult." (Female, Portugal, Z24, FG 5)

Understanding other internationally trained healthcare professionals seemed to be an added difficulty for ITPs in London. Again, this problem was not mentioned by participants in other cities:

"We have so many nurses here, practising in the UK, that are from the Philippines and sometimes it's difficult to understand them." (Female, Portugal, Z24, FG 5)

All participants reported that after practising in a particular area for a while, they adapted to that that particular regional dialect:

"It's funny because most of the English I learnt was hearing other people talking so when you repeat a word, you repeat the sound they are making, so after a while you realise, you are talking with a dialect." (Male, Spain, Z2, FG 1)

Being able to speak the language with the local dialect gave the pharmacists the perception that they were getting more proficient in communication:

"When you speak with a Mancunian dialect on top of your Spanish accent that makes you feel like, I'm not doing that badly." (Male, Spain, Z3, FG 1)

Pharmacists who became familiar with the local dialect found locuming in a region with a different, strong dialect challenging:

"In Manchester, the accent didn't matter, because it didn't take me long to get used to it. But then when I went to Liverpool to locum, I thought what are they saying? I couldn't understand them very well and they couldn't understand me either ... I had to listen intently to work out this strange way of talking" (Female, Nigeria, Z41, Interview 1-stage 2)

7.4.5 Knowledge of culture and customs

Socio-cultural competence also refers to the suitability with which speakers produce and understand language within a specific context.[233] In the case of ITPs, the issue was how effectively they used the language according to the norms of interaction and interpretation[234] within the pharmacy context. In this area, cultural differences were one of the primary bases why ITPs struggled.

Initially, most ITPs (n=30) believed that their interaction and behaviours in a new and unfamiliar British culture were perceived as "odd" by patients/colleagues within British culture:

"Initially, I was shocked by how easily people decide to put their elderly mum and dad in a nursing home and I guess I came across a bit strange and judgmental when I was discussing this with my colleagues. The thing is, our culture is different. We take care of our elderly till the last day." (Male, Egypt, Z11, FG 2)

In some cases, not knowing which expressions were culturally acceptable to patients/colleagues was sometimes sufficient to cause misunderstanding and even offence:

"One of the problems for me was the culture. I was working with a Scottish lady who had a daughter and the daughter used to come into the pharmacy from time to time. So on this occasion she came in and she was looking quite good. Back in Nigeria it's a compliment to say you're looking good, you've put on a bit of flesh, so when she came in I said, "oh, you're looking good," and the way I said it, she interpreted it as I was telling her that she has put on weight and she took offence. She got the wrong impression of what I meant. So the cultural context was an issue. You might be trying to express yourself in a particular way but their understanding would be quite different from what you would be trying to present. In Nigeria, for example, if you put on weight it's regarded as a sign of good living. If you are skinny, people think you are not eating so it's a class separation thing, this is the culture and you find yourself moving from that culture to a culture where size zero talks." (Male, Nigeria, Z10, FG 2)

One of the important cultural differences raised by most of the EU pharmacists (n=25) was the fact that they were direct when it comes to dealing with people, unlike the culture in British society:

"In Polish, you are much more direct than in English, saying "Listen, listen. Do this and that," and that's it. Here, they try to make everything sort of pretty." (Female, Poland, Z26, FG 5)

Not being so direct and clear sometimes caused confusion for EU pharmacists in their work place:

"I think it's a Dutch cultural thing to be very direct and if somebody asks you whether you like something, you will say what you think and here, that's not done here. If I asked somebody here "Do you like this?"and they say "I don't mind." I think "oh, it's fine", when actually it's not fine. They actually think it's rubbish. And if they do that for something which is work related then it's sad because you've put effort into it, you thought it was okay and it turns out that they said "I don't mind," which means it is not clear at all if it is good or bad."
(Female, Netherlands, Z25, FG 5)

EU pharmacists believed the culture of 'not being direct' prevented their colleagues from correcting their communication errors, a habit which they were not pleased about:

"One thing English people don't do is tell you that something is wrong or you need to change, they just think it's rude to correct you. But please tell me, I mean don't be afraid of telling me that this is wrong and that's what you don't see very often." (Female, Spain, Z29, FG 6)

"In the beginning I remember I would say to everybody that they should correct my English, be it spoken or written, until now I've never, ever had any single person saying to me I should write something differently or speak differently, when I know I'm definitely making mistakes. People will not tell you, people will absolutely not tell you. I mean certainly, language wise, I would have wished that people would have corrected me more." (Female, German, Z31, FG 6)

Similar to findings from stage one, the direct approach of EU pharmacists (n=13) had been interpreted as "being rude" by patients or colleagues in GB:

"Coming from a Spanish culture, the main difficulty is the manners. We are too direct in Spain and here you learn that you have to be more polite and don't say things so straight, because people interpret things in a wrong way or find it offensive." (Female, Spain, Z6, FG 2)

A few EU pharmacists (n=3) also recognised the fact that, after working in GB for a while, their behaviour started to change and, as one German pharmacist explained, being 'so direct' did not come naturally to her anymore:

"If I go back to Germany with my half Scottish head now, I'll be shocked at the way they talk to me, absolutely shocked. I'm like, "How can you be so rude?" I never picked it up before when I lived there, you're just the same. I'm more rude than the Scottish people here but I've probably slowed down a bit, but I'm still more rude or 'in their face' than they might want." (Female, Germany, Z37, FG 8)

ITPs' (n=14) limited knowledge of the socio-cultural aspect of communication made initiating or engaging in 'small talk' with colleagues and patients difficult. The initial reason given for this difficulty was the problems they had understanding slang, idioms, colloquial terms and the various dialects:

"I used to not understand people when they were chatting amongst each other because it was so 'slangish' and quick. It took me several years before I got comfortable when I sat in the tea room with colleagues."(Female, Sweden, Z1, FG 1)

"When people talked amongst each other, it was difficult. When two people from Liverpool talked to each other, I didn't understand them. That was my problem for the first year. I used to live in the hospital accommodation and I used to go back to my room for lunch. I didn't stay for lunch at work with my colleagues because I couldn't engage properly in a conversation and so I used to go to my room." (Male, Malta, Z12, FG 3)

Beside the stated obstacles, ITPs also identified the difference in cultures as another barrier that prevented them from actively engaging in a conversation with their British colleagues:

"For me, I feel it's difficult to get involved because it's also the way they live, it's different from the way that I'm used to living. Here, they watch so much TV and they love those kind of programmes where they can see each others' lives and they love to talk about that. So I think for example, when I'm in the dispensary, I can't step into a conversation because I don't like Big Brother, I've never seen it and they love that kind of stuff...so because I'm not like that and I don't see that kind of stuff, I see that as a barrier. Also, they don't talk personally to each other for the whole week, but then on Friday it's like "let's go and have a beer." It's kind of, it's kind of strange to suddenly on a Friday go out and everybody's your friend." (Female, Portugal, Z24, FG 5)

ITPs were challenged to understand the British culture and adopt this new way of life. However, occasionally their values and beliefs conflicted with this new system. This affected both their personal and professional life:

"If a young girl comes in and says I'm having sex with my boyfriend, I would think, you are a bit young. So yeah, culturally sometimes I didn't feel very comfortable with some things." (Female, Nigeria, Z41, Interview 1-stage 2)

Two adjudication pharmacists recognised how their cultural backgrounds affected their ability to advise their female patients on emergency hormonal contraception (EHC):

"For me it's difficult to speak to ladies about EHC. The difficulty is choosing the right words and phrases; everything comes into it, the age, the background, the culture. You have to be brave to start and carry on with the conversation."(Male, Egypt, Z11, FG 2)

"With the EHC it is quite difficult...When you want to know when they had sex, it used to be a tough one for me; here you are in a consultation room and you need to ask when they had intercourse so I can make my professional judgment to supply or not supply, but to get that information was not easy. I did not want to say "sexual intercourse" but didn't know how to express myself." (Male, Nigeria, Z10, FG 2)

A few pharmacists (n=5) believed patients do not expect the pharmacist to be embarrassed and this belief helped them to be more comfortable and at ease when asking certain questions:

"I had situations with patients where you would feel uncomfortable...With a man, or maybe a woman, when they talk about sex or terms like "down below", I felt uncomfortable to begin with but then I thought she doesn't expect me to be uncomfortable; so then I decided I wasn't going to be uncomfortable." (Female, Nigeria, Z41, Interview 1-stage 2)

Other pharmacists (n=4) believed instead of being shy and avoiding the use of certain words, it is better to ask a direct question:

"I just think the best thing is to get it over and done with, short and precise, for example, with the EHC, "when was the last intercourse?" They catch it quickly. I think when you are not embarrassed asking these questions, the customers knows then that there is nothing to feel embarrassed about."(Female, Spain, Z6, FG 2)

7.4.6 Knowledge of non-verbal communication

Non-verbal communication involves non-verbal stimuli, such as body language (for example, eye contact and facial expression) or touching conventions that represent or create meaning.[233] Several of the EU pharmacists (n=7) spoke about the importance of non-verbal communication in any interaction:

"As they say, actions speak louder than words. So yeah, body language is important."
(Female, Spain, Z23, FG 5)

Initially, communication over the telephone was difficult for majority of the ITPs (n=29), and they mostly put that down to lack of non-verbal cues for validation:

"I really panicked every time the phone rang... My heart really sank during that first year."
(Male, Spain, Z3, FG 1)

"Talking over the phone is always more difficult than talking face-to-face because you don't get to see the expressions on the face." (Female, Poland, Z26, FG 5)

"Over the phone is so different compared to talking to someone face-to-face. Looking at the body language is so useful which is missing over the phone." (Male, Spain, Z16, FG 3)

On the other hand, EU pharmacists (n=7) described incidents where non-verbal differences accounted for difficulties in communicating:

"Another thing is the body language; we use a lot of body language in Spain. If I touch you slightly on the arm when you are moving in a dispensary it doesn't mean anything but here if somebody touches you in the dispensary it's like "sorry, sorry" and I keep thinking there is no need to keep saying sorry." (Female, Spain, Z6, FG 2)

"If you touch somebody to get their attention because you can't remember their name, they will move back as if you've done something really bad. But that is just normal in Spain."(Female, Spain, Z29, FG 6)

7.5 Functional competence

Pawlikowska-Smith[233] describes function as *""purpose," "intended outcome," or "use." Purposes or use for language are multiple, for example: establishing interpersonal relationships, getting things done, controlling others' behaviour*" (p.12).[233]

The components of functional competence as suggested by Pawlikowska-Smith [233] are presented in textbox 8.

Textbox 8: Components of functional competence

Interpersonal exchange (i.e. greeting and leave taking)
Facts (i.e. asking for and giving factual information)
Opinions (i.e. expressing agreement and disagreement)
Feeling/emotional attitude (i.e. expressing and finding out about feeling and emotional attitude)
Problems/moral attitudes (i.e. apologizing)
Future scenarios (expressing and inquiring about plans)
Suasion (i.e. giving orders and warning, controlling others' behaviour)

Participants explicitly discussed the suasion component of functional competence. However, there was no evidence in the data for the other components of functional competence. Nonetheless, to be able to provide appropriate care to patients, ITPs had to demonstrate competence in the other components, such as asking for and giving factual information and expressing agreement/disagreement. Further data collection is required to see if participants experienced difficulties with other components of the functional competence immediately after arrival into GB.

7.5.1 Suasion

Several ITPs (n=9) talked about their frustration in caring for abusive and aggressive patients. ITPs generally believed that once an abusive patient realised that they were from overseas then the situation became more difficult to handle:

"I had a problem with a patient on the phone. He was quite aggressive, and then he realised that I was a foreigner so he was trying to use that against me. He was like "Do you speak English! Do you understand what I'm saying."" (Female, Portugal, Z24, FG 5)

"I remember once the customer called and was complaining about some drugs that were incorrect. She was very rude and I was trying to explain to her that, "look, this is what is on your prescription" and then she shouted down the phone saying "Can I speak to someone who speaks proper English," and then I asked one of the dispensers to answer the phone." (Female, Spain, Z5, FG 1)

ITPs mentioned that they had to be extra vigilant when dealing with Methadone patients:

"I was in this chemist where we had eighteen daily addicts and in the beginning they did try to be funny sometimes, but as soon as they realised I wouldn't budge, that was the end of it because you need to be serious. In the beginning they were trying to make me confused. When I was asking them their name, they were like, "blah blah," but I was like "no." They were doing it on purpose so I wouldn't understand them." (Female, Spain, Z5, FG 1)

A few (n=4) believed that sometimes an abusive patient could take a step further and make racist comments:

"If they're abusive already and they realise you're a foreigner, they will definitely go a step further and say racist things." (Female, Netherlands, Z25, FG 5)

Participants believed it is more challenging for ITPs to handle abusive patients in a new culture. They stated that their communication abilities were stronger in their own culture, in large measure because they understood the behaviours of patients within their own culture and knew what they wanted:

"I was doing a locum duty and I was alone, I didn't have a technician and it was when I had just arrived in London. I had a lady who was very aggressive and she was blaming me for stealing her prescription...I was already quite stressed because I had never been in a situation where I was on my own... So when she started blaming me, saying that I had stolen her prescription, I think the stress of the situation got to me, I just couldn't say anything. I was just standing there thinking, "someone, come and help me here," so I had to call the security guard. I think because she saw that I wanted to speak but I was only mumbling like, "Oh, oh," she was getting even more aggressive and she was shouting. So I think if I was in my own country, with my own people, I would have known how to react, whereas that time I was just like, "oh.".." (Female, Spain, Z29, FG 6)

7.6 Strategic competence

Immediately after arrival, the majority of ITPs (n=31) had a series of problems understanding and communicating with patients. Initially, to aid their understanding, ITPs (n=12) had to keep a high level of concentration at all times. This was described as exhausting by one participant:

"It was very difficult. It was exhausting because you had to concentrate all the time, every day, whether it was in a meeting or when you were talking to the patients. It makes you tired." (Female, Spain, Z28, FG 5)

The fast pace of the workplace occasionally caused deterioration in ITPs' comprehension and their ability to speak clearly:

"Sometimes in busy patches, when I am checking prescriptions, the staff shout "is it ok to sell so and so?" but I don't understand because I just need to concentrate my mind on one thing at a time." (Female, Spain, Z5, FG 1)

A few ITPs (n=4) mentioned that they found it difficult forming speech or finding the right word while concentrating on the job at hand:

"Sometimes I find myself searching for the right word when I'm working and when I can't find that right word, I just get stressed." (Female, Poland, Z8, FG 2)

To make the situation manageable ITPs used a variety of coping strategies. These coping strategies fit well under the strategic competence.

Strategic competence is coping strategies that may be called into action to compensate for breakdowns in communication. In other words, strategic competence refers to the capability of the individual to get his/her meaning across successfully to communicative partners, especially when problems arise during the communication process. The components of strategic competence as suggested by Pawlikowska-Smith,[233] are presented in the textbox 9.

Textbox 9: Components of strategic competence

Non-linguistic means (i.e. pointing, gestures, drawing pictures)
Request for repetition (i.e. pardon?)
Interpretive summary (i.e. so what you are saying is..?)
Approximation (i.e. 'fish' for 'carp')

7.6.1 Non-linguistic means

ITPs (n=5) talked about using non-linguistic compensatory means to aid their speaking:

"I try to compensate by other means. For example, I get a pen and paper and try to draw a simple diagram showing the body sector, the drug molecule and the pharmaceutical action, the mechanism of action, how they act, what happens." (Male, Iran, Z32, FG 6)

7.6.2 Request for repetition

As ITPs' confidence grew, further tactics were deployed to aid understanding:

"I think the more you do it, the more confident you feel. Sometimes if they're spelling a name really, really quickly I say well, "Can you slow down and repeat please."" (Female, Portugal, Z24, FG 5)

"I think it's just a natural thing to ask, "Could you repeat it?"" (Female, Germany, Z30, FG 6)

7.6.3 Interpretive summary

Paraphrasing was another technique pharmacists (n=12) talked about using. To make sure they had understood correctly, some provided an interpretive summary:

"If there's somebody I've not understood, or not sure if I've taken the information correctly, then I will get back to them, so you know it'll be like, "You're Zainab from Manchester, right? and this is what you want me to do?"So I can throw the ball back in your court."(Female, Sweden, Z40, FG 8)

Asking patients to summarise the advice they were just given, was another technique used (n=6):

"I think I try my best. I ask patients if they've understood me, you know, my accent, ask them to repeat what I said back to me basically, to make sure that they understood what I've been saying." (Female, Spain, Z5, FG 1)

7.6.4 Approximation

A few pharmacists (n=5) talked about using approximation as a technique to convey their messages:

"I didn't know the term 'suspension' in the beginning so I kept saying, "your amoxicillin liquid is ready" instead of suspension."(Male, Spain, Z14, FG 3)

On the other hand, a few of the adjudication pharmacists (n=4) tried to figure out the meaning of the local words, colloquial terms and idioms within the context of the conversation:

"If you try hard, you can understand it [colloquial terms] within the context, so you kind of assume." (Male, Nigeria, Z10, FG 2)

7.6.5 Expansion of responses

Posing open questions was also used as a means to gather further information (n=14):

"What I do now, I say "Can you tell me about the symptoms?"...I say to them "What do you want to treat? Can you explain? Can you give me more details?" and things like that."(Male, Spain, Z18, FG 4)

"I try to tackle the problem from a different angle so I don't ask the patient to repeat themselves; I ask a different question. For example, if a patient comes in asking for a certain medication that I don't know, I ask what the symptoms are and then when you know what's wrong with the patient, you might know what he was asking about." (Male, Poland, Z33, FG 7)

7.6.6 Appeal for help

Telling patients that they were new and not used to the language and the system was used as a compensatory mean by some participants (n=8), as illustrated in these quotations:

"Sometimes I might explain myself and say, "I'm sorry I'm struggling to find the right words here," and that can be enough. You can just explain "Sorry, English is not my first language," and then they [patients] are usually ok with that"" (Female, Germany, Z37, FG 8)

"I used to say, "I'm Swedish so I'm not quite sure of the language." They were quite understanding, usually." (Female, Sweden, Z1, FG 1)

7.6.7 Time-gaining strategies

Different techniques were used by ITPs to make sure they could safely advise patients over the phone. One of these was 'stalling' or time gaining strategies (n=5):

"Initially, I couldn't understand a word...your ears need time to get used to English, to the words, to everything. Now, I can understand like 75% but I'm still not sure about the 25% so I'm saying like, "Your voice is breaking up, could you repeat it again?" and they repeat it again." (Female, Iraq/Netherlands, Z34, FG 7)

"I've used this line so many times, "It's a really bad line. Could you please repeat."" (Male, Poland, Z33, FG 7)

Pharmacists (n=10) realised that they did not necessarily need to answer the queries straight away. In some cases, they took the patient's number and called her/him back with an appropriate answer:

"I have realised that you don't need to answer everything straight away. You can take their number and tell them, "ok, I will give you a ring back," and it's not that you are not professional, you just need time to check and you want to give them proper information." (Female, Poland, Z4, FG 1)

Confirming the patients' and medication names by spelling requests was another technique used by ITPs (n=8) over the phone:

"I remember on the phone, they were talking about a drug and I asked lots of questions because I say it's better to ask questions than get the wrong information...So I said "Okay, so how do you spell the drug?" because, for example, Citalopram and Escitalopram sound very similar and you've got background noise and you've got, you know, the cleaner there with a hoover and you have to double check information. So I say "Okay how do you spell it?" I don't care, you know, if the technician says "Oh, she needs her medication to be spelt." I don't care. I need to get the right information.. I still do it; I mean if I get somebody on the phone and I can't understand them, I'll get them to spell out their name and address, date of birth." (Female, Argentina, Z39, FG 8)

7.7 Outside the model

When discussing their communicative proficiency, ITPs specifically mentioned the problems they initially had in understanding abbreviations. This described difficulty appeared to fall outside of the MCP. Consequently, the category of 'outside the model' was created to cover this described barrier.

Abbreviations were frequently mentioned as a barrier in communication by ITPs (n=16). They described not only having to deal with technical abbreviations at work but also not understanding abbreviations when used in day-to-day language:

"I had a problem with abbreviations because there's just so many in everyday language...It's just every other word is abbreviated, honestly, not even in professional language but everyday language." (Female, Poland, Z26, FG 5)

One Spanish pharmacist explained how knowing or not knowing different abbreviations could make a difference between understanding and not understanding a sentence:

"When you read it on paper you are like, of course, I know what this means but when they say it and make a word out of three capital letters, it's hard. Sometimes it makes a difference between

understanding a sentence and not understanding at all because if a word comes up once or twice you know it is an important word but you don't know it." (*Male, Spain, Z2, FG 1*)

ITPs (n=12) believed their colleagues used too many abbreviations in the work place:

"Another thing which I struggled with to begin with, and even now, which I get annoyed about, is the use of abbreviations, like PCT. You name it, thousands and thousands of abbreviations, why don't you just say to me "Primary Care Trust" and I will understand. Don't say ACT, EHC, PCT and it's so common here and sometimes I just think I don't know what you are talking about, but if you say what each letter stands for I will understand." (*Male, Spain, Z3, FG 1*)

ITPs who worked in the hospital sector seem to have had to deal with a greater number of technical abbreviations compared to the community pharmacists. One pharmacist who worked in both sectors acknowledged this:

"I have had a big problem with abbreviations… that didn't come up in the community so much, but came up later on in hospital. There are certain abbreviations for names of drugs, procedures or equipment that were all unknown to me." (*Female, Spain, Z28, FG 5*)

Participants (n=6) explained that abbreviations for medical terms in their home countries were different to the ones used in GB. ITPs believed they needed time to get used to these new abbreviations:

"Let's see, we've got an abbreviation in Swedish for COPD but that's KOL. You need time to learn these new abbreviations." (*Female, Sweden, Z40, FG 8*)

Some ITPs (n=16) believed that you have to practice within the system to be able to know all the specific technical abbreviations. Pharmacists said that even a British trained pharmacist would not know all the specific abbreviations if they did not work within the organisation:

"Ask any English pharmacist, they won't know all these abbreviations because you learn them as you practice. The pharmacist [who] hasn't worked on urology, but worked only in elderly care, won't know the urology abbreviations." (Female, Germany, Z31, FG 6)

7.8 Effects of communication difficulty

Up to this point communicative proficiency of ITPs has mainly been described using the MCP. The following sections describe the emotions ITPs experienced due to barriers to communication and its potential impact on patient safety.

7.8.1 Emotions experienced due to the communication barrier

Frequently, communication difficulty was compounded by embarrassment, frustration, stress and fear and prevented some ITPs from performing at their best. Initially the majority of ITPs (n=28) had problems expressing themselves and this caused enormous frustration for the participants:

"Especially at the beginning, when you don't know the words, I was very frustrated. I knew what I wanted to say but I didn't know how to express it. You know, you just can't put it into words, that's really bad. I tried to overcome it by using different words but sometimes it came out funny. You think you are saying one thing but you're saying completely something opposite. So I think it was really frustrating at the beginning." (Female, Poland, Z26, FG 5)

"You feel really frustrated because you are like, I know what I want to say but I'm not saying what I want to say." (Female, Spain, Z13, FG 3)

Another emotion experienced by ITPs was embarrassment (n=17):

"I definitely had a language barrier in the beginning...it was really difficult. I was really embarrassed, especially with the accent of English people, it varies from one person to another, so in the beginning I was really embarrassed, but step by step you get used to it." (Female, Iraq/Netherlands, Z34, FG 7)

The language barrier also affected ITPs confidence in themselves and their professional practice was mostly combined with stress and fear:

"In my first year, I was with xxx and I was scared every single time I had to ask people if they needed advice." (Female, Sweden, Z1, FG 1)

"It's hard when they ask you something and you don't understand. You get like a panic attack. Like "what are you talking about."" (Female, Spain, Z5, FG 1)

Language was a key factor for distress in ITPs and some blamed themselves for not picking up the language fast enough:

"To be honest there were actually three of us. Me and another two friends of mine started working in the UK more or less at the same time. For all of us it was the same, it was horrible when we started working, it was so stressful and the thing is that you didn't see any improvement. We were working for one month and every single day when you went to work you were stressed because there was so much to take in. Yyou just felt that you were not really improving." (Male, Poland, Z33, FG 7)

Not being able to perform their duties to the highest standards left a few of the ITPs (n=7) feeling angry and inadequate:

"I also felt very angry with myself for not being able to do my job properly. When they [patient] look at me and think "Does she know what she's doing." That's what really bothers me." (Female, Spain, Z19, FG 4)

7.8.2 Patient safety

Participants did not perceive that they could make an error based on their communication barriers. To prevent harm, they made sure that they had fully understood what the patient was saying:

"Barrier of the communication was never an issue for me… because if you weren't sure what they were saying or you didn't understand properly, you'd refer them to somebody else." (Female, Spain, Z19, FG 4)

"I always felt that I could do the job. Everything that I needed to say was clearly understood." (Female, Nigeria, Z41, Interview 1-stage 2)

"If you don't recognise something you wouldn't just assume." (Female, Sweden, Z1, FG 1)

"I always took the safe side. I preferred just to double check or ask a colleague to come and confirm what I understood, even if they thought I was stupid, than do harm to somebody. That is my approach." (Male, Spain, Z2, FG 1)

Several EU pharmacists (n=10) mentioned initially that they needed more time to get their job done safely and effectively:

"For me, jeopardizing patient safety has never crossed my mind but I have to admit that I take more time to do my job than the time that they give me. So, for example, when I started in the hospital, you rotate through different wards to see all the patients. They said that I'm really conscientious but I think it's not conscientiousness, I think professionally you have to do your job well. I would come before the time I should have started but I wouldn't tell anyone that I was doing that, just because I would feel safe like that, because I knew that I needed more time to do the job than the time that they would give me." (Female, Portugal, Z24, FG 5)

"I would say, overall, you just need more time to get things done. You know, when advising patients maybe you ask them to repeat things because you don't understand the first time round; or over the phone, if you don't understand you have to get another member of the staff and all of this takes time....Sometimes I just think maybe because we take so much time, we don't come across as competent" (Female, Poland, Z17, FG 3)

"I was initially quite anxious about anything going wrong.... So I was probably being a little more careful and triple checking things all the time and not doing anything I wasn't sure about until I got used to the practice here." (Female, Bosnia/US, Z36, FG 7)

Although the ITPs believed patient safety was not compromised based on their communicative proficiency, they perceived that their lack of ability in providing clear advice and consultation had resulted in some patients losing faith and trust in them (n=12):

"Sometimes I find myself searching for the right word and when I can't find that right word I just get stressed and I think sometimes I don't look trustworthy to the patients, when I can't communicate clearly." (Female, Poland, Z8, FG 2)

"Not being able to speak properly does make customers lose trust. They might not say anything but you know they are not satisfied with what you've said and I find this when you want to explain something and they don't understand. If they don't understand they go with an impression that you don't know what you are doing, they might not tell you but that is how they feel." (Male, Nigeria, Z10, FG 2)

"I think, I had a couple of moments, when I couldn't express myself properly and you just get these looks and you think to yourself, "These people don't trust you."" (Female, Germany, Z30, FG 6)

"It's not that you don't have the knowledge as such but you don't know how to express it properly and then they look at you like "you have no idea what you're doing."" (Female, Spain, Z19, FG 4)

Several ITPs (n=8) used the support of their colleagues to win back patients' trust:

"When I worked in community, I found it quite hard… as soon as I started struggling with the answer or with the language, they [patients] lost faith in me and they were like, "I don't believe in what you're saying," and to get a bit of support there….I turned around to the girls and it's like, "would you agree with me?" and if they agreed with me or said, "yeah, that's what we would suggest for this thing," then you get reassurance and then the patient is happy because they've heard it from someone else. So I use that quite a lot." (Female, Sweden, Z40, FG 8)

7.9 Discussion

This chapter has described the bulk of the findings from stage two of this programme of work – the focus groups with the ITPs. The MCP was used as a tool to explain and describe the data obtained from the focus groups which explored ITPs' communicative proficiency and its potential implication on patient safety.[233] Based on this model, similar to Xu,[241] the researcher believes the communication difficulties of ITPs come from two main sources: linguistic competence (that is, pronunciation and vocabulary) and socio-cultural competence (that is, dialect, knowledge of idioms and colloquial language, knowledge of culture and customs and knowledge of body language).

Effective communication is a primary way of transmitting vital information in the pharmacy setting and is an important aspect of patient care, to ensure patient safety. Although the communication problems of ITPs could be perceived as a problem of English oral proficiency, in this chapter, the researcher established that, for ITPs, the

aim is effective language usage while performing the role of responsible pharmacists in GB. This requires cultural awareness as well as language proficiency.

In this stage, some of the challenges identified in pharmacist-patient/colleague interaction fell into the category of linguistic competence. Pronunciation and limited vocabulary were identified as a barrier. It was noted that the fast pace of the workplace occasionally caused deterioration in the ITPs' comprehension and their ability to speak clearly. ITPs had to keep high levels of concentration at all times to aid understanding. The literature indicates that more time is usually required by second language speakers to process an interaction when fluency is being developed.[237;245] It is also more challenging for second language speakers to find the right words for communication when concentrating on what is being done.[237;245] Xu *et al*.[242] conducted the first study to quantitatively document linguistic problems amongst IRNs in the US. This study suggested that pronunciation problems could be successfully reduced in a short space of time` by intervention, regardless of variables such as age, country of origin and gender.

To successfully integrate, ITPs are required not only to be competent in general English, but they also must learn pharmaceutical terminology, which could be described as a second language in itself.[237;246] This is often made more difficult by the fact that there is not a direct word-for-word translation from their own language. The majority of adjudication pharmacists completed their undergraduate pharmacy degree using English as the medium of instruction (see section 5.4.2.5). Similar to some ITDs,[247] who were educated in English, they were familiar with medical textbooks and terminologies. On the other hand, technical vocabulary and terminology were identified as a barrier by most of the EU pharmacists. They encountered differences even in some medication names or formulations. However, they usually managed to master the more technical terminology in a short period of time by studying relevant textbooks but, similar to their adjudication counterparts and other overseas colleagues, they still had difficulty understanding "Street English", different dialects, idioms and colloquial terms.[55;83;110;112;126;140;144;126;145] For instance, to a newly arrived adjudication pharmacist the British use of "water tablets" for "diuretics" was new and unfamiliar. This is what Gupta and Chattopadhyaya[248] call the "*many fuzzy subforms nested within it* (the language)" (P.21), the socio-cultural part of the language that is mastered over time by living in the culture.[258]

ITPs in different sectors described different communication challenges. Communicating emotional support to 'very ill patients' was a challenge described by pharmacists in the hospital sector. Similar to ITDs,[143;148;249] they expressed disappointment with their lack of ability to show concern and compassion towards patients in a new culture, both by word choice and non-verbal actions.[102] They felt that they had been unable to provide appropriate care and psychological support to the patients and their families. Similarly, male adjudication pharmacists in the community sector struggled to provide what they defined as 'sensitive' care across culture and genders. For example, two pharmacists perceived that they could not advise their female patients properly on emergency hormonal contraception because of cross-cultural differences in values and beliefs. They did not want to use direct words such as "sexual intercourse" but did not know how to rephrase it. This was similar to experiences of male ITDs who believed their cultural background affected their ability to perform gynaecological examinations[143] or take sexual history.[151]

Another novel aspect of this study was the difference in the experiences of ITPs in London compared to the other cities. There are unverified reports that over 250 languages are spoken in London, making the GB capital the most linguistically diverse city in the world.[250] A major problem for ITPs in London was in understanding patients who were not fluent in English. ITPs in London had great difficulties understanding the accents of their ethnic minority patients or fellow co-workers. This problem, however, was not talked about in the other cities where the focus groups took place. ITPs in Manchester, Liverpool and Glasgow only spoke about the difficulties they had understanding English being spoken with Mancunian, Scouse and Glaswegian dialects. This could be because the ITPs in Manchester, Liverpool and Glasgow did not have to care for as many ethnic minority patients as ITPs in London.

Participants recognised culture as an important aspect of communication. Although culture is difficult to define, most interpretations of the notion suggest that culture is dynamic and constantly changing.[251] Kramsch[252] believes culture and language are intimately connected; one necessarily influencing the other. Considering the communication styles and preferences of people with whom they came into contact was a major task for ITPs. Every communicative interaction within the clinical setting

requires the use of a specific set of pharmaceutical terminology (for example, not using jargon in front of patients), the technique of explaining, suitable pitch to match the listeners and situation, the amount of information revealed and the element of understanding and caring.[102;141] ITPs from developing countries, Poland and Spain, did not have prior experience in dealing with other healthcare professionals (see section 5.2.2).[102] In addition, adjudication pharmacists from developing countries described their relationship with patients as vertical – that is, they had the authority in the relationship and therefore made the decisions (see section 6.5.2). This is different to the Anglo-American pharmacy context, where pharmacists are seen as patient advisors.[167] Therefore, as was seen in this chapter, on arrival ITPs had only limited communication skills necessary to deal with all people meaningfully.[102] This sometimes gave way to confusion and misinterpretations. McCloskey[253] states that misunderstandings could bring anxiety to parties involved in the interaction. In the case of some ITPs, similar to IRNs,[54;253] these misunderstandings sometimes led to underestimating the ITPs' competence and these experiences left some ITPs feeling embarrassed and, to a certain extent, frustrated.

Similar to ITDs[143;146;147] and IRNs,[54;156] communication problems existed at a more subtle level, even for adjudication pharmacists who were more proficient in English. Each culture maintains different expectations regarding non-verbal communication.[102;255] According to Gudykunst[254] cultures are either high or low context. In a high context culture individuals use and understand communication through a higher degree of non-verbal codes, while the opposite could be said for the low context culture, meaning communication relies heavily on the spoken words. Based on this interpretation, Anglo-American culture has a low-context culture.[255;256] In the focus groups, Spanish pharmacists described how it is acceptable, back in their home country, to touch someone to get their attention; however, they perceived such an action as unacceptable in GB culture. ITPs need to understand the non-verbal cues in an interaction and respond appropriately. Since non-verbal communication is usually unconscious, it may be more difficult and time consuming to master.[102;237;256]

Initially ITPs faced basic problems because of the way they interacted in a new culture. ITPs indicated that they were unprepared for the 'culture shock' and described some of

the basic cultural differences they experienced. For example, English people were perceived as not speaking their mind[140] and the EU pharmacists' direct approach was interpreted as rudeness.[141;148] Acculturation is defined by Berry *et al.*[257] as '*a process individuals undergo in response to a changing cultural context*' (P.271). Migration to another country transfers people from their culture and puts them in an unknown territory.[258] This can result in overwhelming experiences and the acculturation process can be filled with dissatisfaction and struggle.[140;251] This correlates well with experiences of ITPs in this study and is also shared by ITDs[143;147] and IRNs.[54;55;89;110;140] In some cases, because of cultural differences, ITPs could not actively engage in a conversation with their British colleagues to find or further their friendships. This led to feelings such as "loneliness" and "otherness", which was described in chapter six (see section 6.4.2).

The literature has described the communication problems that are most common and challenging for ITDs and IRNs. [55;83;110;112;126;140;144;145] In this part of the research, apart from inadequate oral proficiency in English and lack of awareness with regards to different dialects, idioms and colloquial language, different pronunciation, combined with accented speech exacerbated the communication gap between ITPs and patients. However, the pharmacists in this study were adamant that this gap did not compromise patient safety. ITPs perceived that they guaranteed patient safety by ensuring mutual understanding. ITPs described how, over time, they had identified and adopted different coping strategies to overcome the language barrier. Similar to other learners of a second language, ITPs used compensatory strategies such as paraphrasing (that is, describing or exemplifying the target object or action), non-linguistic means (for example, mime, gesture or drawing), direct appeals for help (asking dispensers) and self and other-repetition to overcome communication difficulties.[237;259] However, not all of these strategies could be described as foolproof. For example, it is common for good language learners to let pass stretches of language that they have not understood, knowing that context will usually help them to make sense of the difficult to understand parts. Using this technique, the possibility for missing essential clinical information is obvious.[141;259] Other strategies, such as getting other staff involved, double-checking and getting patients to repeat their requests meant ITPs took longer to complete a task which could possibly have been done swiftly by a pharmacist who was a competent speaker. Besides

the communication barrier, this could be another root cause for patients losing trust in the pharmacists' abilities.

The literature indicates that communication is fundamental to the role of healthcare professionals.[162] Furthermore, people judge a speaker's intelligence, character and personal worth on the basis of the language used.[260] Trust in healthcare professionals may be lost if the information provided indicates ambiguity or uncertainty about the correct course of action.[261] Certainly ITPs in this study perceived that communication difficulty led to patients losing trust in the ITP as a healthcare professional. Further collection of data on ITPs communicative proficiency from the patients' and service users' perspective is required to see if communication problems had an actual negative impact on patients' perspective of ITPs' knowledge and abilities.

The potential impact of communication problems on patient safety and quality of care has only recently been highlighted in the literature on IRNs.[153-155] What the literature states is different to what the ITPs suggested in this study.[106;107] Candlin and Candlin[262] believe that there is a direct association between the care provided and the quality of communication between those involved. This is supported by other research on IRNs, which suggests that communication problems, and breakdowns in some cases, pose both real and potential risks to patient safety and quality of care.[106;107;153-156] For example, the risk to patient safety because of lack of language proficiency was implicated in Yi's[156] study when Korean nurses were too frightened to ask questions. The analysis of discipline records by Austin and Dean[170] over 10 years indicated that, despite representing only 25% of all registered pharmacists in Canada, ITPs were accountable for 63% of all guilty findings. These pharmacists were more often cited for practice related errors, including dispensing errors and incorrect interpretation of the prescription, compared with their American peers.[170] The analysis detailed case reports relating to issues of communication and showed that, while most ITPs practising in Canada have a high level of pharmaceutical knowledge, they struggled to transfer this into the Canadian clinical context. Even though the pharmacists in this programme of work were adamant that the communication gap did not compromise patient safety, their communication problems could possibly affect communication in the clinical setting and therefore affect patient safety and quality of care. However, further collection of data is required to see if this is the case.

7.10 Chapter summary

The bulk of the data obtained in the second stage of this programme of work – the focus groups with ITPs – was described in this chapter. ITPs experienced communication difficulties through new dialects, use of idioms, abbreviations and colloquial language in their workplace. The differences between the "BBC English" they learned formally and the "Street English" used in GB also led to difficulties. ITPs in this study were adamant that communication difficulty did not compromise patient safety and perceived that they guaranteed patient safety by ensuring mutual understanding by using a variety of coping strategies. Findings from the third stage of this programme of work – the interviews with ITPs employers – are presented in the next chapter.

Chapter 8

Employers' perspectives of the internationally trained pharmacists they had recruited

8.1 Introduction

This chapter presents qualitative research findings from the nine semi-structured interviews conducted with employers of ITPs in the community (n=7) and hospital (n=2) settings in GB. As detailed in chapter four, the community employers who participated in the interviews were based in two large national pharmacy chains, a medium pharmacy chain and a national supermarket pharmacy chain. Both hospital and community participants were working, or had worked, directly with ITPs and this gave them a good awareness of ITPs' abilities, including language, and the standard of care they provided. Although part of the remit was to get information from the employers on both EU and adjudication pharmacists, the majority (n=8) of the interviewed employers only had experience of working or knowing European pharmacists. Consequently, interviewees were only able to comment on their EU recruits and data on adjudication pharmacists could not be collected.

This chapter begins by describing the recruitment process from the employers' perspective in section 8.2, before moving on to describe the adaptation programmes provided in section 8.3, the employers' perspective of challenges faced by ITPs in section 8.4 and the challenges faced by the employers and employers' responsibilities towards the ITPs in sections 8.5 and 8.6.

8.2 Recruitment

8.2.1 Recruiting from overseas

The grey literature suggests that, when confronted with pharmacist shortages, pharmacy employers in GB actively recruited pharmacists from abroad.[132;134;165] This anecdotal evidence was confirmed by the employers interviewed for this part of the research study. All the interviewees mentioned that the initial recruitment of EU pharmacists started six to seven years ago and was done actively. From the descriptions given by the two hospital interviewees, they were one of numerous NHS employers recruiting from overseas at that time:

"Our first Spanish pharmacist was recruited about six years ago when there was a short-fall in basic grade pharmacists. So a number of chief pharmacists went over to Spain and did a big recruitment event on behalf of the whole North West region." (E1, Hospital employer, Chair of Safety Medication Practice)

"My boss had the idea of maybe recruiting from Spain. So the British Embassy at that time was running a programme of recruiting staff for the health service across the board and pharmacy was one of those areas, so I went over with my boss. We interviewed quite a lot of pharmacists and we employed four of them." (E3, Hospital employer, Training and Education Pharmacist)

After this initial active recruitment phase, further employment of EU pharmacists into the hospital sector was conducted through the 'normal' channels:

"We went over and did the recruitment, that was six, seven years ago… since then we have had two more EU pharmacists who have just started …The two that we took were already working in a community pharmacy in the UK. We interviewed them like all the other candidates and took them on." (E3, Hospital employer, Training and Education Pharmacist)

The ceasing of active recruitment did not stop EU pharmacists from directly applying for jobs in GB:

"Our last pharmacist, the xxx one, he applied through NHS jobs' website." (E1, Hospital employer, Chair of Safety Medication Practice)

The same hospital employer described how the EU pharmacist who was already working for the organisation identified new potential EU recruits for them:

"The other two Spanish pharmacists we employed later on were actually introduced to us by him [1ˢᵗ Spanish pharmacist who was initially recruited]. So he recommended two of them, we had jobs available and they applied and we took them on through the normal recruitment process, but obviously they were identified for us by him." (E1, Hospital employer, Chair of Safety Medication Practice)

Employers within the community sector also used a previously recruited EU pharmacist to identify and actively recruit new pharmacists:

"We used a current Polish pharmacist that we had to design an advert to go into the local paper in Poland. They [pharmacists] would then reply to that advert. With the help of our Polish pharmacist we would then check their CVs to make sure they were all suitable...We then arranged to go out to Poland, booked a hotel, a conference room, did a presentation to them and then did interviews with them." (E9, Community employer, Operation Manager)

Other community employers used a local consultancy for a more efficient recruitment approach:

"In the past we used to actually go out and recruit them [pharmacists] on away-days but we actually didn't find this particularly effective as a methodology for recruitment. So we did use a consultancy for our overseas pharmacists and I would say that 90% of our European pharmacists have come from agencies." (E8, Community employer, UK Resourcing Officer)

"We basically have a dedicated recruitment department who liaise with agencies in various countries for recruitment purposes." (E2, Community employer, Area Pharmacy Manager)

The analysis of the transcripts indicated a shift in the countries from which EU pharmacists were recruited. It appeared that the expansion of EU influenced this as there was a tendency towards recruitment from countries that had recently joined the EU:

"We recruit them [EU pharmacists] through an agency…Every year we have like a concentration area, a few years ago it was Spain, a huge amount came from Spain, but more recently it has been from Poland." (E4, Community employer, Cluster Manager)

8.2.2 Recruitment process

During the interviews, employers were asked about the recruitment process and specifically if language testing of the EU pharmacists was conducted. One hospital and one community employer mentioned that their active recruitment process only involved interviewing the EU candidate. They explicitly mentioned that testing for language proficiency was not carried out uniformly:

"It was just a basic interview [to recruit]. At the time, we didn't test their language." (E1, Hospital employer, Chair of Safety Medication Practice)

The community employer, who did not test the language proficiency of EU candidates during active recruitment, believed no guidelines were available from the Society concerning language proficiency of EU pharmacists at the time when they were actively recruiting from abroad. She perceived that, if her company were actively recruiting EU pharmacists today, they would have to go through further assessments to prove language competence:

"We did an interview with them to look at their language and their knowledge…last time we went to Poland there wasn't really any guidance from the Society…at that point we weren't doing any formal language testing... I think if we were to recruit again we would be doing some more assessments." (E6, Community employer, Business Development Manager)

All the other seven employers mentioned that, in addition to interviewing the candidate, they also aimed to test language proficiency by other means. One hospital employer explained that their active recruitment process involved completion of an English proficiency test just before the interview began:

"They [pharmacists] all had to sit an English test, both written and spoken, and they were marked accordingly. So when they came for their interview, they gave us a mark, as to how good their written and spoken English was... So we had a fair idea what their English was like

before we started doing the interview, but then you can pick it up from the interview and we tended to pick candidates that were stronger in their English." (E3, Hospital employer, Training and Education Pharmacist)

Most employers were familiar with IELTS as a mean to test language proficiency but three shared several concerns related to it:

"We never used IELTS. I could never really see the benefits of, you know, doing a general test…I was also a bit concerned because anecdotally we were hearing that people were being coached to pass it." (E5, Community employer, Pharmacy Training Officer)

Two of the community employers talked about specific language tests that had to be completed by EU candidates before they could join the company:

"They [pharmacists] had to also pass a test. Our standardised test is the Linguarama test. However, we will accept certain other tests, like IELTS, for example, and there are certain levels that they should have attained in order to join us." (E8, Community employer, UK Resourcing Officer)

"We specifically choose UBELT rather than IELTS because they tailored it around the medical profession so they test for pharmacy, dentistry and for medicine… EU pharmacists we recruited in Poland had to pass this before they could join us." (E5, Community employer, Pharmacy Training Officer)

Employers highlighted that they were involved in the interviewing process. If an agency was used, the agency usually did the first sift through initial interviews before passing a shortlist to the employers. Employers then conducted interviews in GB or another EU country. A combination of human resources, staff and expert pharmacists usually conducted this final interview. A combination of qualifications and experience were usually sought and were explored in the interview. Detailed technical questions relating to pharmacy practice were used to test EU pharmacists' expertise and knowledge. Some employers used 'Behaviour Interviewing'. This involved using questions to explore how an applicant might deal with, or react to, a particular situation, or how they had dealt with such a situation in the past. Employers always emphasised that they were looking for the best person for the job:

"They would be asked technical questions during the interview. For example, how they would deal with an asthmatic child who is suffering with a persistent cough?...We were looking for a range of skills." (E8, Community employer, UK Resourcing Officer)

Another employer described how different arrangements were made by his company to make sure EU candidates were screened properly:

"We would do either a video interview or a telephone interview or, on occasions, we have actually gone over to Romania, for example. I went to Romania once and we interviewed a number of people there or sometimes they are flown to an airport and we would meet them in the airport and interview them there. There are various ways of doing it really." (E2, Community employer, Area Pharmacy Manager)

8.3 Adaptation

As established previously (see section 1.3), ITPs had to go through different routes to be registered with the RPSGB, depending on which country they had qualified in. For example, a pharmacist who had qualified in the EU did not need to undergo any form of adaptation programme and could register with RPSGB if all the necessary documents were provided.[40] However, all seven community employers stressed that they provided adaptation programmes to actively recruited EU pharmacists to prepare them for work in GB. The adaptation programmes varied in length but usually lasted between four to twelve weeks:

"All EU pharmacists who we recruit from overseas must go through a minimum of eight weeks adaptation period and that would be in a branch that has an experienced pharmacist manager and they have an adaptation programme. So, although they are already registered with the Society before they come over, that's a pre-requisite that we have and we put them through the programme, which really kind of teaches them about xxx pharmacy, how the company works, but more importantly how community pharmacy works in the UK." (E2, Community employer, Area Pharmacy Manager)

All community employers explained that the EU pharmacists were initially provided with an induction in a 'classroom' format before moving on to work under supervision of another qualified pharmacist for four to twelve weeks. The content of an adaptation programme offered to EU pharmacists was captured in this quote:

"They [EU pharmacists] are brought to xxx, where the Head Office is based, for the first month. They would come to Head Office for a week to start with, to give them some basic grounding and also to get to know them. They get taught basic stuff such as law and ethics, responding to symptoms, a bit of Drug Tariff, stuff they need to know about before they go into a pharmacy, what happens to a prescription, practising on the computer. They then all work in a pharmacy in xxx with a tutor and they have to travel to work and get there for nine, like everybody else on public transport...For a month they are monitored on a weekly basis by their tutor. They also come to the Head Office as well, so we can review where they were up to. So yeah, it is really intensive in a sense of, we are watching what is happening to them all the time and areas of weakness are pointed out to them so they can improve on it...They are given a whole list of what they are supposed to do. From you know, obviously, dispensing to talking on the phone or on the counter, so it is like a mini pre-reg really. By the end of that month, we would have decided where we want them to go if they had made the grade. If everything goes ok they would be told where their location would be and they would have time off to find accommodation there." (E6, Community employer, Business Development Manager)

One community employer stated that one of the main aims of the adaptation programme in her company was to standardise the level of knowledge of all the recruited EU pharmacists:

"It [adaptation] is basically about how pharmacy works in the UK, teaching them how they could get their accreditation for MUR, for example, or helping them to understand the legislation behind pharmacy in the UK and the ethics behind pharmacy in the UK, because it's so varied across the whole of Europe. If you compare a Lithuanian pharmacist to a Spanish pharmacist, the two are like night and day. In some parts of Eastern Europe, you still prepare and make up creams and remedies. It's all very diverse so by doing this eight weeks under the constant supervision of another pharmacist, we ensure that they are standardised across the whole of the business." (E8, Community employer, UK Resourcing Officer)

Adaptation programmes for the EU pharmacists in the hospital sector also involved working under supervision. EU recruits were taken on as Band Six [p] pharmacists and had to work under the supervision of an experienced pharmacist to gain competence and trust:

"We took them on as a Band Six but we made sure they were supervised until they were happy and we were happy." (E1, Hospital employer, Chair of Safety Medication Practice)

Once EU pharmacists in the community sector had completed the adaptation programme provided and were signed off by their tutors, then they had to complete a law and ethics and a calculation test to prove competency:

"After the eight weeks of training, there is a law and ethics test and there is also a calculation test, which they [pharmacist] have to sit." (E2, Community employer, Area Pharmacy Manager)

Two community employers went on further to add that, if the EU pharmacist did not get signed off by his/her tutor or failed to pass the final test, then they were asked to leave:

"If it does get to 12 weeks and we are still not confident they are fit to practice, I can think of one or maybe two, who we've said, "It's not really going to work" and we've asked them to leave." (E8, Community employer, UK Resourcing Officer)

One community employer stated that her company did not believe in 'pushing' the EU pharmacists through the adaptation programme. She believed pharmacists should be given time and the space to learn at their own pace, even if this meant having to supervise them for a longer period. However, she stated that if this strategy did not work

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[p] Newly qualified pharmacists usually start work as junior pharmacists in the hospital setting, occupying Band Six.

and the EU pharmacist was still not ready to practise on his/her own after extensive supervision, a lower ranking job within the company was offered to the pharmacist to give him/her a further opportunity to gain competency:

"We say eight weeks but sometimes people take longer and we are not going to push people through it. You know, people learn at different speeds so we have some that perhaps might take 12 weeks to do it. We have had the odd occasion where we thought that actually they are really struggling and perhaps we would feel uncomfortable making them a pharmacist, even if they were going to complete the test and pass it. So what have we done on these few occasions, they worked as a dispenser for a period of time until they got a really, really solid training in pharmacy before then becoming a pharmacist."(E6, Community employer, Business Development Manager)

One community employer perceived that EU pharmacists were not initially aware of the long process involved before obtaining their final job offer:

"A lot of pharmacists come, thinking that their job is already there but they still have to pass a lot of tests before they get accepted basically." (E4, Community employer, Cluster Manager)

Employers were asked if they provided language training for EU pharmacists during their adaptation programme. There were mixed responses to this question. One community employer said they provided further support with language if it was requested:

"If they wanted to do any sort of further training with their English that was supported, but only one or two were actually interested in that and I didn't think it was necessary to be honest, but it was just to make them a bit more confident." (E3, Hospital employer, Training and Education Pharmacist)

Another employer believed it was not necessary to provide language training because all their recruited EU pharmacists were competent in English because they were language tested:

"In terms of language we would hope that they're not going to struggle a lot purely because every single European pharmacist who joins us is actually language tested and we will not allow people to start working unless they have sat and passed a recognised English language test." (E8, Community employer, UK Resourcing Officer)

Another employer explained that they did not pay for language courses, but guided EU pharmacists to find the right training:

"They [pharmacists] have asked us to pay for language courses, to which we have said: "No". But we helped them find language classes, helped them look in the right place, on the internet or local newspapers, we would help them." (E6, Community employer, Business Development Manager)

One of the community participants gave a comprehensive description of the company's adaptation programme and how language support was provided to the new recruits through their adaptation programme:

"All the newly recruited EU pharmacists had to complete a adaptation programme for 12 weeks under supervision and then, at the end of the 12 weeks, we did like a mini pre-reg exam…we talk to other companies about our adaptation programme and I think we are the only company that runs a language course alongside our sort of technical course...Alongside our professional and knowledge training, we ran a 12 week language programme through Bath [university] as well…With the language training, they [pharmacists] had tutorials every week by phone and the phone was actually a big issue for them, as far as having the confidence to answer it. So yeah, they had a weekly tutorial with one of the linguists from the University of Bath so, for example, if we said "this week we are going to do pain control" then the language module was developed around the language of pain, you know, all sorts of words that they would come across from customers who would describe pain as 'throbbing' or as 'excruciating' or whatever and not only did they do the language of pain but they would also have done some of the grammatical elements around language. We made them collect evidence just in the same way you would as a pre-reg and they submitted a piece of that evidence every week to Bath by fax and then, when they had their tutorial with the Bath people, they were able to talk to them around the language that they've used in that piece of work, making sure that their written work developed." (E5, Community employer, Pharmacy Training Officer)

Despite repeated questions to establish if the employers had identified areas of training that might have been overlooked, no further training needs were identified for EU pharmacists.

8.4 Challenges for internationally trained pharmacists from the employers' perspective

8.4.1 Communication challenges

All employers interviewed believed the language skills of ITPs have to meet professional standards before they can be employed and they insisted that they had a rigorous process in place to ensure their competency:

"Communication is very important and EU pharmacists have to be able to communicate, otherwise there is no point in recruiting them. We did our best to make sure of that." (E1, Hospital employer, Chair of Safety Medication Practice)

Nevertheless, some employers identified several language challenges for EU pharmacists, including difficulty understanding local dialects and colloquialisms:

"Local dialects and colloquialisms are hard to understand, as expected." (E9, Community employer, Operation Manager)

"You will always get kind of regional variation within accents and dialects and you know that's on top of the fact that they are actually speaking a second language, so I suppose that's always going to be difficult." (E2, Community employer, Area Pharmacy Manager)

An employer described another communication challenge that their international recruits had to deal with, which was the matter of advising patients in a lay language:

"One of the issues is like trying to explain something technical in a lay language and, if you start to say long words, the patient is not going to understand. We do have quite a few medical books that are translated in various languages for people who come over, which talk to them about colloquial medical terms, parts of the body and stuff like that." (E6, Community employer, Business Development Manager)

To aid the EU pharmacists, one company placed them in the region where they eventually hoped to be working during their adaptation programme so they could get used to the specific dialect of the area:

"To help the pharmacists we do tend to place them where they are going to be working, so if they are going to be working in Yorkshire, they'll do their training in Yorkshire." (E9, Community employer, Operation Manager)

Another community employer explained how they learnt to make the process of adaptation easier for their new EU recruits through the feedback given by their previous recruits:

"We sort of put them [EU pharmacists] initially on the counter, thinking that they have to face the public, but what they told us was that they needed a little bit of time to, I suppose, tune into local dialects and local accents. So the second group [of EU pharmacists] we brought in, their initial time was very much spent in the dispensary so that they were working with their colleagues and listening to the language, rather than having to listen to the customer language and then getting embarrassed because they couldn't understand the local accent and dialects and the way customers pronounce drug names." (E5, Community employer, Pharmacy Training Officer)

Verbal communication over the telephone was reported as the "biggest struggle" for ITPs by two community employers, because of the disappearance of non-verbal cues for validation. This community employer, who was originally from Australia himself, remembered his difficulties communicating over the telephone when he came to GB initially:

"The biggest struggle that they have is on the telephone because they can't rely on the non-verbal communication, so they have to concentrate on all the spoken words and that can be a problem. I had a similar problem when I first came to the UK, up in Scotland, and so I could

sympathise with that, but the telephone is usually the main problem initially, but once they get the swing of it they are fine." (E3, Hospital employer, Training and Education Pharmacist)

Employers identified confidence as an important element that had a direct impact on the communicative proficiency of the newly recruited pharmacists. Some employers believed their recruited EU pharmacists had the ability to communicate effectively with patients and colleagues but lacked confidence:

"What I actually find is, it's a confidence thing. I'll pick up people from the airport, for example, and we chat on the way back and I see some of them have very good English, but their confidence is very low; they don't think their English is very good and I think that confidence is the biggest stumbling block for them because actually they are at an acceptable level, but they don't think they are." (E2, Community employer, Area Pharmacy Manager)

"For the Spanish pharmacists I think initially it's probably a lack of confidence in their ability to speak English."(E3, Hospital employer, Training and Education Pharmacist)

8.4.2 Cultural challenges

Similar to ITPs (see section 7.4), two participants also acknowledged the fact that EU pharmacists were challenged culturally as well as linguistically in GB:

"I suppose it's hard. Obviously, it's not their first language so they're going to struggle understanding local languages, slang and abbreviations. But also here, there is obviously a completely different organisation, the society is different, laws are different, so they do struggle in different ways." (E4, Community employer, Cluster Manager)

"First couple of months, it is not so much just the language, it's the different culture as well."(E3, Hospital employer, Training and Education Pharmacist)

One participant believed the ability to communicate was not determined by language skills alone but was also affected by cultural differences. She went on to describe how challenging doctors was strange and unfamiliar to an employed Eastern European pharmacist:

"Challenging doctors was totally against what they believed. Certainly, the xxx pharmacist, he just thought "you can't tell a doctor that he's wrong. You just have to do what they say." So yeah, it was a big challenge for us to get him to realise that our role does involve challenging the doctors." (E1, Hospital employer, Chair of Safety Medication Practice)

A hospital employer believed that working in mental health as an EU pharmacist presented particular cultural challenges. He believed mental health problems were dealt with differently in different cultures and EU pharmacists had to become used to and adapt to the way mental health patients were treated in GB:

"With mental health patients, you do come across different challenges with how different cultures deal with mental health...When you are dealing with mental health patients, if the patients are suffering from what we call a 'challenging behaviour', which may need settling down, here in the UK we are quite ok with using drugs to settle down that sort of behaviour. But we don't like using strait jackets or anything like that, whereas Americans are quite happy to use strait jackets; the Dutch don't like using drugs; the Italians don't like using isolation." (E3, Hospital employer, Training and Education Pharmacist)

Attitudes towards 'work' and 'being a pharmacist in GB' varied across pharmacists from different EU countries. One community employer believed Spanish pharmacists had a more relaxed approach to work compared to their Polish counterparts:

"We have seen some cultural issues...it is difficult to stereotype people really, but Spanish people tend to be a lot more relaxed about things. It has not come to the point of being unprofessional, they have a lot more relaxed attitude about things and don't tend to worry about things as much, whereas we want them to worry a bit more. The Polish have been ver,y sort of, similar to the British work ethic and very similar in the way that they look at things and the way they approach things, so they seem to integrate better." (E6, Community employer, Business Development Manager)

8.4.3 Working in a new pharmacy practice system

Hospital employers perceived that working in a new hospital system was a challenge in itself for EU pharmacists. They assumed that a hospital pharmacy back in the pharmacists' home country was not as developed as a hospital pharmacy in GB and this presented challenges, even if the pharmacist was speaking English as his/her first language:

"Working in an area that they haven't worked in before is not easy, because a hospital pharmacy is nowhere near as developed in Spain or Poland as it is here...I think anybody who came from anywhere else outside the UK, even if English was their first language, would still spend a month or two trying to get their head around all the different systems." (E3, Hospital employer, Training and Education Pharmacist)

The fast pace of work, providing methadone for drug dependent patients and the number of prescription items dispensed for the elderly came as a shock to EU pharmacists, as one community employer explained:

"One thing that the pharmacists I've spoken to have mentioned is how fast-paced England is compared to their home country. So everything works a lot faster, from dispensing, to the laws that get passed down, everything really, and obviously cultural differences such as methadone, for example. We do a lot of methadone here and the number of prescriptions from the elderly and things like that." (E4, Community employer, Cluster Manager)

8.5 Challenges for employers

8.5.1 Patient safety

Only one of the nine employers interviewed believed patient safety might be compromised because of communication difficulty:

"The main concern is that the patient would not understand what they're [pharmacists] saying, so they could take the tablet in a different way or they don't really understand how to take them, or when. Also, from the pharmacists' point of view, they might not understand questions that the patients are asking them properly, so there might be some confusion about the medication, so there is a possibility that the patient's safety could be jeopardised." (E4, Community employer, Cluster Manager)

This employer went on further to describe how, besides patient safety, patient loyalty and patient trust could also be affected by poor communication:

"*Also overall loyalty could be affected because patients have to trust the pharmacist and if they don't trust what he is saying, because they don't understand him, that could affect them coming back again, so it could also affect the business." (E4, Community employer, Cluster Manager)*

This employer believed developing an accredited language course that was specifically designed for EU pharmacists would be beneficial:

"I think what they [EU pharmacists] need is more in-depth training round the language. I think it's a good idea to have a specific language training course. I think for their benefit as well as ours; it'll give them more confidence." (E4, Community employer, Cluster Manager)

Relative to the ITPs' ability to provide safe pharmaceutical care, one employer indicated the importance of recognising ones own limitations. In this context, he indicated EU pharmacists should ask for help when needed:

"I haven't had concerns but if I did, I think if they couldn't understand a patient they've got to know that they should ask another member of the staff, rather than just assuming what the person has said. Because they could make a mistake, which could have consequences...we want to make sure that they are able to say, "I'm just going to check with somebody or could you just please repeat it?" This sort of thing. I would be concerned if they weren't doing that because patient safety is, at the end of the day, what we are here for." (E6, Community employer, Business Development Manager)

Although patient safety was a concern that was raised by one employer, the other eight participants did not have concerns concerning patient safety and the quality of care EU pharmacists provided:

"Our concern is medication error, patients' safety. Obviously, we had one bad experience with our EU recruits, but the other three have been excellent pharmacists. I don't want you to get the wrong impression." (E1, Hospital employer, Chair of Safety Medication Practice)

"Coming into a company like ours we are confident that they [EU pharmacists] are able to communicate. We wouldn't recruit them if we didn't believe that their language is good enough, so in this way patient safety is not compromised. We make sure of it." (E8, Community employer, UK Resourcing Officer)

The only employer who had concerns with regards to patient safety also talked about obstacles faced by employers in terms of identifying poor communication. She believed pharmacists were forgotten about once they were accepted into the organisation and the staff who deal with them on a daily basis can pick up on the fact that they might not be as competent in communication in English as expected:

"Once you get accepted you kind of drop off the radar a little bit, you're not being monitored as much. So it's only really if the staff that you're working with pick up on the fact that, maybe, you are not spending enough time with the customers, or the cluster manager picks on the fact that you aren't doing MURs, and when you sit down and talk to them [pharmacists] it might be that "Well, I'm not confident enough with my English to talk about medication with them [patients] or, if they ask me questions, I don't know really how to answer them."" (E4, Community employer, Cluster Manager)

8.5.2 Managing poor communication

One of the questions posed to the employers was how they managed poor communication by EU pharmacists. From the explanations given, it seemed that employers did not expect language incompetency and so did not have a strategy in place to deal with poor communication:

"If you have an answer to that, I'd love to hear it. Certainly, with the one pharmacist who we let go at the end, it was very, very, difficult and time-consuming and a traumatic experience really, both for him and the rest of the department as well, because obviously everybody wanted him to succeed, but it was just so difficult." (E1, Hospital employer, Chair of Safety Medication Practice)

The only employer who had concerns with regards to patient safety believed a longer training period and counselling sessions were needed to manage poor communication. However, she went further to say that, if the pharmacist's competency did not improve after a set period, then he/she should face disciplinary action:

"From my point of view, I mean I don't know about xxx [the company], I would imagine if it was a serious complaint, xxx [the company] would have them do the linguistic test again. But from my personal point of view, the linguistic test doesn't necessarily work. Yyou can pass a test

and still not be great at English. I suppose some kind of counselling and staff management would be needed, where they have to work alongside another pharmacist and spend some more time working with the staff and learning the language, slang and accent and things like that. I think, if it continues and they're not showing any progress, then it needs to go to a counselling session and then a disciplinary." (E4, Community employer, Cluster Manager)

8.5.3 Complaints made against EU pharmacists

When participants were asked if complaints had been made against their EU pharmacists, the majority (n=7) said no:

"No, we haven't had any complaints made." (E9, Community employer, Operation Manager)

"No, I can't think of anything [complaints]." (E3, Hospital employer, Training and Education Pharmacist)

One community employer believed that their recruitment process was rigorous enough to filter out EU pharmacists who had communication difficulties; therefore, a scenario where inadequate proficiency in language could give way to complaints seemed very unlikely:

"To be honest, it's not something that I have come across. I mean, I don't know what our competitors do but perhaps they don't have as a rigorous process as we do, because we do have a three stage filter system before they get to the language test really. If they can't communicate with us then they don't go forward, so if they can't communicate with us they don't get to a point where we would offer them a job and therefore we wouldn't employ them." (E8, Community employer, UK Resourcing Officer)

Another community employer explained that they did not have any complaints from patients but received some negative feedback from the staff who were working with their overseas recruits:

"Just a little bit of feedback from the staff within a branch, where they found it difficult to communicate, but nothing I would deem as being a serious incident if you will, it's just about kind of getting used to it I suppose." (E2, Community employer, Area Pharmacy Manager)

This participant went on further to explain how he handled such negative feedback:

"I mean it wouldn't actually be a complaint, it would be more of a comment and the way I have handled it in the past is, I just explained that these people just need a little bit of time, a little bit of encouragement. You know, once you actually explain that they have actually come to a new country on their own and are speaking in a second language and it's very difficult, they kind of understand and they kind of help them through it then." (E2, Community employer, Area Pharmacy Manager)

One hospital employer talked about complaints made against one of their recruited EU pharmacists:

"We had complaints about one of our EU pharmacists. I don't know if we specifically had one directly from a patient but certainly we had complaints from other healthcare professionals." (E1, Hospital employer, Chair of Safety Medication Practice)

One community employer described an incident where the doctor was unable to understand the EU pharmacist over the telephone and had to come to the pharmacy for a face-to-face conversation. The participant was, however, careful to explain that this pharmacist had gone through an adaptation programme with another company:

"I do know that there are some issues with being, you know, understood on the phone and certainly, in one particular case, we took a girl who had done another programme with another company but there were issues around her language, so we actually put her on the Bath course to support that. You know, the doctor had to go down to the pharmacy because he couldn't understand her on the phone and so that is not where we would have wanted to be." (E5, Community employer, Pharmacy Training Officer)

8.6 Employers' responsibility towards internationally trained pharmacists

During the interviews, the employers were asked about their responsibility towards their recruited ITPs. All employers emphasised the importance of providing ongoing support for their newly recruited EU pharmacists:

"I believe, as employers, we have certain duties and responsibilities to our employees, to provide ongoing support and guidance from whatever origin they are because we are, at the end of the day, accountable for the way they act." (E7, Community employer, Business Development Manager)

The Australian pharmacist, who had gone through the adaptation process and knew how it felt to be a newcomer, talked extensively about his responsibilities towards his EU employees:

"Right from the word go, we make sure they [pharmacists] have absolutely understood where they stood and what we're gonna do for them and what we expect from them and how their career will progress here if they were to follow what we expected of them and that clears so many problems and question marks before they even start. They are then far more likely to want to make an impression and want to get stuck in right from the word go. We support them with accommodation, not so much giving accommodation but finding places for them to live, help them with transferring over from Spain if they need any help with transferring their stuff over, help them to sort out their National Insurance numbers and all sorts of bank accounts and details like that, which can really throw you when you first land and, believe me, I know. If you

go the extra mile, it is not a huge effort to go that extra mile and make life easier for them at that stage and also tell them where they going, what they doing and how we are going to support them and what the education options are and what we expect of them. Then they do fit in much quicker and things like language, they work harder to overcome. I suppose, maybe I'm guessing, but that's why we have been so successful here. I've seen places where they have taken a more back seat approach and, sure enough, their staff only last a year. They go and find something else, which is a shame, but you get out of it what you have put into it." (E3, Hospital employer, Training and Education Pharmacist)

As explained previously (see section 1.14), it is the individual responsibility of the EU pharmacists to ensure their communicative proficiency before starting work in GB.[157;175] However, the onus is on employers to ensure that staff have sufficient technical and linguistic skills to perform their job safely.[157;173] A question was put to the employers, as to who they thought should be responsible for checking the language proficiency of EU pharmacists. Only one employer believed that the Society should have the responsibility for checking EU pharmacists' language proficiency before registering them:

"We were actually quite shocked at how easy it is to be able to register in the UK, even if you don't speak any English at all... I think it is the Society's responsibility to check the language proficiency. I just don't think they should register somebody unless they know they can speak English and I guess this could be confirmed by them sitting an English test as part of their registration process." (E1, Hospital employer, Chair of Safety Medication Practice)

The other eight employers believed that it should be the employers' responsibility to check the language proficiency of EU pharmacists:

"For me, I think it's the employer's responsibility because, at the end of the day, they would be representing that particular employer." (E2, Community employer, Area Pharmacy Manager)

"I think it has to be up to the employers to know what they have in their pharmacy." (E5, Community employer, Pharmacy Training Officer)

One participant believed it was the superintendent's job to ensure EU pharmacists were competent enough to work as pharmacists in GB:

"I think it's the company's responsibility. It's part of our, or the superintendent's, role. It is for the Society to put that guidance down but we are the people who should make sure that pharmacists are competent." (E6, Community employer, Business Development Manager)

Other employers explained that they have a duty of care to their customers and, as part of that duty, they have to ensure the language proficiency of their EU pharmacists:

"I feel strongly that, as the employer, we have a duty of care to our customers and our patients and part of that duty is to ensure that they [pharmacists] know the language and can

communicate clearly and well with their patients and that's why we feel quite proud that the measures we have in place to ensure that pharmacists who join xxx actually have the necessary language skills to be able to converse with our customers in our pharmacies." (E8, Community employer, UK Resourcing Officer)

A hospital employer assumed some community employers might not be as strict as hospital employers on checking language proficiency:

"I think it is the employer's responsibility to test language because they are the ones who have to face the consequences of any problems. The Society, I don't know but I would feel the tools that they would have to use to do that would have to be fairly robust and bullet proof. I don't really think it is necessary for the Society to work at that level. I'm talking from the hospital perspective here, so for me, we have to have staff who can communicate. If they can't communicate they can't do the job so it is fundamental to be able to do the job, whereas other areas of pharmacy you may have, I mean I haven't worked in community for a long time, but I have the feeling that some community employers may take a more relaxed approach because they want someone with that qualification in their shop to fulfil a legal obligation and so they are not particularly concerned about the level of English and therefore maybe it is something for the Society to think about." (E3, Hospital employer, Training and Education Pharmacist)

Another hospital employer had a general concern concerning EU pharmacists accessing the profession through locuming:

"I guess the major difficulty is with locums. They [EU pharmacists] could come over and start locuming straight away and no one would know how good their English is. If the Society could test the language then it wouldn't be such a worry for employers." (E1, Hospital employer, Chair of Safety Medication Practice)

8.7 Discussion

The findings from the one-to-one interviews with employers of ITPs provided an insight into how employers recruited and trained ITPs, their perceptions of the challenges pharmacists faced in communicating in a second language and how they viewed their responsibility in terms of testing and supporting the language proficiency of ITPs.

All seven employers interviewed explained that the initial active recruitment of EU pharmacists started six to seven years ago. Some went further to say that the number of unfilled pharmacy positions at the time was the drive for active recruitment. This further supported the anecdotal evidence that suggested high vacancy levels were the justification for seeking pharmacists from abroad.[132;134;165] The EU countries were especially targeted, particularly after June 2006, when pharmacists from Australia and New Zealand were no longer automatically deemed qualified to work in GB.[132;134;165] Large multiple companies started recruiting in countries such as Spain, but with the

expansion of the EU, shifted their interest to Eastern European countries such as Poland and the Czech Republic.[132;165] The interview data also indicated a shift in the countries from which EU pharmacists were recruited. It seemed that employers started recruiting in Spain and, with the expansion of the EU, shifted their interest to countries such as Poland. From the interview data, it seemed that EU expansion had a direct influence on the countries being selected and targeted by the employers.

For employers, it was essential that all pharmacists have the ability to communicate.[237] All interviewees mentioned the significance of having some process in place to assure the overall language proficiency of EU pharmacists in the workplace; however, these processes varied in type and rigorousness. Two employers only conducted interviews to assess proficiency, while others tested the language proficiency of the EU candidates immediately prior to conducting an interview by asking them to take part in a pre-designed English language test. Some community employers used established English language assessment tools such as: (1) IELTS; (2) UBELT; and (3) the Linguarama English Assessment Test for Pharmacists to assure language proficiency of their recruited EU pharmacists. Participants were most familiar with the IELTS, but some employers shared several concerns in relation to this assessment option.[237] There was an observation that some pharmacists pass the test but still have communication problems.[237] IELTS was described as being too general and not occupation specific, and passing it was not seen as an indication of fluency in the workplace.[237] One participant mentioned that there is anecdotal evidence that candidates can be coached to achieve a high level without actually being competent. Some employers therefore considered this assessment process questionable. These findings were no different to the literature.[102;162;263;264] Clinical instructors and colleagues often found that advanced English proficiency, as measured by IELTS, in no way guaranteed that internationally trained professionals were able to perform competently in healthcare contexts.[102;162;263;264] There is no doubt that IELTS is considered as an appropriate English language testing system to measure language proficiency for entry to academic studies.[173] However, the question of whether the IELTS testing system is appropriate for testing broader skills, such as those required for a professional pharmacist, arises. Health professionals interviewed in the Merrifield research pointed out that there were major differences between the spoken language needed for communicating in an academic context, such as language of discussion and argument and presentation skills,

and that required by a practising pharmacist.[265] As well as being able to ask specific questions from young and old to determine symptoms, pharmacists must also be able to interact with patients to provide new, expanded services such as MURs. While IELTS includes an interactive language component, health professionals have argued that it lacks occupation specific components.[265]

To overcome these issues, some community employers developed and used English language assessment instruments related to the pharmacy setting in GB, such as UBELT and the Linguarama English Assessment Test for Pharmacists. Although community employers preferred pharmacy specific assessments, some still accepted pharmacists with IELTS accreditations. While the proliferation of tests offers more choice to the EU pharmacists, it could also add to the confusion.[237] Some of these tests are cheaper than others are and more accessible.[237] [q] ITDs, IRNs and ITPs, in Read and Wette's study, initially tended to favour the Occupational English Test (OET) [r] on the grounds of its familiar content. However, during the research, many participants came to the conclusion that IELTS is more advantageous, because of lower fees and the availability of introductory courses and practice materials.[268] Furthermore, it could be argued that, if IELTS is responsive enough to test language proficiency of adjudication pharmacists, why should it not be used to do the same job for the EU pharmacists? Employers believed that the system they had in place in selecting and interviewing EU pharmacists was rigorous and EU candidates who were recruited through this system had the potential to become a practising pharmacist after completing their adaptation programme. They described using different techniques, such as behaviour interviewing, to get the best people for the job. Community employers also believed that they had a comprehensive adaptation programme in place, which prepared the EU pharmacists to work independently after four to twelve weeks. However, as seen in chapter five, this view was not shared by the majority of EU pharmacists as they criticised the adaptation programmes they underwent in the community sector. The programmes were described as generally being non-specific to their unique needs and were inadequate in content and length. While some EU pharmacists expressed the need to have access to specific

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[q] IELTS, UBELT and Linguarama cost £115, £165 and £135 respectively.[176;266;267]

[r] OET is an ESP test developed in Australia for the assessment of health personnel.

language training courses during adaptation, only one community employer described providing such a course alongside their adaptation programme. This technical language training course, was similar to the English for Specific Purposes (ESP) training, provided in the IPG programme in Canada.[170] In IPG, a team approach to teaching and assessment was modelled for ITPs. Pharmacy academics provided training and appraisal in pharmacy-specific clinical skills areas, while English language teachers provided training and appraisal with respect to communicative proficiency.[170] Support was provided to pharmacists so that sound-alike drug names such as 'Lasix' and 'Losec' do not become confused.[170] Hoekje[149] has argued that there is a significant role for ESP teachers in dealing with ITDs' language concerns. Wette and Basturkmen[269] reported on an Overseas Doctors' Training Programme by analysing the comments that the ITDs received from the medical teachers on their performance in role-plays. The results demonstrated that the teachers either ignored many language problems and mistakes or referred to them only in a non-specific way, which was not useful for the ITDs in knowing how to develop their language use. The authors agreed with Hoekje[149] that there is a role for ESP teachers in dealing with ITDs' language concerns.[269] Based on this evidence, similar to the IPG perhaps, there is possibly a role for ESP teachers during the adaptation of EU pharmacists.

While some employers acknowledged that, initially, communication dilemmas could exist, they mostly put that down to lack of self-confidence and not language incompetency. Although this might be true in some cases, this does not explain every language difficulty described by the EU pharmacists. This further highlighted the gap that exists between the perception of pharmacists and that of their employers.

Despite recognising English as a challenge, all but one employer believed that the delivery of safe and ethical care was not compromised when their EU recruits first entered the practice setting in GB. They believed that their high standards were maintained by their rigorous recruitment and adaptation programme. There was only one community employer who believed patient safety could be jeopardised based on EU pharmacists' communicative proficiency. She believed communication problems could affect patient loyalty, as well as patient safety, because the element of 'trust' between patients and the pharmacist, which is partly built on communication and understanding, was lacking and this could adversely affect the business. This was in line with the

findings from stage two of this programme of work, where ITPs also mentioned patient trust could be jeopardised because of their communication skills. Further primary data collection is required in order to gather patients' perceptions and confidence in the ITPs' ability to provide pharmaceutical care services in GB.

As described previously (see section 1.14), although pharmacists are obliged to ensure that they have sufficient language competence to communicate and work effectively, the onus is on employers to ensure that staff have sufficient technical and linguistic skills to perform their job safely.[157;175] At the time of this research, the RPSGB had expressed concern and put forward arguments as to why the regulator should be allowed to check language proficiency of EU pharmacists.[157;173] However, all but one of the employers interviewed believed that this responsibility lies with employers. Many stated that their fundamental responsibility is to ensure patient safety and checking the language proficiency of their new EU recruits was one of the steps through which this was achieved. However, there was concern about EU pharmacists accessing the profession through locuming. A hospital employer argued that if the Regulator was able to check the language proficiency of applicants then all EU pharmacists, including those who enter and work as locums, would be treated uniformly. Concerns about the performance of locum pharmacists have been raised in the literature.[200;222] Due to the fact that self-employed locum pharmacists are not captured in the same kind of management structures as employed pharmacists means that they could 'fall through the gap', with no organisation having responsibility for either identifying and managing, or sharing, information on their performance concerns.[200,222] If independence for EU locum pharmacists means pharmacists slip through the gap in terms of access to training, and regulation, patient safety and quality of care could be compromised when an EU locum pharmacist, who has problems communicating and is unfamiliar with the general set-up of the store, is on duty. This issue needs to be monitored as there is a possibility that the number of EU pharmacists could increase in the locum workforce.[222]

It is of importance to mention that, some of the pharmacists (n=40) who participated in stage one and two of this programme of work, were employed by community employers E6, E8, E9, E7, E2, E4 (see Table 16). However, as demonstrated, the overall picture painted by these employers was somewhat different from the narratives given by their employed EU pharmacists. Furthermore, data collected in this stage did not support the

findings of the Society's survey, where 63% of employers disclosed language testing of European job applicants was not routinely undertaken and more than a third had experienced problems with employees' grasp of English.[157;177;178] The majority of employers in this study seemed to have language tested their EU pharmacists and did not appear to experience language-related difficulties. Perhaps the validity of the findings in this stage could be strengthened by employing a different method of data collection, such as postal questionnaires, in future research. Nevertheless, one should interpret the data obtained in this stage with caution due to the limited number of employers who participated.

8.8 Chapter summary

In this chapter, qualitative research findings were presented from the nine semi-structured interviews conducted with employers of ITPs in the community and hospital settings in GB. In addition to recruitment, training and deployment of ITPs, employers' perceptions of the challenges pharmacists faced in communicating in a second language, and their responsibility in terms of testing and supporting the language proficiency of ITPs, were presented. All participants mentioned the importance of having processes in place to assure EU pharmacists' language proficiency in the workplace. However, different strategies were used during recruitment to assure language proficiency. Some employers only conducted interviews to assess competency, while others required candidates to achieve a certain level of proficiency in English language assessments. IELTS was described as being too general and not unique to pharmacy and passing it was not seen as an indication of fluency in the workplace. To overcome these issues, English language assessment instruments related to pharmacy in GB were used by some community employers. Although employers preferred pharmacy-specific assessments, some still accepted EU pharmacists with IELTS accreditations. The conclusion and the recommendations made from this programme of work is presented in the next chapter.

Chapter 9

Conclusions and Recommendations

9.1 Introduction

This concluding chapter discusses the findings presented in the previous five chapters and draws together some of the key findings, reflects on the methods used and suggests some recommendations from the work conducted. Finally, possibilities for future research and concluding remarks are presented.

When this PhD study started in 2008, there was a lack of data on ITPs in GB. All that was known was the fact that, since 2002, there had been an increase in the number and proportion of ITPs in GB. This was to the point where, in 2008, 12.1% of pharmacists on the GB Register had actually entered via one of the European, adjudication or reciprocal routes.[7;28] No data was available on why ITPs migrated to GB, how they were recruited, the permanence of their movement and the quality of care they provided to patients. Furthermore, little was known about the physical, psychological and social adjustments they had to make to integrate into, what was for them, a new culture and society. In addition, no research had been conducted to look at how employers recruited and trained ITPs or whether they had dealt with poor performance by an employed ITP and its consequences. Consequently, this study on the novel topic of ITPs in GB was conducted in an attempt to shed light on this un-researched area.

The aims of this programme of work were threefold: firstly, to understand more about the migration of ITPs and to gather information and understand ITPs' expectations and experiences of working in GB; secondly, to understand more about the communicative proficiency of ITPs and its potential implication on patient safety from the ITPs' perspectives; and thirdly, to explore the communicative proficiency of ITPs and its potential implication on patient safety from the perspective of the ITPs' employers. It attempted to do this by investigating the following three areas:

- The ITPs' reasons for migration to GB, work experiences and future plans.
- The ITPs' perceptions of their communication challenges in English as a second language, its potential impact on patient safety, strategies used to overcome potential communication barriers and their perspective on the level of support provided by the employing bodies for these communication challenges.

- Employers' perspectives on the potential impact on patient safety resulting from operating in a second language and their views on their responsibility in terms of testing language proficiency and supporting ITPs.

Each of the above areas have been covered in the course of this programme of work and a summary of the findings are presented next.

9.2 Summary of the findings

Data collected from ITPs in stage one contributed to increasing the understanding of the phenomena of pharmacist migration, particularly in relation to the reasons for migration, recruitment, adaptation, experiences and future plans of ITPs. ITPs came to work in GB for numerous reasons and not entirely for economic motives. They also expected professional, social and personal improvements. This study found that the majority of adjudication pharmacists came to GB to experience modern pharmacy practice, improved earnings and to provide a better education for their children, while 'Old EU' and reciprocal pharmacists came with some degree of personal desire for travel and adventure. Pharmacists from the 'New EU' migrated to experience economic advancement, learn the English language and experience life in a different country. The findings of this stage confirmed that the migration of ITPs was multifactorial, resonating with the existing literature on the immigration motives of other internationally trained healthcare professionals.[53;54;55;58;60;62;67;68;70;136] Additionally, this study was successful in differentiating the reasons for migration and the permanence of movement between professionals who migrated from the developed and the developing countries. The speculations made by Schafheutle and Hassell,[27] in terms of EU and adjudication pharmacists being short and long term migrants respectively, were confirmed by this study. The majority of EU pharmacists interviewed, expressed a desire to return to their home country and start a family there, while the majority of adjudication pharmacists considered the possibility of returning home only after retirement.

The ITPs in this study came to GB through different routes; some were actively recruited by recruitment agencies, while others came to GB independently and then applied for work. Experiences were mixed regarding the adaptation programmes

provided. Adjudication, reciprocal and hospital-recruited EU pharmacists were generally satisfied with their adaptation, while the individually designed adaptation programmes for EU pharmacists in the community sector were criticised. The criticisms given were such as: unsupportive attitudes from colleagues, lack of structured mentoring, lack of language support and being kept in training for longer were similar to the literature on adaptation of IRNs in independent nursing homes.[52;54;66;89]

While overall the reciprocal pharmacists were happy with their work experience in GB, EU and adjudication pharmacists' narratives included some dissatisfactory experiences. Some of the reasons given for this dissatisfaction, such as heavy workload and working with a shortage of support staff, were also identified as a source of dissatisfaction by British-trained pharmacists.[217-219] Similar to IRNs, some EU participants felt alienated and believed colleagues saw them as 'foreigners'. Others reported that their skills and expertise were not fully recognised and they felt under pressure to prove competency.[54;66;70;90;93;121] EU and adjudication pharmacists also reported experiencing discrimination and racism with language, colour and foreignness identified as root causes for these experiences. These findings were also supported by the available literature on IRNs and ITDs.[54;66;89;110;112-115;117-120;122,127-131] Furthermore, this study identified differences in discriminatory experiences between EU and adjudication pharmacists. When EU pharmacists talked about discrimination, most of their accounts seemed to focus on experiences concerning colleagues and employers. Yet, for adjudication pharmacists their main accounts of discrimination were concentrated on patients.

In the focus groups, communication was described as a challenge by both EU and adjudication pharmacists, especially during the initial period after their arrival. Similar to IRNs and ITDs, ITPs experienced communication difficulties through new dialects, use of idioms, abbreviations and colloquial language, inside and outside their workplaces.[55;83;110;112;126;140;144;145] The differences between the "BBC English" they had learned formally and the "Street English" used in GB also led to difficulties.[54] The pharmacists, however, were adamant that their communication difficulties did not compromise patient safety. Adjudication pharmacists believed that the pre-registration period very much prepared them linguistically for practising as independent pharmacists in GB. All the ITPs perceived that they had ensured patient safety by using a variety of

strategies to achieve mutual understanding. However, ITPs described how communication problems could affect patient loyalty because the element of 'trust' between patients and the pharmacist, which is partly built on communication and understanding, was lacking.

The employers of ITPs in the community and hospitals interviewed, mentioned the importance of having processes in place to assure EU pharmacists' language proficiency in the workplace. However, different strategies were used during recruitment to assure language proficiency and these varied in type and rigorousness. Some employers only conducted interviews to assess proficiency, while others required candidates to achieve a certain level of proficiency in English language assessments. Participants were most familiar with the IELTS assessment option, although a few shared several concerns related to it. There was an observation that some pharmacists pass the test, but still have communication problems.[237] IELTS was described as being too general and not unique to pharmacy and passing it was not seen as an indication of fluency in the workplace. These findings were supported by other studies which suggested that, in addition to the socio-cultural dimensions of the language, the high levels of speaking, listening, reading and writing skills required in pharmacy practice are simply not measured in a valid way through standardised, generic tests, such as IELTS and TOFEL.[162;174] To overcome these issues some community employers used English language assessment instruments that were related to pharmacy in GB, such as the UBELT and Linguarama English Assessment Test for Pharmacists. Although employers preferred pharmacy-specific assessments, some still accepted EU pharmacists with IELTS accreditations. Despite recognising the English language as a challenge, all but one employer believed that the delivery of safe and ethical care was not compromised when their EU recruits first entered the practice setting in GB.

9.3 Potential limitations

The findings of this programme of work were based on the qualitative views of a purposive sample of participants. Although the researcher was successful in capturing the diversities of gender, age, race, country of origin, sector of employment and length of time on the Register in her sample, the findings are not generalisable as only 29 pharmacists were recruited for the qualitative interviews in stage one. Another potential

limitation was a geographical bias to this work, in that the majority of the purposive ITPs interviewed in stage one worked in Manchester, or within travelling distance from Manchester. However, the dynamic nature of the focus groups in stage two resulted in participants discussing many aspects of their work experience in GB. Issues that were covered in stage one, such as training of ITPs, their relationships with patients and colleagues and their experiences of discrimination and racism, were often raised and discussed. Consequently, some of the themes that were raised in stage one were further confirmed by the 42 ITPs who participated in the focus groups in London, Glasgow and Liverpool and hopefully this mitigated some of the geographical bias in stage one.

In stage two, participants were asked to talk about the initial barriers they faced in communicating in a second language and their perceptions on its impact on patient safety. In any study that asks the participants to report their perceptions and opinions, there is a risk that the responses will be those that participants believe the researcher wants to hear, rather than what they actually think. To minimise this, the confidential nature of the focus groups was highlighted at the beginning of the data collection. In addition, the range of responses to individual questions was monitored and cross-checked with the available literature on ITPs, IRNs and ITDs to ensure the trustworthiness of the data.

In stage three, there was a poor response rate, which meant that the sample was a convenience sample, rather than the intended purposive sample. Consequently, the findings represent the views of a small number of employers and cannot be said to be representative of all employers. In addition, there is a possibility that employers did not report problems with their recruited ITPs as it would show their organisation in a poor light. It is suggested that perhaps a different method of data collection should be used in future research to strengthen the validity of findings in this stage.

9.4 Strength of the study

This study was the first of its kind and shed light on ITPs in GB with regards to their reasons for migration, experiences of work and their future plans. It also provided information on communicative proficiency of ITPs and its potential implication on patient safety from the ITPs' perspectives as well as that of the ITPs' employers.

The utilization of qualitative approach was one of the strength of this programme of work. The flexibility of this approach allowed the researcher to adapt and react right away to what participants said by tailoring the following questions to information the participants had provided. This was crucial as the researcher had the opportunity to insert follow-up questions if the respondents mentioned something that the researcher would have liked to clarify or explore in greater detail. Through this process the researcher was able to explore ITPs' feelings, attitudes, behaviours and experiences. Overall, adopting a qualitative approach allowed the researcher to extract an in-depth account, detailed description and context rich data.

In stage one and two of this programme of work the researcher was successful in capturing the diversities of gender, age, race, country of origin, sector of employment and length of time on the Register in her sample. The data collected could possibly be transferred to other ITPs in a similar setting. Throughout this thesis the researcher has provided a thick description of what she did and her findings, as quotes are given with every statement, so others could assess the transferability of the findings.

During data collection in stage one and two, the researcher was often asked where she was originally from and if she was a pharmacist. Once these questions were answered, the participant usually went on further to ask where the researcher had done her pharmacy degree, i.e. to see if she was an ITP herself. Once these information were revealed the interview often took on a different tone, with the interviewee revealing more information and generally warming to the interviewer. In the process of data collection, it was usually made clear that researcher's ethnicity and cultural background were seen as a foundation for greater mutual understanding, this was especially evident when participants talked about some potentially upsetting personal experiences such as discrimination. Participants believed the researcher understands the sense of pain and unease they went through, using phrases like, "you must know how it feels to be different". Consequently, the positioning of the researcher as a British trained pharmacist was suspended when issues such as discrimination were being discussed. The researcher believes this recognition of commonality was important in establishing trust, which increased participants' confidence, leading them to reveal further information. However, one might argue that this recognition of commonality by participants could have stopped them from describing their experiences in detail as they could have made the

assumption that the researcher is already familiar with some of their experiences. To avoid this, the researcher made sure to ask follow-up questions to clarify statements and get exact descriptions of participants' feelings and attitudes. Through this process the researcher was able to obtain context rich data.

By collecting data from the employers of ITPs, this thesis was successful in highlighting the gap that exists between the perceptions of EU pharmacists with regards to their adaptation with that of their employers. This finding highlights the importance of carrying out further research with the aim of improving the adaptation and transition of EU pharmacists to pharmacy practice in GB.

9.5 Recommendations

Individual pharmacy companies, the NHS in general and the regulatory body can use the findings of this programme of work to inform the development of standards to support the recruitment and the working experiences of ITPs in GB. Furthermore, this information will assist employers to prepare training materials and targeted interventions for ITPs, which will hopefully leading to a better transition of these pharmacists to British pharmacy practice. The recommendations mainly revolve around the different areas explored and also around the specific problem reported by the ITPs – their communicative proficiency.

9.5.1 For policy makers

At the beginning, and during the course of this PhD research, numerous calls were made by the RPSGB to remove the restrictions placed on it with regards to language testing of EU pharmacists, because of its implications for patient safety.[157;166;173] However, one must question if the language testing of EU pharmacists is so critical that the issue rises to the level of regulatory significance.

Currently, the language testing of adjudication pharmacists is a regulatory issue. As described in chapter one, adjudication pharmacists who seek registration in GB have to meet specific English language requirements by passing the standardised IELTS test.[41] Additionally, they have to successfully complete the OSPAP, the pre-registration year and several examinations in English.[41] If all the stages are completed successfully, it

would take an adjudication pharmacist a minimum of two years to become a registered pharmacist in GB. On the other hand, EU law currently prohibits healthcare regulators from testing the language proficiency of EU healthcare professionals and, although pharmacists have a personal responsibility to ensure that they have sufficient language proficiency to communicate and work effectively with colleagues, the onus is on employers to ensure that staff have sufficient technical and linguistic skills to perform their job safely.[157;173] The findings from this work suggested there were some communication challenges for EU pharmacists, especially when they initially started to practise in GB. Unfamiliarity with idioms, colloquial and lay language, medical terminology and medication names caused obstacles at work for this group of pharmacists. Communication via telephone was particularly difficult, due to the loss of non-verbal clues. Equally, inadequate knowledge about the cultural norms aggravated the communication gap. However, both EU pharmacists and their employers believed delivery of safe and ethical care was not compromised when they initially stated practising in GB healthcare settings. Employers in this study stated that their fundamental responsibility was to ensure patient safety and checking the language proficiency of their new EU recruits, and providing adaption programmes was a step through which this was achieved. All but one of the interviewed employers believed the responsibility for checking the language proficiency of EU pharmacists lies with the employers. On the other hand, EU pharmacists ensured patient safety by achieving mutual understanding through various strategies, such as paraphrasing, non-linguistic means and self and other-repetition. Further collection of data linking language proficiency of EU pharmacists to clinical outcomes and patient safety must be conducted to see if communication challenges pose a real risk to patient safety. The findings from such studies could then help establish if language testing of EU pharmacists should become a regulatory matter.

9.5.2 For employers of EU pharmacists

Recruitment process

In this programme of work, pharmacists migrated to GB for various reasons and they had different perceptions of, and expectations from, their work in GB. In some cases, these perceptions and expectations were not met and pharmacists' experiences in GB were filled with frustration. This does not form a good basis for a motivated and long-

lasting workforce.[270] Therefore it is useful to provide better pre-recruitment information and materials for future EU pharmacists, informing them about life in GB, differences of culture and behaviour and types of work they may encounter.[54] This will give the pharmacists more realistic expectations about work and life in GB. A more realistic job preview is likely to lead to a more satisfactory work experience and, hence, increased retention.[271]

Adaptation process

Although, currently, there is no need for employers to provide adaptation programmes for their EU recruits, all the employers interviewed provided such programmes to prepare their EU pharmacists for safe and effective practice in GB. Although it is beyond the scope of this thesis to detail a model adaptation programme for EU pharmacists, it appears from this programme of work that, besides the pharmacy specific component, communication training should also be included in the adaptation programmes for EU pharmacists in the form of a common core, with regional supplementation. This is supported by the literature on IRNs and ITDs (see section 1.9.2), where communication training has been identified as an important aspect of a successful adaptation programme.[87;94;95;100;102]

From the socio-cultural angle, such a common core might include familiarising pharmacists with the language of the patient and other healthcare professionals in GB. Over the course of this programme of work, the researcher was able to compile a set of terms, suggested by ITPs as being confusing when they initially started practising in GB. This list (appendix 25) includes lay terms for body parts (''down below''), illnesses (''flu''), symptoms (''bunged up'') and drugs (''water tablets''). It would be useful to review the terminology already collected in a classroom format, to cushion the shock that pharmacists undoubtedly feel when first confronted with such terms in community pharmacies or on hospital wards.

As discussed earlier (chapter seven), the ability to communicate correctly is based on a knowledge of culture and a level of language proficiency in English. On the cultural side, British attitudes and approach to family life, sex, friendship, body language, eye contact and relationships could be explained to EU pharmacists. The acculturation course for pharmacists should also include familiarisation with the cultural values

underlying patient behaviour. The EU and adjudication pharmacists labelled GB patients as demanding and well informed. For pharmacists who have never been challenged by patients in their own home country, it is important to understand the cultural basis of this behaviour.

On the language side, the common core might include customised language support, designed around the advanced requirements of professional practice, delivered by English for Specific Purposes (ESP) teachers. During adaptation, the ESP teachers could work in conjunction with pharmacy educators to provide support with pronunciation, for example, so that sound-alike drug names such as 'Lasix' and 'Losec' do not become confused, leading to potential errors.[170] Other areas that could be targeted by ESP teachers could include word choices, grammatical accuracy and voice intonation.[242] As discussed previously (chapter seven), Xu *et al.*[240;242] demonstrated that a 10 week linguistic training course offered by a certified speech-language pathologist was successful in reducing pronunciation errors by IRNs, regardless of gender, age, country of origin or length of residency in the US. One of the employers interviewed also highlighted the importance of language support. This employer ran a 12 week language programme through Bath University for their recruited EU pharmacists. Such programmes could be made available to all the recruited EU pharmacists.

At the local level, listening to the local dialect would ensure at least a degree of understanding. It is, therefore, suggested that, during adaptation, pharmacists be placed in the area that they are eventually expected to work in, so that they can familiarise themselves with the local dialect before taking on the role of the responsible pharmacist.

Similar to IRNs,[105,106,107] mentorship was perceived as essential by EU pharmacists during adaptation. However, problems were identified concerning their designated mentors. Mentors sometimes lacked the necessary skills and knowledge to guide the pharmacists through the adaptation programme but, in some cases, they were also insensitive in front of patients or colleagues. In order for adaptation programmes to work effectively, the mentors need to learn about their new overseas recruits. It is suggested that mentorship training programmes should be provided for mentors to prepare them for mentorship of newly qualified or more experienced EU pharmacists. Components of such training programmes could include diversity training/issues,

language differences/support and the emotional effects of migration.[54;201;224] Adaptation also involves aspects that are beyond professional practice, such as day-to-day activities. In order to provide support and ease adjustment immediately after arrival, it might also be useful to assign a 'buddy' to the newly arrived EU pharmacists. The number, length and types of contact between the new EU pharmacist and the 'buddy' could vary depending on the needs of the pharmacist. It might be useful for the 'buddy' to be from the same country of origin or speak the native language of the new pharmacist fluently.

<u>Working experiences</u>

In general, EU pharmacists felt lonely and marginalised by colleagues and they were pressurised to prove competency. Prior to the arrival of the new recruits, colleagues should be made aware of the advantages of having a multicultural workforce and how they can support the adaptation of EU pharmacists and this could be sponsored through classroom sessions or workshops. Once in GB, formal meetings between colleagues and EU pharmacists could be held to explore any problems encountered and the solutions that could be offered for the problems identified. According to Hunt, this induction of British managers and staff would hopefully aid a faster integration process.[270]

There was also a general feeling amongst some of the EU pharmacists that the recruiting companies had exploited them. To prevent future exploitative treatment, awareness should be raised amongst EU pharmacists about their employment rights so that they could make an informed decision before signing their contracts. In addition, such awareness would allow the pharmacists to seek help in challenging poor or abusive practice by their employers.[54]

Both EU and adjudication pharmacists described incidents where discrimination and racism blighted their experience. All institutions must impose, monitor and implement a 'zero tolerance' policy towards discrimination and racism. Employers should give information about existing anti-discrimination guidelines, the process for reporting cases of discrimination and racism to their internationally trained employees.[54]

9.5.3 For the General Pharmaceutical Council

Currently, the nationality of the registered pharmacists is not being kept on the GB Pharmacy Register (see section 1.2). To identify accurate migration patterns, it is necessary to keep the pharmacists' nationality on the Register. The researcher also recommends that the number and the proportion of ITPs on the GB Register should continue to be monitored, so that the GPhC is aware of the proportion of ITPs within the GB pharmacy workforce. These data provide important insights for future planning of the pharmacist workforce.

9.5.4 For the Royal Pharmaceutical Society

Currently, the Royal Pharmaceutical Society has an Overseas Pharmacists Group, which caters for members who do not live and/or practice in GB.[272] "*This provides a forum for discussion on professional matters of common interest to pharmacists, including new developments and methods of practice in Great Britain*".[272] Similar local and regional support groups and forums could be formed for ITPs in GB. In this environment, ITPs' experiences and unique needs could be discussed openly and the pharmacists who have been on the Register for longer could provide support and advice for the newly registered pharmacists on the adaptation and adjustment process.

9.6 Future research

In terms of further research, one potential way of extending the current study would be to further validate the findings by primary collection of quantitative data. Survey questionnaires could be designed and sent to all ITPs on the GB Register to see if the findings from this study are generalisable.

Further studies need to be carried out to see if ITPs' communication challenges have a direct impact on patient safety and outcomes. If this is the case, the research must explore how, and to what degree, these challenges affect safety and outcomes and if there are any differences between the EU and adjudication pharmacists. If replicable studies provide evidence showing the communication challenges of EU pharmacists directly affect clinical outcomes and patient safety, regulatory measures can then be proposed and implemented. In addition, further collection of data is required to establish the relative merits of pharmacy specific language tests, such as UBELT and

Linguarama, as instruments for assessing the English language proficiency of EU pharmacists in GB.

This programme of work provided a novel perspective into ITPs' work experiences and their perceived communicative proficiency. It would also be useful to seek service users' and colleagues' perspectives on the ITPs' communicative proficiency as this perspective could provide further evidence for policy-making in this regard.

In this programme of work, the overall picture painted by the employers interviewed was somewhat different from the story told by the majority of the EU pharmacists. Perhaps future research should employ other methods to investigate further employers' perspectives of their recruited ITPs.

9.7 Concluding remarks

Prior to this research, there was only limited information on immigration of ITPs into GB.[27] This qualitative programme of work drew on the perspectives of both ITPs and their employers. It also drew on the body of literature describing the migration of other internationally trained healthcare professionals, their communicative proficiency and employers'/regulators' perspectives on this group within the workforce. The findings now provide a foundation for the migration, recruitment, adaptation and experiences of ITPs to be understood, examined and improved.

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Appendices

Appendix 1: Definition of Great Britain, the United Kingdom and the Interpretation Act (1978) regarding definitions of British nationality

Precise terminology of 'Great Britain' and the 'United Kingdom of Great Britain and Northern Ireland' and British nationality: **Interpretation Act 1978**

Great Britain:

England, Scotland, Wales and includes small adjacent islands BUT does not include the Channel Islands and the Isle of Man.

United Kingdom:

The official name 'United Kingdom of Great Britain and Northern Ireland' came into use in 1922 after the constitution of the Irish Free State (1992-1937), the former name of the Republic of Ireland.

The United Kingdom of Great Britain used to refer to the political union of ESW, but in the 20[th] century this was expanded to include Northern Ireland: the 'United Kingdom of Great Britain and Northern Ireland' − as it now appears of passports.

The Isle of Man and the Bailiwicks of Jersey and Guernsey are **not** part of Great Britain, they are not part of the United Kingdom and neither are they part of the European Union. They are British crown dependencies.

The British Islands
As defined in the Interpretation Act 1978 this includes the United kingdom, the Channel Islands and the Isle of Man. The republic of Ireland is not included in this definition.

The British Isles
This expiration is 'geographical' and not 'political'. They are a group of islands off the northwest coast of Europe consisting of GB, the Whole of Ireland, the Orkney and Shetland Islands, the Isle of Man, the inner and Outer Hebrides, the Isle of White, the Scilly Islands, Lundy Islands, the Channel Islands and many other small islands.

Nationality

Sometimes in legislations the term 'British' is used to refer to the United Kingdom as a whole, such as, matters relating to nationality.

Interpretation Act 1978, Sched.1. By the British Nationality Act 1981, s. 50 (1), the United Kingdom includes the Channel Islands and the Isle of Man for the purpose of nationality law.

Appendix 2: List of EU countries with appropriate reference date as specified in the Annex V, section 5.6.2 of Directive 2005/36/EC

EU countries	Reference date
Austria	1 October 1987
Belgium	1 October 1987
Cyprus	1 May 2004
Czech Republic	1 May 2004
Denmark	1 October 1987
Estonia	1 May 2004
Finland	1 October 1987
France	1 October 1987
Germany	1 October 1987
Greece	1 October 1987
Hungary	1 May 2004
Ireland	1 October 1987
Italy	1 November 1993
Latvia	1 May 2004
Lithuania	1 May 2004
Luxembourg	1 October 1987
Malta	1 May 2004
Netherlands	1 October 1987
Poland	1 May 2004
Portugal	1 October 1987
Slovakia	1 May 2004
Slovenia	1 May 2004
Spain	1 October 1987
Sweden	1 October 1987
United Kingdom	1 October 1987

Appendix 3: List of countries who joined the EU in 2004 and 2007

Romania	1 January 2007
Bulgaria	1 January 2007
Cyprus	1 May 2004
Czech Republic	1 May 2004
Estonia	1 May 2004
Hungary	1 May 2004
Latvia	1 May 2004
Lithuania	1 May 2004
Malta	1 May 2004
Poland	1 May 2004
Slovakia	1 May 2004
Slovenia	1 May 2004

Appendix 4: Copy of topic guide (stage one)

Background information:
What is your marital status?
Do you have any children?
How old are your children?
Is your family here with you?
Give me a brief history about yourself. Where were you born and where did you do your pharmacy degree?
How was pharmacy practice back at home?

Decision making:
Why did you decide to migrate to GB?
What were your expectations before you came here? What did you think GB could offer you?
What was the most important factor in your decision to work in GB?
What other factors played a part?
Were you actively recruited?
How much of a role did your family play in your decision to leave your country?
What opportunities are there for your family in this country?
Before you migrated, did you have friends or family already living/working in GB?
What did they tell you about GB as a place to live/work in?
Do you think you have met your expectations?

Language:
How good was your English before arriving here?
Did you expect to face any barriers communicating in a second language?

Initial experiences:
Talk to me about what you had to go through to become registered as a pharmacist here?
Was your training satisfactory? Did it suit your needs?
In what ways was the training different from what you had expected?
How could things be improved?
Tell me about your first position as a pharmacist in GB?
How long did you stay in your first position? Why was that?

Working condition:
Tell me about your working conditions today? Are they satisfactory?
How would you describe your workload/hours and pay/support staff?
How long do you intend to stay in your current position? Why?

Future intentions:
I know you are working as a community/hospital/locum pharmacist but where do you see yourself in the next five years?
Do you know if you will return to your home country to settle?
What would affect your decision to stay/leave?

Is there anything else why would like to add that might help me understand why pharmacists come to work and stay in GB.

Appendix 5: Copy of invitation letter (stage one)

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

(Pharmacists name and address)

(Date)

Supervisors:
Professor Karen Hassell, Tel: 0161 275 2422, Email: karen.hassell@manchester.ac.uk
Dr Ellen Schafheutle, Tel: 0161 275 7493, Email: ellen.schafheutle@manchester.ac.uk

Dear (Name of pharmacists)

I am a first year PhD student in the Centre for Pharmacy Workforce Studies at the University of Manchester. I am looking at the international movement of pharmacists, specifically at **overseas qualified pharmacists** moving into Great Britain. Your name has been identified from the Society's Pharmaceutical Register, because you are an overseas qualified pharmacist who live and work in England. I am contacting you to see if you would be interested in taking part in an interview to share with me your experience of living and working here.

Would you be kind enough to read the **information leaflet**, which provides you with further detail. If then you are happy to help with this research, please could you return the enclosed reply slip in the FREEPOST envelope provided.

If you need further information please do not hesitate to contact me or if you would rather talk to my supervisors about this project please feel free to do so.

Thank you for your time, and I look forward to hearing from you.

Yours sincerely,

Zainab Ziaei

Appendix 6: Copy of participant information sheet (stage one)

Title of the project: *Overseas qualified pharmacists: their contribution to, and experience of, working in the Great Britain (GB) labour market*.

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being carried out and what it involves for you. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of this study?
This study is being undertaken as part of a PhD research project exploring overseas qualified pharmacists' expectations and experiences of working in GB. There has been a growing shortage of health professionals worldwide, and this is no different in GB. Literature has shown that there appears to have been an increase in EU and international health professionals working in Britain to fill vacancies- such as doctors and nurses. Overseas qualified health professionals are an important part of domestic workforce but little is known about pharmacists who come to work in GB. Exploring this topic may help the profession understand about the international movement of pharmacists especially into Great Britain.

Why have I been chosen?
Your name has been identified from the Society's Pharmaceutical Register, because you are an overseas qualified pharmacist practising in England either as community or hospital pharmacist. This research is independent from the RPSGB and all details will be dealt with confidentially and anonymously- no link will be made to you.

What will happen to me if I take part?
If you decide to take part, we will sit together to have a discussion on some interesting key issues such as: training, registration, reasons for choosing Britain to work in and your future plans. There are no right or wrong answers; I am interested in your opinion, and what you have to say. If you decide to take part I will contact you to arrange a time to conduct an interview with you. The face to face interview will be held in a place convenient for you and would not take more than 1 hour. With your permission the interview will be audio recorded.

Will information about me remain confidential?
All the information which is collected about you during the course of the research project will remain confidential. In the highly unlikely event you disclose information in the interview that may reveal a serious patient safety issue (e.g. dispensing a ten-fold overdose of warfarin for a patient) then confidentiality will be broken to allow details of the disclosure to be given to the relevant authority.

What will happen to the results of the research study?
All information from the interview will be treated confidentially. I will transcribe the interview to be able to analyse it. The transcript will be anonymised so that it will not be possible to identify you. The result of the study will contribute to completion of my PhD. It may also be presented at conferences or published in journals. However, you will not be identifiable from data used and published.

Do I have to participate?
No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw from the study at any time, without giving a reason.

What if something goes wrong?
If something goes wrong during this study and you wish to make a complaint, please contact a research practice and governance co-ordinator on either 0161-2757583 or 0161-2758093 or by email to research-governance@manchester.ac.uk

Contact details for further information.

If you have any further questions about this study please do not hesitate to contact me:
Zainab Ziaei,
Centre for Pharmacy Workforce Studies
The University of Manchester,
Stopford Building 1st Floor Oxford Road
Manchester
 M13 9PT

Tel: 0161 275 2363
 Email:zainab.ziaei@postgrad.manchester.ac.uk

If you happy to help with this research, Please complete all sections of the enclosed reply slip

Appendix 7: Copy of reply slip (stage one)

ID number:

Are you willing to take part in an interview? (Please send the Reply slip back)

Yes, willing to take part ☐

No, not willing to take part ☐

The reason for me not taking part is:…………………………………

Ideally, I would like to conduct all the interviews face to face. But if you can not take part in a face to face interview, I can conduct a telephone interview.

Please indicate what type of interview you are willing to take part in:

Face to face interview ☐   Telephone interview ☐

Please indicate how you would prefer to be contacted to arrange your participation in the interview. Please provide your telephone number / email address:

·Telephone:……………………………   ·Email:……………………………………

Best time of contact:…………..

Please indicate your current employment sector:

·Community

·Hospital

·Locum

·Other, please specify……….

Please indicate your country of origin:……………………………

Please indicate your nationality/ies:……………………………

Please return this consent form using the stamped address envelope provided, thank you. FREE POST, Centre for Pharmacy Workforce Studies, The University of Manchester, Stopford Building, 1st Floor Oxford Road, Manchester, M13 9PT

Appendix 8: Copy of reminder letter (stage one)

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

(Pharmacists name and address)

(Date)

Dear (Name of pharmacists)

I have been looking at the responses I have received about my research on the overseas qualified pharmacists practising in GB, and it appears that I have not received any information from yourself as yet. I would be most grateful if you decide to take part. Please let me know of your decision by either phoning or e-mailing me.

Many thanks,

Zainab Ziaei

Appendix 9: Copy of confirmation letter (1) (stage one)

<div align="right">

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

</div>

(Pharmacists name and address)

(Date)

Dear (Name of pharmacists)

Overseas qualified pharmacists: their contribution to, and experience of, working in Great Britain labour market

Thank you for agreeing to a telephone interview with me at (date and time). In the interview we will talk about your expectations and experiences as an overseas qualified pharmacist currently practising in England. I would be most grateful if you could fill in the enclosed consent form and return it in the FREEPOST envelope provided so we could go ahead with the interview.

Many thanks,

Zainab Ziaei

Appendix 10: Copy of confirmation letter (2) (stage one)

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

(Pharmacists name and address)

(Date)

Dear (Name of pharmacists)

Overseas qualified pharmacists: their contribution to, and experience of, working in Great Britain labour market

Thank you for agreeing to a face to face interview with me at (location, date and time). In the interview we will talk about your expectations and experiences as an overseas qualified pharmacist currently practising in England.

In the meantime, if you have any question please do not hesitate to contact me on the details above.

Kindest Regards

Zainab Ziaei

Appendix 11: Copy of consent form (stage one)

Title of project:

'Overseas qualified pharmacists: their contribution to, and experience of, working in the GB labour market'

Please initial:

1. I confirm that I have read and understand the information sheet ☐

2. I have had an opportunity to ask questions and discuss this study. ☐

3. I have received satisfactory answers to all my questions ☐

5. I understand that my participation is voluntary and that I am free to withdraw at
any time, without giving any reason. ☐

6. I agree to the interview being audio-recorded and give permission for the researcher
to have access to this information for analysis. ☐

7. I agree to the use of anonymised quotes from the interview in publications arising from
this study. ☐

8. I understand that relevant sections of personal data provided for the purposes of this study may
be looked at by individuals from the University of Manchester, from regulatory authorities or from
the NHS Trust, where it is relevant to my taking part in this research.   I give permission for
these individuals to have access to my records. ☐

9. I agree to take part in the study ☐

Name of participant	Date	Signature

Researcher	Date	Signature

Appendix 12: Copy of ethical approval (stage one)

NHS

National Research Ethics Service
Oldham Local Research Ethics Committee

Room 181
Gateway House
Piccadilly South
Manchester
M60 7LP

Telephone: 0161 237 2336
Facsimile: 0161 237 2383

08 January 2009

Miss Zainab Ziaei
PhD student
University of Manchester
The Centre for Pharmacy Workforce
University of Manchester
Stopford Building 1st Floor
M13 9PT

Dear Miss Ziaei

Full title of study: Overseas qualified pharmacists: their contribution to, and experience of, working in the Great Britain (GB) labour market.

REC reference number: 08/H1011/82

Thank you for your letter of 05 January 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research

This Research Ethics Committee is an advisory committee to North West Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

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Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Confirmation Letter - Face to Face Interview	3	20 November 2008
Confirmation Letter - Telephone Interview	3	20 November 2008
Reminder	3	20 November 2008
CV - Professor Karen Hassell		
Letter of invitation to participant	3	20 November 2008
Interview Schedules/Topic Guides		
Compensation Arrangements		
Summary/Synopsis	3	20 November 2008
Covering Letter		24 November 2008
Protocol	3	20 November 2008
Investigator CV		20 November 2008
Application	2.0	24 November 2008
letter to RPS to request contact details		
Reply slip	4	28 December 2009
Response to Request for Further Information		05 January 2009
Participant Consent Form	4	28 December 2009
Participant Information Sheet	4	28 December 2008
data use approval		
Data use declaration		28 May 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review –guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
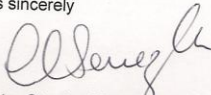
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H1011/82	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Peter Stanley Klimiuk
Chair

Email: carol.ebenezer@northwest.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Karen Shaw

Appendix 13: Copy of topic guide (stage two and three)

Stage two:

What was it like communicating for you, once you came here? How would you describe it?
What were the biggest barriers in communicating, particularly in professional settings?
Can you give me examples of things that you didn't understand initially at work because of language?
Tell me about any challenges you have faced when communicating with patients in GB?
Have you had positive or negative comments from patients because of your language?
What are some of the challenges you faced giving one to one consultation to patients?
How did you manage to overcome communication difficulties?
What strategies did you employ to overcome these challenges?
Can you tell me what sorts of things have gone wrong at work because of the language barrier?
How much English does an overseas pharmacist need to know before starting to work in GB?
Is there implications on patient safety because of language barrier?
Did your employers check your language abilities before employing you?
How did they check your language competency?
Did you get any language training from your employers?
What was the training like? Was it useful?
What training could be provided to help you with your communication with patients?
Have you ever felt uncomfortable because of communication barrier?
Do you think communication barrier has an impact on patient safety?

Stage three:

How did you start recruiting ITPs?
Which countries did you target?
How good was ITPs' English when they started to practice in GB?
What challenges do ITPs face in terms of language when they start to practise here?
Do you check ITPs language abilities before they start to work in your organisation?
What training do you provide for ITPs to help them improve their language abilities?
What barriers do you face in identifying poor communication?
How do you mange poor communication?
Give me example of an incident that has happened or complaints that have been made against ITPs because of communication issues?
Do you think communication barrier has an impact on patient safety?
What responsibility do you think employers should have towards recruiting ITPs?
Do you think it is your responsibility or the society's responsibility to check the language proficiency of ITP?

Appendix 14: Copy of invitation letters (stage two)

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

(Pharmacists name and address)
(Date)

Supervisors:
Professor Karen Hassell, Tel: 0161 275 2422, Email: karen.hassell@manchester.ac.uk
Dr Ellen Schafheutle, Tel: 0161 275 7493, Email: ellen.schafheutle@manchester.ac.uk

Dear (Name of pharmacists)

I am a PhD student in the Centre for Pharmacy Workforce Studies at the University of Manchester. I am looking at experiences of internationally trained pharmacists who practise in Great Britain (GB). Your name has been identified from the Society's Pharmaceutical Register, because you are an internationally trained pharmacist who lives and works in GB. I am contacting you to see if you would be interested in taking part in a discussion to share with me your experience of working here.

Would you be kind enough to read the **information leaflet**, which provides you with further detail. If then you are happy to help with this research, please could you return the enclosed reply slip in the FREEPOST envelope provided. I shall then contact you by your preferred method, and arrange for you to attend a session that is most convenient for you.

If you need further information please do not hesitate to contact me or if you would rather talk to my supervisors about this project please feel free to do so.

Thank you for your time, and I look forward to hearing from you.

Yours sincerely,

Zainab Ziaei

Appendix 15: Copy of participant information sheet (stage two)

Title of the project: Language proficiency of internationally trained pharmacists in Great Britain (GB)

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being carried out and what it involves for you. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of this study?

This study is being undertaken as part of my PhD research project. I am looking at the experiences, opinions and problems experienced by internationally trained pharmacists who speak English as a second language. From interviews I conducted previously it became apparent that many internationally trained pharmacists encounter difficulties due to the language barrier in initial months of their practice in GB. Therefore I have decided to examine this matter further.

Why have I been chosen?

Your name has been identified from the Society's Pharmaceutical Register, because you are an internationally trained pharmacist practising in GB either as community or hospital pharmacist. This research is independent from the RPSGB and all details will be dealt with confidentially and anonymously- no link will be made to you.

What will happen to me if I take part?

If you wish to take part, you will be asked to participate in a group session with approximately 6-8 other internationally trained pharmacists like yourself. In the session, we will discuss issues such as: difficulties experienced initially with the language and how things could have been improved. There are no right or wrong answers; I am interested in your opinion, and what you have to say. Overall the group session will last about 2 hours. Refreshment will be available and to show my appreciation for your willingness to take part a £20 voucher will also be provide. The group session will be held in a place convenient for you. Your travelling costs will also be reimbursed.

What are the other possible advantages and disadvantages of taking part?

I am not aware of any risks or disadvantages that you may experience. However, participation may provide you with a chance to reflect on your practice. Therefore, you may also submit your participation in this study as a CPD entry on your online log, as an attendance certificate will be provided.

Will information about me remain confidential?

All the information which is collected about you during the course of the research project will remain confidential. In the highly unlikely event you disclose information in the interview that may reveal a serious patient safety issue (e.g. dispensing a ten-fold overdose of warfarin for a patient) then confidentiality will be broken to allow details of the disclosure to be given to the relevant authority.

What will happen to the results of the research study?

With your permission the group session will be audio recorded. I will transcribe the recording to be able to analyse it. The transcript will be anonymised so that it will not be possible to identify you. The result of the study will contribute to completion of my PhD. It may also be presented at conferences or get published in professional journals.

Do I have to participate?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw from the study at any time, without giving a reason.

What if something goes wrong?

If something goes wrong during this study and you wish to make a complaint, please contact a research practice and governance co-ordinator on either 0161-2757583 or 0161-2758093 or by email to research-governance@manchester.ac.uk

Contact details for further information.

If you have any further questions about this study please do not hesitate to contact me:
Zainab Ziaei,
Centre for Pharmacy Workforce Studies
The University of Manchester,
Stopford Building 1st Floor Oxford Road
Manchester
 M13 9PT

Tel: 0161 275 2363
 Email:zainab.ziaei@postgrad.manchester.ac.uk

If you happy to help with this research, please complete all sections of the enclosed reply slip

Appendix 16: Copy of reply slip (stage two)

ID number:

Please indicate if you speak English as a second language.

☐ Yes   ☐ No

Ideally, I would like you to participate in a group session. But if you cannot take part in a group session, I can conduct a one to one interview.
Please indicate which of the following you are willing to take part in:

☐ Group session   ☐ One to one interview

Please indicate how you would prefer to be contacted to arrange your participation. Please provide your telephone number / email address:

·Telephone:…………………………….   ·Email:…………………………………………
  Best time of contact:…………….

Please indicate your current employment sector:
·Community
·Hospital
·Locum in………….
·Other, please specify……….

Please indicate your country of origin:……………………………..

Please indicate your nationality/ies:…………………………….

Please return this consent form using the stamped address envelope provided, thank you.

FREE POST, Centre for Pharmacy Workforce Studies, The University of Manchester, Stopford Building, 1st Floor Oxford Road, Manchester, M13 9PT.

Appendix 17: Copy of reminder letter (stage two)

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

(Name and address)

(Date)

Dear (Name of pharmacists)

I have been looking at the responses I have received about my research on experience of internationally trained pharmacists in Great Britain, and it appears that I have not received any information from yourself as yet. You are being asked to participate in this study as you are an internationally trained pharmacist, who has the necessary knowledge skills and expertise to provide a valuable contribution to the present research. You may also submit your participation in this study as a CPD entry on your online log, as an attendance certificate will be provided.

I would be most grateful if you decide to take part. Please let me know of your decision by either phoning or e-mailing me.

Many thanks,

Zainab Ziaei

Appendix 18: Copy of confirmation letter (stage two)

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

(Pharmacists name and address)

(Date)

Dear (Name of pharmacists)

Thank you for your interest in this study. I am contacting you today in order to confirm that you are scheduled to participate in the [group session/interview] entitled 'Language proficiency of international trained pharmacists in GB' at (TIME) on (DATE), at (LOCATION).

I have enclosed a map to the (LOCATION). Parking is available at (DETAILS OF PARKING)

I am very much looking forward to meeting you on (DAY & DATE). In the interim, if you require any further information please feel free to contact me (details above).

Your sincerely,

Zainab Ziaei

Title of project: **'Language proficiency of internationally trained pharmacists practicing in Great Britain'**

Please initial:

1. I confirm that I have read and understand the information sheet ☐

2. I have had an opportunity to ask questions and discuss this study. ☐

3. I have received satisfactory answers to all my questions ☐

5. I understand that my participation is voluntary and that I am free to withdraw at
any time, without giving any reason. ☐

6. I agree to the interview being audio-recorded and give permission for the researcher
to have access to this information for analysis. ☐

7. I agree to the use of anonymised quotes from the interview in publications arising from
this study. ☐

8. I understand that relevant sections of personal data provided for the purposes of this study may
be looked at by individuals from the University of Manchester, from regulatory authorities or from
the NHS Trust, where it is relevant to my taking part in this research.   I give permission for
these individuals to have access to my records. ☐

9. I agree to take part in the study ☐

——————————————— ————————— ————————————————
Name of participant   Date   Signature

——————————————— ————————— ————————————————
Researcher   Date   Signature

Appendix 20: Copy of invitation letter (stage three)

<div align="right">

Zainab Ziaei
Centre for Pharmacy Workforce Studies
The University of Manchester
Stopford Building, 1st Floor
Oxford Road, Manchester, M13 9PT

Tel: 0161 275 2363
zainab.ziaei@postgrad.manchester.ac.uk

</div>

(Pharmacists name and address)

(Date)

Supervisors:
Professor Karen Hassell, Tel: 0161 275 2422, Email: karen.hassell@manchester.ac.uk
Dr Ellen Schafheutle, Tel: 0161 275 7493, Email:
ellen.schafheutle@manchester.ac.uk

Dear (Name of pharmacists)

I am a PhD student in the Centre for Pharmacy Workforce Studies at the University of Manchester. I am contacting you to see if you would be interested in taking part in an interview to share with me your experience and knowledge of employing internationally trained pharmacists with a particular focus on issues related to pharmacists operating in a second language.

Would you be kind enough to read the **information leaflet**, which provides you with further detail. Could you then email me to let me know if you are interested in taking part.

If you need further information please do not hesitate to contact me or if you would rather talk to my supervisors about this project please feel free to do so.

Thank you for your time, and I look forward to hearing from you.

Yours sincerely,

Zainab Ziaei

Appendix 21: Copy of participant information sheet (stage three)

Title of the project: Language proficiency of internationally trained pharmacists in Great Britain (GB)

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being carried out and what it involves for you. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of this study?

This study is being undertaken as part of my PhD research project. I am looking at the experiences, opinions and problems experienced by internationally trained pharmacists who speak English as a second language. From interviews I conducted previously it became apparent that many internationally trained pharmacists encounter difficulties due to the language barrier in initial months of their practice in GB. Therefore I have decided to examine this matter from the employers' perspective. I am looking to gain insight into your experience of employing internationally trained pharmacists in order to make recommendation for the recruitment process.

Why have I been chosen?

Your name has been identified through personal contacts, because you are an employer of internationally trained pharmacists practising in GB. This research is independent from the RPSGB and all details will be dealt with confidentially and anonymously.

What will happen to me if I take part?

If you decide to take part, we will have a discussion on some interesting key issues such as: language abilities of your internationally trained pharmacists. There are no right or wrong answers; I am interested in your opinion, and what you have to say. If you decide to take part I will contact you to arrange a time to conduct an interview with you. The face to face interview will be held in a place convenient for you and would not take more than one hour. With your permission the interview will be audio recorded. Your travelling cost will get reimbursed. If you are unable to take part in a face to face interview, a telephone interview can be conducted instead.

Will information about me remain confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. All your electronic data will be pass word protected. All your hardcopy data and audio media will be destroyed after the minimum period of time required by The University of Manchester.

What will happen to the results of the research study?

I will transcribe the interview to be able to analyse it. The transcript will be anonymised so that it will not be possible to identify you. The result of the study will

contribute to completion of my PhD. It may also be presented at conferences or published in journals. Direct quotes will be used but in such a way as not to identify any participants.

Do I have to participate?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw from the study at any time, without giving a reason.

What if something goes wrong?

If something goes wrong during this study and you wish to make a complaint, please contact a research practice and governance co-ordinator on either 0161-2757583 or 0161-2758093 or by email to research-governance@manchester.ac.uk

Contact details for further information.

If you have any further questions about this study please do not hesitate to contact me:
Zainab Ziaei,
Centre for Pharmacy Workforce Studies
The University of Manchester,
Stopford Building 1st Floor Oxford Road
Manchester
 M13 9PT

Tel: 0161 275 2363
 Email:zainab.ziaei@postgrad.manchester.ac.uk

Please let me know if you are planning to take part by e-mailing me.

Appendix 22: Copy of reminder email (stage three)

Dear (Name of employer)

I have been looking at the responses I have received about my research on language proficiency of internationally trained pharmacists in Great Britain, and it appears that I have not received any information from yourself as yet. You are being asked to participate in this study as you are an employer of internationally trained pharmacists, who has the necessary knowledge skills and expertise to provide a valuable contribution to the present research.

I would be most grateful if you decide to take part. Please let me know of your decision by either phoning or e-mailing me.

Many thanks,

Zainab Ziaei

Appendix 23: Copy of confirmation email (stage three)

Thank you for agreeing to an interview with me at (location (if applicable), date and time). In the interview we will talk about the language proficiency of internationally trained pharmacists in your organisation.

In the meantime, if you have any question please do not hesitate to contact me on the details above.

Kindest Regards

Zainab Ziaei

Appendix 24: Copy of ethical approval (stage two and three)

National Research Ethics Service

North West 12 Research Ethics Committee - Lancaster

Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7818
Facsimile: 0161 237 9427

12 March 2010

Miss Zainab Ziaei
PhD student
University of Manchester
School of Pharmacy
University of Manchester, Oxford Rd
Stopford Building, 1st floor
M13 9PT

Dear Miss Ziaei

Study Title:	Language proficiency of internationally trained pharmacists in Great Britain
REC reference number:	10/H1015/26
Protocol number:	3

The Research Ethics Committee reviewed the above application at the meeting held on 11 March 2010. Thank you for attending to discuss the study.

Ethical opinion

The Chair welcomed you to the REC and told you that the Committee had found no major ethical issues with your application

The Committee pointed out that the Participant Information Sheet needs to explain that if bad practice is identified there is a duty to disclose. The Committee also suggested that you Ziaei might like to send out the information again with the reminder in case it has been lost. The Committee also suggested that the Participant Information Sheet be proof read to correct typographical errors

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, **subject to the conditions specified below.**

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to

This Research Ethics Committee is an advisory committee to North West Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

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the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

a. the Committee would like to see the Participant Information Sheet revised under "Will information about me remain confidential?" to include a further sentence "However, should you reveal unsafe practice during the interviews I have a duty to report it under the Royal Pharmaceutical Society of Great Britain"

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		18 February 2010
REC application	2.5	22 February 2010
Protocol	3	18 February 2010
Investigator CV	Ziaei	
Supervisor CV	Hassell	
Participant Information Sheet: Participant Information Sheet	3	18 February 2010
Participant Information Sheet: Participant Information Sheet	3	18 February 2010
Letter of invitation to participant	3	18 February 2010
Letter from Sponsor	1.0	10 January 2007
Participant Consent Form: Consent Form	3	18 February 2010
Interview Schedules/Topic Guides	3	18 February 2010
Reply slip	3	18 February 2010
Confirmation letter	3	18 February 2010
Reminder	3	18 February 2010
Letter of invitation to participant	3	18 February 2010

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1015/26	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Lisa Booth
Chair

Email: carol.ebenezer@northwest.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

Copy to: Dr Mohammed Zubair

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23 March 2010

Miss Zainab Ziaei
PhD student
University of Manchester
School of Pharmacy
University of Manchester, Oxford Rd
Stopford Building, 1st floor
M13 9PT

Dear Miss Ziaei

Full title of study:	**Language proficiency of internationally trained pharmacists in Great Britain**
REC reference number:	10/H1015/26
Protocol number:	3

Thank you for your email of 18 March 2010. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 11 March 2010. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	Version	Date
Participant Information Sheet	4	18 March 2010

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

10/H1015/26	Please quote this number on all correspondence

Yours sincerely

Rowen Callaghan
Assistant Co-ordinator

E-mail: rowen.callaghan@northwest.nhs.uk

Copy to: Dr Mohammed Zubair – University of Manchester

Appendix 25: List of the lay terms collected in this programme of work

Water tablet
Bundled up
Drawing ointment
Stye
Runs
Flu
Pain killer
Down below
Athlete's foot
Congestion
Lightheaded
Soothing
Nits
Sick
Bunion
Water infection