

Research paper

Cultural health capital and professional experiences of overseas doctors and nurses in the UK

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What is known on this subject

- The UK healthcare workforce is increasingly diverse, with a significant number of staff being migrants who qualified abroad.
- Making the best use of the resources of overseas healthcare professionals is complex, as they face difficulties transferring and utilising their knowledge and skills to the UK healthcare sector.
- These professionals' post-migration experiences may lead to poor psychosocial well-being outcomes, such as low self-esteem, frustration, depression, demoralisation and disappointment.

What this paper adds

- Our findings show the important role that migration status plays not only in the participation of overseas nurses and doctors in the UK's labour market, but also in their professional progression. Participants with a temporary migration status experienced barriers and delays as they tried to develop professionally, whereas those with a more permanent status progressed more quickly.
- There was discordance between medical doctors and nurses in terms of professional development and psychosocial well-being, with doctors being more negative about their professional prospects and nurses emerging as more psychosocially resilient.
- The theoretical framework of cultural health capital is a useful tool for considering the relationship of professional development and psychosocial well-being in participants' narratives and for exposing structural and institutional barriers to career aspirations compounded by social inequalities faced by immigrant groups.

ABSTRACT

Drawing on autobiographical narratives of a small sample of overseas doctors and nurses working in the UK, this study analysed emerging subjective theories of their professional experiences and explored how these are related to the theoretical framework of cultural health capital, an expert theory on a form of cultural capital which is leveraged in healthcare contexts and may result in more optimal healthcare relationships. The findings of our analysis demonstrate that there is a wealth of expertise and experience among overseas healthcare professionals, and that it is underutilised because of structural and institutional barriers. Healthcare professionals with temporary migration status faced longer delays in their career progression than those with EU citizenship

or work permits. Irrespective of migration status, career aspirations were thwarted by external circumstances with negative consequences for individuals' well-being, with doctors being affected more severely than nurses. Structural and institutional barriers that have an impact on professionals' ability to progress into the UK healthcare system are discussed. The paper concludes with a discussion of the potential of cultural health capital as a framework for capturing and explaining the career trajectories experienced by overseas healthcare professionals.

Keywords: cultural health capital, migrants, professional experiences, psychosocial well-being, refugees, subjective theories

Introduction

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

The post-migration experiences of highly skilled migrants and refugees in the UK are neither simple nor straightforward (Psinos, 2007). Studies of overseas professionals from the healthcare and welfare sectors indicate that they struggle to utilise their skills because of interconnected reasons, such as complicated systems for assessing and converting their educational and professional qualifications, recruitment processes and professional development which are often indirectly discriminatory, racism experienced in the workplace, and inadequate levels of local support and mentoring (Butler and Eversley, 2009; Henry, 2007; Sinclair *et al*, 2006; Smith *et al*, 2006). Studies exploring these professionals' post-migration experiences also report poor psychosocial well-being outcomes, such as low self-esteem, frustration, depression, demoralisation and disappointment (Alexis *et al*, 2007; Cohn *et al*, 2006; Stewart, 2003).

In this article we explore the meanings that overseas doctors and nurses in the UK attach to their professional experiences, and we examine the processes that impede or facilitate their professional progress and influence their psychosocial well-being (see Box 1). We do so by drawing on an innovative framework for the interactional dynamics that occurs in healthcare

contexts. We use the theoretical approach of cultural health capital (CHC) (Shim, 2010) while exploring the subjective theories of overseas healthcare professionals in the UK institutions that employ them. The aim is to highlight some of the micro-interactional and also macro-structural mechanisms that affect the development and well-being of these groups. Following a brief literature review of the field of migration of healthcare professionals, we discuss the CHC approach and how it can address the shortcomings in this area. We then employ this approach to analyse the subjective theories conveying the professional experiences of a group of overseas doctors and nurses in the UK.

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

Post-migration experiences of overseas healthcare professionals

An increasing shortage of healthcare staff has led to recruitment of these professionals from less developed countries as one of the main responses of developed countries to this challenge (Clark *et al*, 2006). The main motives for this migratory movement include poor remuneration, bad working conditions, political instability and discrimination, as well as personal motives such as a need for security, escape from the threat of violence, and better education of children (Pang *et al*, 2002). Common attracting factors are better working conditions, better quality of life and greater career opportunities. Migration of healthcare professionals occurs in two ways, namely through active recruitment by employers or agencies, or through passive recruitment by professionals' access to infor-

Box 1 Definition of overseas healthcare professionals

Overseas doctors, nurses and social workers are not UK nationals. They have qualified outside the UK and then entered the country to work as either refugees, post-qualifying students or economic migrants.

EU citizens make up the largest number of overseas doctors (General Medical Council, 2011), but many migrants originate from outside Europe.

mation and work opportunities via new communication technologies (Batnitzky and McDowell, 2013; David and Cherti, 2006; Troy *et al.*, 2007).

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

In the second area, which looks at socio-economic dimensions, most studies draw on theories such as that of Loury (2002) on how racial/ethnic inequalities are structured, and they often use the theory of Bourdieu (1986, 2001) about the forms of cultural capital, while exploring highly skilled migrant groups' integration into the receiving society's labour market. According to Bourdieu (1986), migrants' cultural capital refers to non-financial assets, that is, the educational, intellectual and social resources that people either inherit from their family through socialisation or consciously acquire over time, for instance, through formal education. Cultural capital includes formal or institutionalised cultural capital, such as educational and professional qualifications and recognised work experience, as well as informal/incorporated cultural capital, such as migrants' affiliation to ethnic communities and social and professional networks both in their country of origin and the host country, and the values, motivation and the strategies that they use to cope with change.

Bourdieu's theory of cultural capital has been criticised for not paying enough attention to people's self-concept, because Bourdieu assumes that professionals seek to maximise their status out of habit (Lamont, 2010). In contrast, Lamont (2002) conceptualises cultural capital as stemming from people's self-worth, and she assigns to cultural capital a nuance which is both habitual and purposeful.

Criticisms of these two theories of acculturation and cultural capital, when applied to research with overseas professionals, suggest that psychosocial acculturation models focus too much on intra-individual or interpersonal states. Consequently, they cannot explain the macro-mechanisms that suppress collective minority rights and perpetuate socio-economic inequalities between native-born and foreign populations (Rudmin, 2003). Criticisms of sociological

approaches such as cultural capital do not explain the psychological processes which are co-constructed in sociocultural contexts (García-Ramírez *et al.*, 2010) and through which people respond to the challenges that they face during acculturation.

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

The theoretical framework of cultural health capital

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

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

- 1 *purposeful*, since patients enact health-related practices such as engaging in self-surveillance and risk reduction, but also *habitual* in that many patients engage in the above practices because these are rooted in their experiences and long-lasting ways of organising action

- 2 *empowering* for individuals, and *structurally restricted* because holders of CHC are not entirely free agents who can use resources at will, but are also constrained by systematic inequalities
- 3 *deeply relational* because, in interacting with patients, clinicians can encourage them to be the kinds of actors they would like them to be.

This description of CHC suggests that this is indeed one of the integrative theoretical frameworks that combine agency and structure. Moreover, similarities between the American and British healthcare systems, in terms of an emphasis on ill health prevention and risk reduction, maximising people's capabilities through lifelong learning and enabling them to have control over their lives, and citizen participation and community engagement in healthcare decision making, indicate that this framework can be applied to the current UK healthcare context (Marmot, 2010).

Through our analysis in the following sections, we show that the CHC theoretical framework can be valuable for exploring the repertoire of competencies, attitudes and interactional styles that not only patients but also healthcare professionals cultivate. It may also highlight social inequalities in clinical encounters, and help to explain how barriers that overseas healthcare professionals may face at the workplace shape their professional development and well-being.

The study

The project aimed to explore the experiences of overseas health and social care professionals before and after migrating to the UK, and the relevance of cultural capital for their professional development. The project focused on medical doctors, nurses and social workers, as these professions attract the majority of overseas-trained professionals in health and social care (Bach, 2003). We employed purposive sampling to recruit 5 doctors, 5 nurses and 5 social workers via our professional networks in London. For the purposes of this article, we discuss findings referring to the doctors and nurses in our sample. The Faculty Research Ethics Committee issued a favourable opinion. All participants were ensured of confidentiality and anonymity with regard to the accounts that they provided.

Participants

The study participants originated from a mix of developing and European countries, and their ages ranged from 28 to 52 years. Two participants were EU citizens, and four were economic immigrants with work permits. One was on the Highly Skilled Migrant

Programme (HSMP), one was a refugee with British citizenship, and two were asylum seekers with limited leave to remain (LLR) (see Table 1).

The sample of doctors consisted of four men and one woman. Four had lived in the UK for an average of five years. One arrived in the early 1990s as a refugee, and although he had lived in the UK for much longer than the other participants, we still consider his experience to be relevant since, at the time of the study, he was still actively trying to join the UK medical workforce. All of the doctors had a university degree in medicine and significant work experience in their home countries and elsewhere. Two were working as doctors in NHS hospitals. One had a managerial post in the NHS, the refugee doctor with British citizenship worked as a health officer in a local authority, and the doctor with LLR status was a project officer in a private healthcare agency.

The sample of nurses consisted of four women and one man; they had lived in the UK for an average of seven years. All of them had nursing qualifications from their home countries, and one also had a degree in social work. They had significant work experience in their home and other countries. Three were employed as NHS nurses, one was working part-time as a carer in a community support agency, and one was a staff nurse in a private care home.

Data collection

The participants were invited to take part in an autobiographical narrative interview. Each interview was conducted in English, lasted for approximately 1.5 hours, and was audio-recorded with the participants' consent. Three interviews were conducted at the participants' homes, and two were conducted in a public place suggested by the participants (coffee shop and community centre). The remaining interviews were conducted at the participants' workplace, after they had finished work.

At the start of each interview, the interviewer described the aim of the study in detail, provided an opportunity to ask further questions and obtained written consent. The interviewer began by saying 'I would like to ask you to tell me the story of your educational and professional life before and after you came to the UK. A good way to do this would be to start talking about your education and work experience you gained in your home country, and then about your education and work experience in the UK until today. After that you can also tell me your thoughts about your professional future.' There were also specific narrative questions regarding experiences with UK institutions ('Did you approach an employment agency or job centre?'), psychosocial resources ('How are your relations with other compatriots?')

Table 1 Demographic characteristics of participants

	Gender	Region of origin	Work experience in home country	Work experience in UK	Migration status
Medical doctors	Male	Central Asia	Military hospital doctor	Health officer in local authority	Refugee/ British citizenship
	Male	South-East Asia	Public health medical doctor	Project officer in a private healthcare agency	Limited leave to remain
	Female	Central Europe	Hospital psychiatrist	NHS psychiatrist	EU citizen
	Male	South Europe	General hospital doctor	NHS oncologist	EU citizen
	Male	South Asia	Healthcare manager in private sector	Consultant in pharmaceutical company/ NHS strategy manager	Highly skilled migrant
Nurses	Female	South Asia	General hospital nurse	Healthcare assistant in nursing home/NHS senior nurse for elders' rehabilitation	Work permit
	Male	East Africa	Mental health nurse	Part-time carer in support agency	Limited leave to remain
	Female	South-East Asia	General hospital nurse	Healthcare assistant in nursing home/NHS nurse for elders' rehabilitation	Work permit
	Female	South Asia	Military hospital nurse	Healthcare assistant in nursing home/NHS hospital nurse	Work permit
	Female	South Africa	Paediatric hospital nurse	Staff nurse in care home	Work permit

and individual coping ('Do you think you are in control of things in your life?') and psychosocial well-being ('Are you satisfied with the way your life is?'). After the interview each participant was asked to complete a questionnaire to gather information about their educational and professional history and demographic data.

Analysis

Verbatim transcriptions of interview data were analysed with the assistance of a qualitative data analysis software program, NVivo version 8. Thematic network analysis was used to organise the narrative interview material and to interpret the participants' emerging subjective theories (Attride-Stirling, 2001). Thematic analyses of qualitative data in general attempt to reveal the themes that are salient in a text at different levels,

and thematic networks in particular aim to facilitate the structuring and depiction of these themes (Attride-Stirling, 2001, p. 387).

The first step in a thematic network analysis is to code the material. This was done by dissecting the text into meaningful text segments related to three themes:

- 1 first work-related experiences in the UK
- 2 the psychosocial resources that the participants said they used while facing various post-migration challenges
- 3 psychosocial well-being.

Sections initially coded as *psychosocial resources* were further coded according to CHC elements such as health literacy, an enterprising disposition presupposing a sense of mastery and self-efficacy, an orientation toward the future and its control through action, and adaptive interactional styles. Once the text was coded, the themes were abstracted by going through the text segments in each code and by extracting the common

or significant themes (Miles and Huberman, 1994). Inter-judge reliability was attained by creating codes and themes separately and then cross-checking the codes and themes that each of the researchers had found. Discrepancies were resolved through discussion and re-examination of the data.

The emerging themes were assembled into groupings based on content and theoretical grounds. These groupings became the basic themes. Clusters of basic themes centred on larger, shared issues from which the organising themes were created. Finally, the main claim to which the organising themes referred was summarised and became a *subjective theory*, a term that refers to the fact that each interviewee constructs a complex stock of knowledge about the topic under study. This knowledge includes assumptions that are explicit and immediate and which the individual can express spontaneously when answering an open question. These are complemented by implicit assumptions, which can be derived through more direct questions (Flick, 2002, p. 80). Subjective theories do not refer to objective stocks of knowledge that people hold, but rather they are shaped by existing social norms and cultural values and are influenced by interactions with others. Individuals create meaning from interactions, relating their existing beliefs to new ideas and social situations (Schwandt, 1998).

In this study, the meanings that overseas doctors and nurses attached to their experiences were constructed through various interactions in different social contexts in the UK.

Subjective theories can be contrasted with *expert theories* through which scientists, researchers and policy makers explain participants' experiences. Expert theories, such as the CHC framework, make claims that attempt to describe an 'objective' social-psychological reality (Denzin and Lincoln, 1998). In this paper we open a dialogue between what is objective, expert knowledge and the subjective. Thus we discuss overseas doctors' and nurses' subjective theories of their professional experiences while exploring how they use the attributes comprising CHC, when constructing these theories.

Findings

Two thematic networks, consisting of basic and organising themes, are presented. The basic and organising themes are first discussed and relevant quotes are integrated, to illustrate how these themes link together into a subjective theory. After each quote the gender, occupation and migration status of that interviewee are noted in parentheses.

Basic themes

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

The process of accrediting qualifications and its dependence on migration status

Recognition of qualifications acquired depended largely on participants' migration status. This was far from straightforward, especially for refugees. For one refugee doctor who later acquired British citizenship, the long delay in the accreditation process affected his professional development:

Because I had no documents I was not eligible to update my training or continue my training and follow registration. So I was just waiting for my status to be clarified by the Home Office. After two years, with the help of [X] University, they sent my diplomas for recognition to the British Council. Then the British Council doesn't recognise my qualification and they say that because of the [time] gap.

(Male doctor, health officer in local authority, refugee/British citizen)

The process was more straightforward for EU citizens:

I had my interview before I had my certificate of completion of training and I emigrated [to the UK] very quickly after receiving the certificate. So I worked in my home country for about 6 years and then I came to the UK and I have worked here for about 5 years as well.

(Female doctor, NHS psychiatrist, EU citizen)

Pace of recruitment based on migration status

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

I sent in my application [in] July and then in October the agency phoned me. ... I went for an interview and it is this Trust, so I'm lucky I got the job. I came here in January 2001 so it's very quick. It's a straightforward process, after the interview, in 3 months I came here.

(Female nurse, employed in the NHS, with work permit)

Interviewees with a temporary status faced a more complex and slower recruitment process. Delays due to migration status were compounded by time spent out of the UK workforce:

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

(Male doctor, project officer in private healthcare agency, LLR)

Organising themes

The organising themes refer to the participants' *active use of resources* in order to progress professionally in the UK. This active use of resources was selected as the main principle linking the basic themes because it showed what they claimed to *do* in order to overcome difficulties. The resources presented here refer mainly to aspects of CHC such as *health literacy*, *sensitivity to interpersonal dynamics* and *ability to adapt one's interactional styles*, an *enterprising disposition which presupposes self-efficacy*, *orientation toward the future and its control through action*. We selected quotes in which interviewees described what they did in order to progress professionally, and where the above aspects of CHC are captured.

Enhancing health literacy

Opportunities to undertake training and thus improve one's health literacy were positive experiences, allowing the participants to progress professionally. In the following example, an NHS nurse highlighted the complexity of the training that she was required to undertake. She acknowledged that it enhanced her health literacy, and thus improved her chances of career progression:

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

(Female nurse, employed in NHS hospital, with work permit)

Sensitivity to interpersonal dynamics/ adaptability

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

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

(Female nurse, employed in NHS rehabilitation ward, with work permit)

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

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

(Male doctor, NHS oncologist, EU citizen)

Orientation towards the future and its control through action

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

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

(Female doctor, NHS psychiatrist, EU citizen)

An enterprising disposition that presupposes self-efficacy

Another element of CHC, an enterprising disposition that presupposes self-efficacy, also emerged in some narratives. The doctor in the next quote discusses the different professional pathways that he took while trying to attain his main professional goal:

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

(Male doctor, NHS strategy manager,
highly skilled migrant)

Subjective theories

Two subjective theories emerged from our interpretation of the narrative material. Their differences were not immediately evident, but the significant ones rest on the psychosocial well-being outcomes that they presented.

First subjective theory

Four nurse participants made sense of their professional experiences in the UK through the first subjective theory (see Table 2). They all discussed having positive psychosocial well-being and reported using various resources to cope with problems.

In this subjective theory, the basic themes referred to accreditation of qualifications and recruitment, and in particular how these depended on migration status. Other issues, such as initial problems of acculturation,

were also raised. With regard to the organising themes, participants said they used several resources, such as adapting their interactional styles at work and improving health literacy. Finally, this theory contained a positive psychosocial outlook, since this group presented itself as resilient, optimistic about the future and expressing overall satisfaction with their post-migration life.

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

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

(Male nurse, carer in support agency, LLR)

Another participant, who experienced difficulties in securing a post as a hospital nurse, provided another example using a different CHC element. She adapted her interactional style at work and eventually emerged as resilient and satisfied in her post:

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

(Female nurse, working in private care home,
with work permit)

Table 2 First subjective theory: basic and organising themes

Basic themes	Organising themes
Accrediting qualifications	Improving health literacy
Pace of recruitment	Being active and future-oriented
Acculturation issues	Adaptability in work-related interactions

Second subjective theory

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

In this subjective theory, the basic themes again related to the issues of accreditation of qualifications and recruitment, and how these depended on migration status. The participants discussed the resources that they attempted to activate in order to cope with some of their difficulties, and how they still failed to attain the state they were aiming for. With regard to psychosocial well-being these interviewees presented themselves as lacking the confidence to overcome difficulties, and being dissatisfied with their professional lives in the UK.

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

Then I was applying for jobs here and there, one position with Oxfam, monitoring evaluation, that's my specialisation, and also with a PCT in London, a position of Public Health Information Officer there. With Oxfam, I didn't even get an interview. With the PCT I got one interview, but I didn't do well, my English or my presentation skills were still not good ... then friends told me 'Why don't you work in the supermarket?' I was controlling myself not to say anything. ... They are graduates but not in any

profession, so they don't understand how we build up our professional pride. ... Even if I'm not qualified here as a medical doctor, still as a public health professional, I am qualified to work somewhere and I am still getting interviews. ... But it's quite depressing, I feel this is quite difficult.

(Male doctor, project officer in private healthcare agency, LLR)

Another doctor also felt ashamed of his professional exclusion. Despite his efforts to cultivate the CHC element of adaptability, he was not given the opportunity to convey his skills as a medical doctor in the UK:

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

(Male doctor, health officer in local authority, refugee/British citizen)

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

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

(Male doctor, NHS strategy manager, highly skilled migrant)

Table 3 Second subjective theory: basic and organising themes

Basic themes	Organising themes
Accrediting/transferring qualifications	Being active and future-oriented
Pace of recruitment/development	Enterprising disposition based on self-efficacy
Acculturation issues	Sensitivity/adaptability in work-related interactions

Discussion

Our study is limited by its small sample and the participants' diverse backgrounds. We therefore need to be cautious when drawing conclusions about the professional experiences of overseas doctors and nurses in the UK. Also, although we attained inter-judge reliability, the participants did not validate our interpretations, mainly because of the difficulties of researching mobile populations, such as migrants and refugees, who may be unable to meet the researcher more than once. Despite these limitations, our findings add in-depth knowledge to an expanding body of research related to health workforce development and highly skilled migration, and offer an alternative way to conceptualise professional experiences and career development.

Our findings show the crucial role of migration status in overseas nurses' and doctors' professional progression in the UK. Participants with a temporary migration status experienced barriers and delays as they tried to develop professionally, whereas those with a more permanent status progressed more quickly. The finding that migration status largely shapes foreign-born professionals' participation in the labour market confirms the results of previous research (Bloch, 2004).

There was an obvious divergence between doctors and nurses in terms of professional development and psychosocial well-being. Doctors appeared to be more negative about their professional prospects, despite the fact that some of them had succeeded in initiating a career in the UK healthcare sector. They expressed dissatisfaction with their life in the UK. Two doctors reported that they often felt depressed and two others, one of whom was preparing to leave the UK, were deeply disappointed with their experience. In contrast, despite initial difficulties and slow professional development, nurses emerged as more psychosocially adjusted and satisfied with life in the UK. Only one nurse appeared psychosocially vulnerable, and this was due to specific family circumstances. This difference between the two professional groups could perhaps be attributed to psychosocial factors such as perceived and experienced discrimination. However, these factors have been identified in relation to both doctors (Esmail, 2007) and nurses (Larsen, 2007), so they could not explain the differences in well-being between the two groups.

Structural factors could offer another explanation (Hugman, 1991). The historical dominance of medicine restrained other professions such as nursing from asserting its professional identity and seeking equal treatment to doctors. According to this analysis, nurses were often perceived as semi-professional and 'tended to "silence" themselves in order to maintain

the culture of the workplace' (Roberts, 2000, p. 74). The nurses in our sample could have been sharing this traditional view of their profession, an attitude that was possibly reinforced in the developing countries. Perhaps their expectations about their career progression were lower than those of doctors, who regarded themselves as having 'a strong and unchallenged position in medical work' (Svennson, 1996). However, it is still unclear why doctors emerged as psychosocially vulnerable.

Alternatively, doctors' low well-being could be attributed to their inability to use CHC effectively. The 'deeply relational' (Shim, 2010, p. 4) aspect of their CHC was affected by work relationships and environment restrictions. The narratives of doctors who were EU citizens and worked in the NHS suggested that they felt constrained by what they saw as distorted doctor-patient interactions (in which patients requested 'happy pills'), working conditions in which overtime was expected, and competitive relationships with colleagues. These observations support previous findings that overseas-trained doctors are constantly more supervised than UK-trained doctors because they are not trusted to use their discretion and have low morale (Oikelome and Healy, 2007). It is highly possible that interactional difficulties, compounded by increased regulation of the medical profession (Case, 2011), lead doctors to feel frustrated and disappointed. Such observations echo Foucault's thesis that 'power is everywhere', diffused and embodied in discourse, knowledge and 'regimes of truth' such as the highly regulated English medical environment (Foucault, 1994, p. 194). Foucault points to a kind of 'disciplinary power' that can be observed in the administrative systems and welfare services. Their systems of surveillance and assessment no longer require force or violence, as people learn to discipline themselves and behave in the ways that are expected.

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

Conclusion

Overseas healthcare professionals are a significant group of workers in the UK. Although they represent a great opportunity for diversification and multiculturalism

of healthcare provision, their multifaceted professional experiences and needs cannot be fully understood by applying existing theories of acculturation and cultural capital. Instead, an integrative, more specific approach, such as CHC, is needed. Our analysis supports an integration of macro- and micro-perspectives (Larsen *et al*, 2005). Having established the usefulness and applicability of the CHC framework, we conclude with some recommendations for improving the professional experiences of overseas doctors and nurses.

The work-related experiences of highly skilled workforces such as healthcare professionals are more favourable than those of unskilled workforces because of their qualifications and bargaining power (Wickramasekara, 2002, p. 3). This distinction should not divert attention from the vulnerability of overseas professionals who are trying to integrate into the healthcare sector (Bach, 2003). Our findings highlight the importance of removing barriers which obstruct their entry into the workforce and hamper their career progression. This will benefit not only individual professionals but also communities that require a diverse workforce to meet local healthcare needs. In the current UK context, migration is not only greater in terms of numbers in comparison with previous decades, but is also more diverse. This diversification of migrant populations is beginning to have an impact on what diversity means and how to take advantage of it (Kyambi, 2007). Policies that encourage highly skilled migrants' socioeconomic inclusion are needed now as never before.

It is also necessary to attend to the professional advancement of overseas doctors and nurses who are fully employed. Maintaining one's professional identity is important for highly skilled migrants in modern western societies (Liversage, 2009). Continuing professional development is crucial for their well-being (Dawson *et al*, 2009). This is especially the case for staff working in the NHS, where changes in terms of managerial processes can produce shifts in the balance of power between healthcare staff and managers, with the locus of control having clearly shifted towards the latter (Sheaff, 2008, p. 16). Maintaining sensitivity to interpersonal dynamics is crucial in both clinical and interprofessional encounters. Attending to this will again benefit not only individual doctors and nurses but also the organisations and the communities that they serve. Further research drawing on CHC theory and utilising larger, more ethnically diverse samples of overseas healthcare professionals is required to provide a deeper understanding of how to use these populations' potential for the delivery of healthcare in the best possible way.

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CONFLICTS OF INTEREST

None.

