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Human rights conflicts experienced by nurses migrating between developed countries

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Abstract

Background: Some developed countries have recently changed their role in the context of international recruitment, becoming donors due to socio-economical and political factors such as recessions. This is also the case in Italy, where there has been a flow of immigrant nurses out of the country that has been documented over the past several years. In a short time, it has become a donor country to other developed European countries, such as the United Kingdom.

Aims: To advance knowledge in the context of human rights conflicts and ethical implications of the decision-making process of nurses who migrate between developed countries, such as from Italy to the United Kingdom, during times of recession.

Research design: A case study based on the descriptive phenomenological approach was undertaken in 2014.

Participants and research context: A total of 26 Italian newly graduated nurses finding a job in the United Kingdom were interviewed via Skype and telephone.

Ethical considerations: The Internal Review Board of the University approved the project.

Findings: In accordance with the descriptive phenomenological approach undertaken, three main themes emerged: (1) escaping from the feeling of being refused/rejected in order to be desired, (2) perceiving themselves respected, as a person and as a nurse, in a growth project and (3) returning if the country changes its strategy regarding nurses.

Discussion: Ethical implications in the context of human rights, such as autonomy of the decision, social justice and reciprocal obligation, non-maleficence and double effect, have been discussed.

Conclusion: The call for investing in nurses and nurses' care in developed countries facing recession is urgent. Investing in nurses means respecting individuals and citizens who are at risk of developing health problems during the recession.

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Keywords
Developed country, donor, ethical implications, newly graduated, nurses, plurilingualism in healthcare, receiving, recession

Introduction

A global migration of nurses has been reported worldwide, and it is expected to increase over the next years.[1] Among the many reasons for the nurses' migration, a complex of 'push' and 'pull' factors has been documented in the literature. On the list of 'push' factors, the following are usually mentioned: economic factors (e.g. unsatisfactory remuneration), institutional factors (lack of work facilities and equipment, bad working conditions, patient load), professional factors (limited career prospects, delay in promotion) and socio-political factors (instability of the country-of-origin, financial crisis, war). 'Pull' factors mainly include the following: freedom of movement and globalisation, opportunities for better pay and development, better labour laws, work conditions, environment and effective nursing organisations, availability of communication technology and improvement of quality of life and personal safety.[2–7] The individual decision of a nurse to migrate to another country is influenced by the combination of all of the above-mentioned factors.[7]

According to the data available, receiving countries recruiting the largest number of nurses are the United Kingdom, the United States, Ireland, Norway, New Zealand and Australia.[8] In contrast, the chief donor countries are those countries educating nurses who later decide to migrate abroad. Examples of these chief donor countries include the Philippines, India and other South Asian countries.[9]

While the roles as donor and receiving countries are, in general, stable over time, some, such as Ireland, have changed their role over a short time.[2–7] Italy has also experienced a national nursing shortage over the last 10 years of around 40 to 60,000 units,[10] therefore requiring a large international recruitment of nurses, mainly coming from the Eastern Europe. Due to the economic crisis that has emerged since 2008, and given that the number of university-educated nurses has remained stable over time, the opportunity to find a nursing job in the National Health Service (NHS) once graduated has been tremendously reduced due to hiring freezing.[11,12] The new generation of nurses are mainly unemployed. 1 year after graduation, the unemployment national ratio is around 38%[13] and is even higher in some regions. When few positions are available in the NHS, public selections attract around 5000–10,000 unemployed nurses.[14] Therefore, newly graduated nurses decide to go abroad to search for a nursing job, given that finding a different job in Italy while waiting for work as a nurse is also difficult.

In light of the above, the main intent of this study is to advance knowledge in the context of human rights conflicts and ethical implications of the decision-making process of nurses who migrate between developed countries, such as from Italy to the United Kingdom, during times of recession.

Background

The scientific and professional debate regarding nurse migration is complex and involves different aspects, from those related to individual migrating nurses, patients and citizens to the sustainability of the healthcare systems in both the donor and the receiving countries. Not surprisingly, such debate is also engaged ethically.[4,5,15,16] Ethical implications emerge, especially in the case of so-called 'brain drain' or 'brain and skills drain', when educated nurses or other healthcare personnel migrate from low- to high-income countries.[4,7,8] This practice has been labelled as theft and is morally questionable.[4] However, different patterns of nurse migration have been observed recently and nurses migrate, not only from developing to developed countries but also between developed countries, such as from the United Kingdom, Ireland or

Canada,[17] or between developed countries facing different degrees of recession, such as from Italy to the United Kingdom.[18]

The concepts of ethical recruitment, transition and retention are considered in debates regarding nurse migration,[16] and two opposite arguments can be found. Some researchers, professional bodies and policy decision makers argue that due to several disadvantages, nurse migration is unethical. Others, noting some negative effects, emphasise mainly positive outcomes of migration and therefore evaluate it as being ethically permissible.[19] In accordance to the later position, nurse migration should be considered as 'brain circulation' or 'brain gain' because many elements may positively affect donor countries, like money from nurses sent back to their countries of origin, the knowledge and skills they gain and use when they return, and the experiences gained from working in different cultures and healthcare systems.[5,7] Nevertheless, appropriate policies, codes of ethics and other guidelines have been developed to prevent or mitigate the negative impact of migration.[20]

Among many ethical arguments against migration, global injustice and inequalities between countries and the principle of not harming the poor[4,20,21] have been considered. Additionally, human rights violations in the scope of living standards for everyone, including medical care and the right to health protection, which is put in danger in the donor country in the case of migration of healthcare workers abroad, have been also emphasised.[4]

Migration is considered a personal choice and freedom of movement.[22] Thus, the conflict between human rights becomes even more complicated. On one hand, the right to autonomous decisions regarding one's personal life is accepted; but on the other hand, the responsibility of the international and national bodies for healthcare of every person globally, and furthermore, the responsibility of healthcare professionals to ensure the health of the entire society, are also recognised.

The nurse's right to migrate looking for better perspectives in accordance to freedom of movement and migration, perceived as a human right, is acknowledged.[20] However, other facts should be considered. One country drains another from highly qualified nursing staff, usually during nursing shortages. Yet, the receiving country tempts nurses from other countries by offering good remuneration and working conditions, which can be perceived as being positive intentions with the aim of protecting citizens' health and thus creating social justice. However, it leaves the donor country with limited healthcare personnel, creating social injustice.[23]

Some argue that individual rights need to be balanced against societal needs, and harm done by donating countries themselves should be factored in as well – balance between sustainability of healthcare systems and individual freedom of movement.[4,20,23] But others argue that there is no evidence that emigration of skilled, professionally educated personnel causes damage to the health outcomes of donor countries, which is why there is not an argument that such emigration is morally impermissible.[19]

It is obvious that nurse migration affects human rights in very complex way. Host countries recruiting nurses try to protect their patients' right to health; this in turn puts the health of citizens of the donor country in danger, draining it of professionally educated nurses. When we add the issue of personal human rights (right of nurses to decide, a better life, respecting dignity and seeking good working conditions),[4,23] a conflict between individual and social rights emerges, raising the issue of international justice.

To deal with this issue, codes of ethics are being developed by different entities, both at the national and at the international levels. The first one was launched in the United Kingdom, followed by many other countries, mainly in the OECD region.[20] Such codes include the Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Health Professionals to the United States,[24] the International Council of Nurses (ICN) Position Statement[22] and the World Health Organization (WHO) Global Code on the International Recruitment of Health Personnel.[25] Different entities have Memoranda of Understanding, which are bilateral agreements, such as the one between the United Kingdom and the Philippines or Poland and the Netherlands.[20] The above-mentioned codes have three main objectives: (1) to

protect the individual healthcare worker from unfair recruiting and employment, (2) to ensure that the individual worker is sufficiently prepared for the job and is supported and (3) to ensure that migration of healthcare workers does not destroy the healthcare system's stability in the donor country, in addition to protecting the efficiency of healthcare services.[20]

However, it is difficult to monitor the effectiveness of these codes, given that migration flows are an unrecorded phenomenon.[20] The compliance of countries and organisations with these codes is optional, as the ethical arguments regarding outcomes of active recruitment of healthcare workers are different. For some, the moral harm of such practices is questioned.[19] Other researchers, for example, Brock,[26] argue that in the name of global justice and fairness, codes of ethical recruitment should work as a foundation for creating reforms in order to help donor countries to improve their situation, and authorities of every country should be encouraged to comply with these codes.

Despite the importance of the ethical debate regarding nursing migration and its implications, to date, no discussions have emerged with regard to new phenomenon in nurses' migration, between developed countries in times of recession. Therefore, our research question was What are the human rights conflicts and ethical implications of the decision-making process of nurses who migrate between developed countries, such as from Italy to the United Kingdom, during times of recession?

Method

A case study[27] based on the descriptive phenomenological approach[28] was undertaken in 2014.

Participants

A purposeful sample of new Italian graduates who migrated to the United Kingdom and were working as registered nurses (RN), and who were willing to participate in the study, was used. The nurses were approached via e-mail or Skype. An initial list of participants (=13) was obtained from the coordinators of the bachelor degree in nursing programmes where the potential participants graduated (Udine, Trieste, Verona, Modena and Reggio Emilia Universities). In addition, a second list of participants (=13) was obtained using a snowball sampling method,[28] asking the first participant to indicate one or more colleague(s) working in the United Kingdom, as a new Italian graduate who did not graduate from the same university. Each recruited nurse involved one nurse, among those working with she/he and preferable educated in different university. A total of 26 nurses were approached and agreed to participate; data saturation[28] was achieved, as judged independently by two researchers (A.S. and A.P.), and recruitment was ended.

Data collection process

Data were collected using an open-ended interview conducted by the same researcher (A.S.) via telephone or Skype, in accordance with the preference of each participant. According to the aims of the research project, the work position held before the migration, if any, the decision-making process undertaken to migrate, the reasons determining the decision to remain in the host country and the factors that would determine the decision to return to Italy, as narrated by the participants, were also collected. In Table 1, the list of open-ended questions used in the interview is reported.

The interviews were audio-recorded and then typewritten. Demographic and professional data were also collected: age, gender, date of migration, modality of the migration process (with colleagues or alone), sources of information regarding where and how they found work abroad, the actual work position as an RN and the nature of the job contract (permanent or tenure track).

Table 1. List of open-answer questions.

After having explained the aims of the study and having asked for the permission to be audio-recorded, the following questions were formulated:

- When did you decide to leave Italy in order to look for a job in UK? When did you arrive in UK and in which position were you working at the beginning and today? Which job contract (temporary or not) did you have at the beginning and now with the hospital/nursing home or your employer?
- Were you working in Italy before undertaking the decision to expatriate? In which position did you work?
- Would you share your decision-making process, as well as the factors that have influenced your decision to migrate in UK?
- Did you decide to expatriate on your own or did you decide it with friends or other nurses, forming a group?
- How does one find a nursing position in UK? Can you share the recruitment process and also any factors affecting the decision to work in a specific UK context/field?
- How do you feel as a migrating nurse in the UK context? Can you share with me any factors influencing your staying as a nurse in UK?
- Are you planning to return to Italy? Which conditions or factors are influencing your decision to remain in UK? Which factors would determine your decision to return to Italy?

Other demographic data (age, gender), year of graduation, the university where the graduation was obtained, the region where the nurse were living before migration

Data analysis and rigour

The researchers bracketing was assured in order to avoid the influence of personal bias and misconceptions.[28] Next, in an independent fashion, the researchers read and re-read the transcripts of the recordings to verify their accuracy using Giorgi's method.[28] A list of descriptive units was created and subsequently revised to eliminate repetition and redundancy. Descriptive units were, therefore, collected in thematic categories. The researchers, who agreed on the final list of themes describing the phenomenon being studied, developed the revision of the themes and the relationships between each other. For each team, exemplary quotes were collegially identified and indicated in an anonymous fashion (e.g. RN no. 1, RN 1). The discussion of the themes was developed on the basis of the ethical principles documented in nursing migration literature.[4,15,16,19–23]

Aiming to increase the credibility of the data analysis, the findings were collegially discussed involving all researchers until a complete agreement was achieved. In addition, in each step of the analysis, researchers maintained a reflexive attitude towards the phenomenon under study, considering and reinterpreting the participants' phrases and grounding their analysis on the interviews' texts.[29] To improve trustworthiness, data emerging from the interviews were triangulated with the participants (member checking).[29] The main themes that emerged were submitted to 10 participants (using e-mail, telephone or Skype), asking them to express their level of agreement. Participants expressed their total agreement on each of the three themes.

Ethical considerations

The Internal Review Board of the University (2014) approved the project. The coordinators of the universities involved provided the initial list of participants after requesting consent from the potential participants to share their personal e-mail. The second list of participants was created after having ensured that the first nurse proposing the second nurse had obtained his/her authorisation to share the personal e-mail with researchers.

All interviews were conducted after describing the aims of the study and obtaining the participants' consent. The participation was voluntary. The anonymity was assured by assigning each interview a random number (e.g. RN no. 4), therefore removing the personal data of the interviewee.

Findings

Participants

A total of 26 newly graduated RNs were involved; their average age was 26 years (range = 22–39), and 15 (57.6%) were female and 11 (42.4%) were male. They graduated with a nursing degree between 2013 and 2014 from public universities. Some migrated after a short nursing experience (12; 46.1%) in nursing homes, public hospitals, as agency nurses or as nurses on board cruise ships. The remaining 14 participants (53.9%) migrated without finding a job as a nurse despite several attempts.

A total of 18 nurses (69.2%) came from northern Italy, 5 (19.2%) from the south and 3 (11.6%) from central Italy. Another 17 nurses (65.3%) faced the migration journey alone and 9 (34.6%) migrated with colleagues. All of them migrated after having found a work position as an RN abroad, 23 (88.5%) through Internet contacts and the remaining ones through personal contacts (=3). They all migrated to the United Kingdom.

At the time of the interview, the nurses were working primarily in the hospitals (21; 80.7%); only five nurses were working in the private sector (e.g. nursing homes). The work contracts were mainly permanent (20 nurses, 76.9%), while the remaining six were temporary contracts.

The decision-making process undertaken to migrate and to remain in the host country is based on three themes: (1) escaping from the feeling of being refused/rejected in order to be desired, (2) perceiving themselves respected, as a person and as a nurse, in a growth project and (3) returning if the country changes its strategy regarding nurses.

Theme 1: Escaping from the feeling of being refused/rejected in order to be desired

Participants described their decision to move from Italy after graduation as a way to escape from a country that made them feel rejected and go to a country that, on the contrary, would make them feel accepted as young people and nurses, as reported in Table 2. They reported a sensation of conflict of generations, complaining that previous nurses had more chances to work in Italy, while newly graduated nurses were not given this opportunity. There used to be lack of nurses on the marketplace, so previous generations of nurses were highly sought out by hospitals, while nowadays, there is insufficient employment for nurses, and they are hardly hired by hospitals.

Participants experienced how complex it was to find a job in the hospitals where they expected to start their career, since thousands of nurses usually compete for positions in each workplace. They perceived not being considered and desired after sacrifices were made in order to study and graduate since hospitals generally did not need any additional nurses.

Participants tried to find a job in Italy before deciding to move to the United Kingdom. Among them, some were offered a lower position than the RN should have, and others were offered bad salaries. The only workplaces available for nurses were not in hospitals but in the private sector, where they felt disrespected as nurses. In addition, they were offered bad working conditions and low salaries. This is the reason why new RNs chose to move to another country that would appreciate them, where they had the chance to grow and enhance their competences.

They were surprised to see how easy it was to find a job in the new country and how quickly they got an answer to their application and were able to sign a permanent contract; most of all, they were astonished by the many benefits nurses were given by the hospital in order to develop their career. Therefore, participants did not simply move because they were looking for a better work position; their intention was to escape from a country that was not ready to deal with the new generation of nurses.

Table 2. Theme 1: escaping from the feeling of being refused/rejected, in order to feel desired.

Previous generations had the possibility to work as nurses in my country	Today my country does not need me	When my country needs me, it offers me scandalous working conditions, which show a lack of respect for my professionalism	Going abroad I have opportunities, support in my studies, more possibilities in finding a job, career opportunities, a good salary
'The colleagues of the years before used to work' (RN 20, 22) 'For those who preceded us there used to be a lot of work' (RN 13, 18)	'There is no possibility to work as a nurse' (RN 3, 5) 'I've made a lot of job interviews. There are too many candidates, even 4,000 for a few posts' (RN 7) 'Although I was looking for a job and was first in selections, no hospital has ever hired me' (RN 10, 16)	'I had found some opportunities in the private sector, but the economical and working conditions were very bad' (RN 7, 9) 'I felt I was not respected as a nurse' (RN 18, 21)	'They need me here, nurses are needed so it is easy to find a job' (RN 4) 'You can find a job soon, with a good contract, a good salary and support in your study. It is the hospital that pays for your training' (RN 19) 'I have career opportunities and a salary consistent with my job' (RN 3)

RN: registered nurse.

Theme 2: Perceiving himself/herself respected, as a person and as a nurse, in a growth project

As reported in Table 3, what was relevant to participants was not only the economic aspect but also the level of personal and professional acknowledgement provided by the team that they could perceive in the first 6 months of working abroad. This is the reason why some of them expressed that they preferred to keep working in the United Kingdom while not only waiting for a job in Italy but also while planning to build up their career there.

Participants felt welcomed by the English hospitals and staff. In the beginning, when they were not registered as RNs, they gladly accepted a lower position because they knew it would have been a temporary and preparatory step since there was a project waiting for them to work as actual RNs. They were surprised by the many benefits linked to the workplace, which would have never been offered in the Italian context. Having experienced personal, professional and economic uncertainty, they suddenly transformed their lives because they were given the opportunity to be confident about the duration of the work contract and the better working conditions.

Beyond the linguistic proficiency that the newly graduated nurses built day by day, they had the chance to grow as nurses by increasing their professional competences and to choose the nursing specialty where they desired to work; they also appreciated being assisted by the ward manager to find the ward that better suited them and training opportunities offered by the hospital that let them increase their skills.

They were also delighted by the nurse-to-patient ratio and the salary; the workload was lower with regard to the work responsibilities and training required by students that they were used to in their home country, with an average of 12 patients for every nurse (1 patient for each nurse in the intensive care ward and 37 patients for each nurse in a nursing homes). The salary of the participant ranged between £1300 and £2185.

The social background, as well as the many opportunities offered for the newest nurses, was also surprising; participants felt integrated in a country that focused on future outlooks. The individual is valued thanks to a meritocratic system that offers opportunities for development, thus making them feel indispensable as individuals, and important because of the competences acquired. These aspects made them feel more confident about their future.

Table 3. Theme 2: Feeling himself/herself respected, as a nurse and a person, in a growth project.

I was looked for and I feel wanted	I feel professionally and economically safe	I am building linguistic competence and I have the opportunity of being helped in building professional competence	I feel fine because this is a country that has and offers good prospects
'I feel the hospital [staff] is afraid that I might leave, they make me understand that they need me' (RN 8) 'They want me here and they are very kind to me, they let me stay in the apartments of the hospital' (RN 22) 'As employees of NHS we have benefits in shops and medical services' (RN 3) 'There is a lack of nurses and I am very much wanted' (RN 17)	'I have a tenured job, a secure salary and the quality of working condition is totally different' (RN 10) 'One works with more serenity' (RN 22) 'I felt professionally fulfilled for what I do' (RN 8) 'I have a long-term contract' (RN 1, 7, 8, 10, 17, 19, 21)	'I want to better my English' (RN 23) 'Here I have career opportunities. 'There are several branches of nursing, and nurses have freedom of action' (RN 6) 'The system is merit-based. The hospital helps you out, if you stay' (RN 8) 'My chief nurse asks me to organize a training program to develop my knowledge' (RN 7) 'There is the possibility to change one's ward. My ward sister is helping me' (RN 22) 'Here any career opportunities depend on your will, on your merit, on your value, on what you want to do and what you want to reach' (RN 9)	'It is a very youthful city, it has a lot of opportunities for the young, whereas my country had none' (RN 12) 'Even if I am young, I feel they believe in me and give me space' (RN 14, 15, 16) 'There are prospects' (RN 21, 23, 26)

RN: registered nurse; NHS: National Health Service.

Theme 3: Returning if the country changes its strategy regarding nurses

The most frequent reasons why the participants came back to their home country included holidays and visiting with family, but returning to the country-of-origin was never due to a work position, as reported in Table 4. Nevertheless, they state that they would like to come back to Italy to work as long as four unavoidable conditions are satisfied: they should be offered a permanent contract, their skills and proficiencies should be valued and the working environment should be stimulating, indicating, therefore, complex changes in the country. They recognise that these conditions require a significant change in the nursing profession of their home country, especially regarding aspects of nursing practice and its necessity to grow and develop.

Discussion

The demographic and the professional profiles of the newly graduated nurses involved are in line with the characteristics of those nurses graduated as reported by national documents.[30]

Table 4. Theme 3: returning if the country changes its strategy regarding nurses.

I will come back if I can get a job	I will come back if I can get a long-term contract	I will come back if I am recognised and respected	I will come back if my country changes
'I should find a job' (RN 6, 15) 'I should find a job in a public hospital' (RN 3, 14)	'If I have a long-term contract' (RN 7, 21) 'A permanent job in a hospital' (RN 1, 7, 8)	'A bit more respect, also from employers' (RN 26, 11) 'A stimulating working environment' (RN 13, 23)	'Yes, when the general situation changes' (RN 3, 5) 'Perhaps in ten years, if the situation in Italy gets more positive' (RN 4, 11) 'If the political and organizational situation changes' (RN 14)

RN: registered nurse.

Theme 1: Escaping from the feeling of being refused/rejected in order to be desired

The participants' intention was to find a job in Italy and realise their nursing career in accordance with the education received. Therefore, nursing education was not considered, a priori, a passport for getting a job abroad, as documented by several authors,[3,31] and the decision was made after graduation.

The participants reported that after a very demanding period of studying nursing, their country did not give them the opportunity to work or, when possible, the offers were inacceptable. They reported perceiving conflict with the great opportunities given to the previous generation (inter-generational ethical conflicts); they also reported a conflict with the entire society, given that at the point of enrolment, it promised ease of securing nursing positions.[32] In fact, they were educated in public universities that prepared professionals for the specific needs of the NHSs.

As they felt unwelcomed and unneeded in their country, they decided to emigrate to the United Kingdom. In such circumstances, it seems that they were free from the reciprocity obligation, which quite often appears in the debate on the migration of skilled healthcare workers.[4,33] The reasons for the nurses' personal decision brings new perspectives to the discussion of ethical implications of migration and the conflict of individual rights of nurses to emigrate with the obligation of reciprocity understood as paying back the money that was invested in their education to the society of their country-of-origin.

However, we can ask the question of whether the country has the right to expect that nurses will work for the welfare of this country simply because money was invested in their education. In other words, is there any obligation of reciprocity in this case? It seems that a category of trust should be addressed here – trust between the state and an enrolled nursing student. The country that is educating nurses accepts the responsibility for guaranteeing a job that is adequate relative to the obtained education, in addition to providing good working conditions, which is also a human right.[34] It should be noted that these guarantees are broken not only for nurses but also for the society that expects educated, professional nurses are happy to work and share their professionalism and are not escaping from the country looking for better conditions. These phenomena have also occurred in other countries, such as Poland, where last year, a controversial social advertisement was issued on billboards placed in public places, where the following quotations were displayed: 'In Poland, nurses are not valued. Study nursing in Poland and work in the UK, Germany or Norway'.[35] The aim of this advertisement was to make the public aware of problems that the nursing society had regarding employment in Poland and the possible losses of professionally qualified nursing personnel.

According to Dwyer,[23] the right to emigrate[34] should also be balanced against the social responsibility of healthcare professionals – on one side is the right to emigrate, while on the other is the responsibility for the health of the society with regard to the country-of-origin and its citizens. However, if the country does not

take the responsibility for providing good schemes of employment and work conditions, as well as tailoring the number of students placed at the university level to the effective positions required in the NHS, why should individual nurses respect this obligation? Migration is a voluntary decision of the worker, and it has also been argued that there is no evidence that emigration of skilled, professionally prepared health personnel causes damage to the donor countries.[19] On the contrary, Brock argues that the loss for the donor country is quite large, not only in the sense of human capital resources and healthcare system sustainability but also for the economic and social aspects of the country.[26] That is why every country should consider schemes and reforms that entice their healthcare workers/nurses to stay and work for the sake of it and be recognised as valuable and vital elements in the healthcare system of their country.[6] Creating a debate in the society with regard to the ethical implications of personal decisions to migrate on the obligation of reciprocity may stimulate the creation of policies that are capable of retaining the educated nurses.

Theme 2: Feeling himself/herself respected, as a nurse and a person, in a growth project

As reported by Dywili et al.[3] and by Thypayagale-Tshweneagae,[6] there are several main reasons for nurse migration, and being respected as a nurse is one of them. The chances for personal and professional growth and development, although associated with hard work in terms of language development and adaptation, were reported as a chance for being respected as people and nurses. Our participants reported a sense of surprise with regard to personal and professional opportunities that the new country offered; they reported perceiving the possibility of growth and development under multiple dimensions (e.g. personal, professional and language), feeling safe and secure, which was not possible in their own country that was facing recession. Austerity measures, such as reducing public expenditure, constraining the decision-making powers of professionals, and postponing the retirement age of nurses, which reduces job opportunities for new graduates, may reduce the sense of safety, security and respect, as well as the possibility to have personal or professional projects.[36,37] This may affect the younger generation over the long term, for whom no space and opportunities are offered, and may also affect the nurses who remain in the country.

Their professional enthusiasm, motivation and competence may be affected due to the high workloads (given that no new resources are integrated into the teams), the process of ageing (related to the progressive delay in retirement), the lack of stimuli that new graduates are used to in the workplaces and the reduction in available educational resources. Therefore, the decision for nurses to migrate may increase the sense of respect of migrant nurses, but unfortunately negatively affects the nurses remaining in the country-of-origin, a process recognised as double effect.[38] Promoting nursing, investments in nurses development[3] and offering opportunities for on-going education[17] would help to keep nurses in their country-of-origin, but would also sustain nurses working in the home country. In addition, involving nurses and other healthcare professionals in bottom-up processes, aimed at identifying cost containment measures to adopt during recessions, may increase their perception of being respected, also mitigating the negative impact of some measures undertaken at the top level on patients and professionals.

Adaptation of migrating nurses to the host country's culture and system of healthcare is not easy and requires time and work. Discrimination, language barriers, difficulties in adjusting to cultural differences in the society and work environment, differences in nursing practice or the need to wait for obtaining the recognition of their qualifications and experience are reported, and all of these result in ethical implications.[1,16,39–41]

Ethical implications of phenomenon of 'language barrier' should also be better addressed and understood. It is notorious that language difficulties can lead to clinical misunderstandings, negative judgements and stereotyping. Much of the existing literature about plurilingualism in healthcare investigates the issue of illiterate patients and of patients not (fluently) speaking the local language.[42] Less attention has been paid to the opposite situation, in which health workers situate themselves in a continuum of ability in terms of their

accuracy, fluency, structuring of explanations, communicative style and so on. In fact, both the health worker and the patient may be foreign-born and share different linguistic and cultural backgrounds.

However, in our study, participants did not mention all of these difficulties; on the contrary, they were happy that they got the chance for a better life, and even though, in the beginning, they had to agree to work in lower positions, they knew that it was worth waiting for the permanent position. Delays in the registration process after arrival to the host country are often mentioned by migrated nurses, and the problem of working in a lower level working position is also recognised as having the effect of a 'deskilled process'.[39] The steps for recognition of qualifications and licensure should be clearly stated at the stage of recruitment and be mutually accepted by all parties. However, ethical implications regarding the acceptance of lower positions in the host country, but not one's own country, should also be addressed.

Theme 3: Returning if the country changes its strategy regarding nurses

Italian nurses have not ruled out returning to their home country. However, they have given one condition, which is composed of four interrelated factors: getting a job, being offered a long-term contract, indications that the country has changed and introducing reforms of nurses' respect and recognition.

According to the literature, there is evidence that a small number of migrant nurses return home and show willingness to do so.[4,6,7] Therefore, Kirck's[43] arguement holds that nurses return from developed countries to their country-of-origin with new knowledge, skills and money, and thus migration can be understood as a flow of capabilities between countries. This argument is, of course, only adequate in cases where the nurses return. Yet, remittances sent by migrants to their home country are a doubtful remedy and justification when analysing the outcomes of the migration of highly skilled professionals in general. They are good as private gains, but not as fair compensation for public loses.[23,26]

Different strategies are referred to in order to encourage the return of migrants, for example, introducing temporary work visas in the host country, initiatives devoted to closing the wages gap in donor countries or 'return of talent' programmes.[4] Some of them are focused on limiting the stay of migrants in the host country, while others try to develop different kinds of incentives for those who return. Unfortunately, such solutions are of temporary character and may have outcomes only on a small scale.[4]

The most important is to undertake actions and implement policies in countries facing problems with nurse migration regarding promotion of nursing and schemes of fair employment and improvement of working conditions, as these factors were directly highlighted by participants of this study when talking about conditions for their return home. Such actions should be considered as global obligations of a multisectoral character, as underlined in the WHO Code.[25]

Limitations

We interviewed, using different strategies (phone, Skype), a group of migrant nurses from Italy to the United Kingdom. Bias in data collection may have occurred due to the different strategies adopted in the data collection process. In addition, the participants had just migrated and were newly integrated in the host country and new job position. They were interviewed after six months, reporting, therefore, on a short-term experience. Transferability of the findings with regard to the personal decision and related ethical issues to the entire group of Italian migrants to the United Kingdom should be prudent.

In addition, the ethical implications were debated only from one side, involving researchers from donor countries. Therefore, an emic perspective[44] has been adopted, describing behaviours or beliefs in terms meaningfully (consciously or unconsciously) taking into account the specific culture, instead of taking an ethic perspective, which takes into account a description of a behaviour or belief by an observer (mainly represented by a receiving country).

Conclusion and policy implications

To date, most studies have documented ethical implications regarding international recruitment, such as the freedom to decide, the implications on social justice and the non-maleficence as not doing intentional harm, mainly observing the emigration processes from second or third world nations to developed countries.

In times of recession, some NHSs have reduced nurse recruitment, while the numbers of nurses who have newly graduated from public universities have remained constant. These developed countries, such as Italy, have suddenly changed their role, from receiving countries to donor ones, thus offering nurses to other developed countries that are not suffering (or at minor degrees) from the recession or who have already recovered.

We interviewed a group of newly graduated nurses in their first migration experience, a decision made mainly due to the desire to find a job as a nurse. Collecting narratives from migrant nurses may support understanding how codes of international recruitment are put in place in the context of changing social, economical and political conditions, such as those codes from the European Union (EU), which were documented during the last wave of the recession.

From the findings, nurses do not feel any ethical obligation to remain in a country that, despite having ensured their education, does not offer positions and opportunities to develop a professional project. Their autonomy to migrate should be respected as a fundamental human right. This intentional action has positive effects on individuals and their families, but may also have positive effects on the entire society when the nurse decides to return, enriched from lived and professional experiences. However, this personal decision may also have unintentional negative effects on the remaining nurses, citizens and the entire society, which also has ethical implications. The emigrant nurses who were interviewed stated that they will return home when better working conditions for nurses are possible, such as the opportunity to work, being respected and having a professional development project.

Therefore, the call for investing in nurses and nurses' care in developed countries is urgent. Investing in nurses means respecting individuals and citizens who are at risk of developing health problems during the recession. This also means respecting the investment that the society has made throughout its universities. It also refers to ensuring the human right to good working conditions for all generations of nurses, those remaining and those escaping. An increasing amount of evidence documents the association between nurses and patient outcomes. Therefore, policies in the above-mentioned direction should be ethical imperatives for developed countries facing recession, while inertia may be a factor that may transform the narratives of a selected group of newly graduated nurses, such as those interviewed, into a pandemic situation.

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