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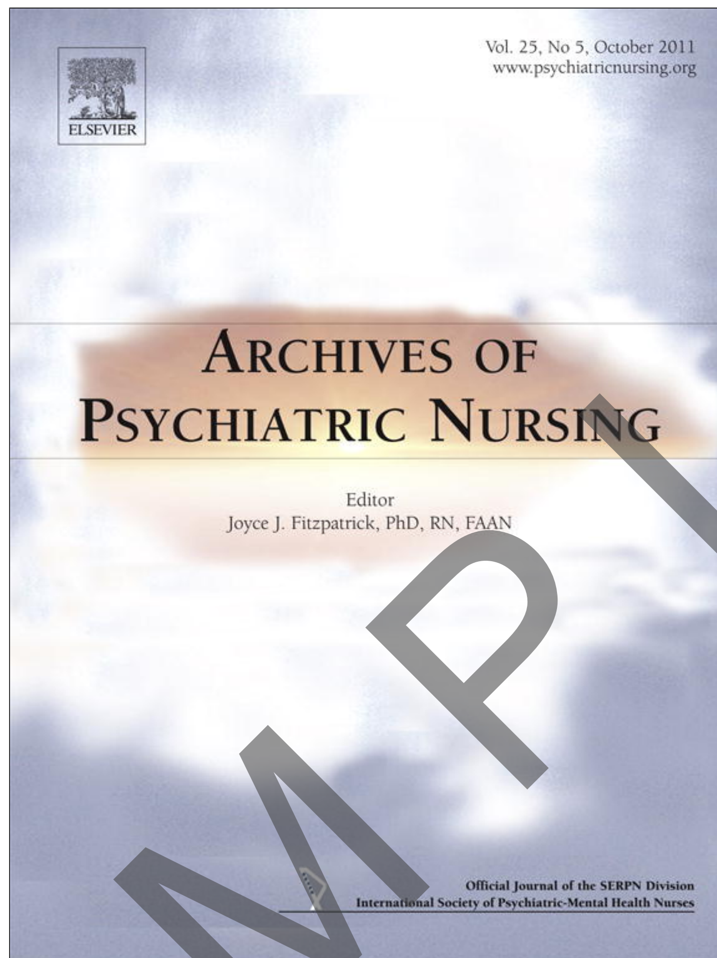

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Nurse Migration in an Increasingly Interconnected World: The Case for Internationalization of Regulation of Nurses and Nursing Regulatory Bodies

John R. Cutcliffe, Renay Bajkay, Stu Forster, Rudy Small, and Rodger Travale

Psychiatric/Mental Health nursing has a long history of professional self-regulation; nevertheless, interest in how governments protect consumers of health care from poor or dangerous practice(s) is on the increase. Correspondingly, there have been calls, in several parts of the world, for greater watchfulness and due diligence from regulatory bodies. Mindful of the concept of globalization and the unequivocal data regarding the significant increase in the migration of nurses, it is difficult to ignore/deny the reality of an increasingly mobile and connected international nursing workforce. However, the extant literature also indicates the existence of significant disparities between countries and even states/provinces within countries as to the enforcement of professional regulation. What this means is that decisions made by one regulatory body can have a direct impact on the standard(s) of nursing quality and practice in a country on the opposite side of the world. As a result, the authors attempt to advance the debate that there is a clear need to reconcile these positions, and they introduce the argument for the creation of an international oversight body. Using case study material, the relevant theoretical and policy literature in this area (such as it is), and by drawing on examples of analogous oversight bodies from other areas, we draw attention to the need to create a genuinely international body for the oversight of nurse regulation.
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MUCH TO ITS credit, in many parts of the world, nursing has a long history of regulation through legislation. Pearson (2005) points out, for example, how nursing and medicine were the first disciplines/professions[1] to have entry to their ranks regulated through legislation in the very early 20th century. Such nursing regulatory bodies, in many parts of the world, make clear reference to their duty to protect the public. See, for example, the United Kingdom's Nursing and Midwifery Council's (NMC) standards of conduct performance and ethics for nurses and midwives (NMC, 2008), in which the protection of the public is enshrined, or the College of Registered Psychiatric Nurses of British Columbia (College of Registered Nurses of British Columbia, recovered 2010). Bound up with or tied to the duty to protect the public are a range of oversight mechanisms and practices such as "fitness for practice," "continuing education," "postregistration education and practice." As a result, many nursing regulatory

[1] The authors recognize that the debate as to whether nursing is a profession (and more importantly, should even aspire to be a profession) remains unresolved. We therefore conservatively use the term *discipline*.

The authors wish to express their sincere thanks to the British Journal of Nursing (Mark Allen Publishing, UK) for their kind permission for the first author to reproduce data and text from the paper Cutcliffe and Yarbrough, 2007).
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bodies mandate that nurses must engage in these mechanisms and practices as a means to stay current (and safe) and simultaneously enable them to maintain their current registration.

Interestingly, Pearson (2005) has highlighted that community interest in how governments protect consumers of health care from poor or dangerous practice(s) is on the increase. Austin (2010) reports how there has been a dramatic increase in the incidence of nursing malpractice over the last decade, and even a cursory examination of various mass media outputs will show that reports of poor, inadequate, unethical, and/or dangerous nursing (and/or medical) practice are reported in all parts of the world. Perhaps, it should come as no surprise then that there have been calls, in several parts of the world,[2] for greater watchfulness and due diligence regarding both the educational/clinical preparation of nurses and their resultant practice (Cutcliffe & Forster, 2010; Pearson, 2005).

Alongside the changes in regulation, sociological study on a worldwide scale since the 1980s has witnessed a complex series of economic, social, technological, and political changes seen as increasing interdependence and interaction between people and companies in disparate locations, and these changes have been encapsulated under the umbrella term *globalization* (Levin Institute, recovered 2010). Although conveying different meanings to different groups, there appears to be widespread consensus that globalization does exist, and this creates associated concepts such as the much touted phrases "global community" and "global health." It also creates the possibility for phenomena to be considered within the context of globalization. One such phenomenon is that of the documented movement of professionals or "the workforce" from one part of the world to another (Cutcliffe & Yarbrough, 2007a, 2007b).

Accordingly, this article considers the issue of nursing regulation within the contexts of globalization and psychiatric/mental health (P/MH) nursing. It draws attention to the increasingly mobile and connected international nursing workforce and yet the existence of significant disparity between countries and even states/provinces within countries as to the enforcement of professional regulation (see, for example, Blythe & Baumann, 2009).

[2] And thus it is an international problem.

The article proceeds to introduce the argument that these positions are irreconcilable; if we are going to ensure public safely through regulation and there is an increasingly mobile nursing workforce, then there has to be more consistency in regulation across provinces, states, and countries. The authors argue that there should be an international oversight body.[3] To illustrate the need for this, we offer a case study. Although all the facts stated are true and accurate, in the interests of confidentiality, all names of people, institutions, and so on, have been changed. The article concludes by highlighting the work that has been undertaken so far in creating analogous international oversight bodies in other fields and joins with others who have proffered constructive suggestions for addressing the documented problems regarding international nursing regulation.

THE INCREASE IN NURSE IMMIGRATION

The World Health Organization (WHO, 2004) has drawn attention to the international shortage of nurses and the increasing health care burden in many countries. Evidence provided by numerous international sources (see, for example, International Council of Nurses [ICN], 2004a, 2004b, 2005) shows the corresponding increase in nurse migration as a result (at least in part) of this shortage. Although the most prominent migration pattern is from "underdeveloped" to "developed" countries, there is also migration within or between so-called developed nations. Consequently, it is necessary to review some data pertaining to nurse migration in a number of countries.

The United Kingdom Example

The number of nurses entering the UK register who had their preregistration educational preparation in a country other than the UK is increasing. Data displayed in Table 1 and Figure 1 indicate a sharp rise in recent overseas admissions to the NMC (2004, 2005) register, a slight drop during the last 2 years, but a clear overall trend indicating significant increases. These data refer to 7 years of overseas registration statistics for the "Top 25" source countries for nurses and midwives being admitted

[3] Just as there is in law, economics, automotive manufacturing, and we draw on these examples in order to show how analogous international "regulatory" bodies can work.

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Table 1. Initial (overseas) Admissions to the NMC Register by Year

Year	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005
Overseas registrants	3,621	5,945	8,403	15,064	12,730	14,122	11,471

Note. Source: "The Nursing and Midwifery Council—Statistical Analysis of the Register 2005."

to the register. These data do not include nurses and midwives trained within the European Union.

However, it is clear that significant numbers of nurses are migrating from eastern and African countries to the United Kingdom. Indeed, India has become the number one source country after a run of 4 years, which saw the Philippines in that role. Data for 2005 show a 22% rise in admissions from the Indian subcontinent. Further, these data also indicate that, in 2005, 40% of new entrants were foreign recruits. This situation has led the Royal College of Nursing (2006) to declare that recruitment of overseas nurses had become a vital way to boost the flagging numbers of nurses in the UK.

The United States of America Example

According to Paval's (2004) analysis of the health care workers shortage and the potential of immigration policy, foreign-born and foreign-educated professionals play an important role in the delivery of health care in the United States. Indeed, Nash and Gremillion (2004) use verbiage implying that providers are "forced" to recruit clinical staff worldwide to meet the enormous demands resulting from the current shortage of health care workers in the United States. Recent data show that 1.1 million immigrants account for 13% of health care providers in the United States. Further, the foreign-born account for 25.2% of all physicians; 17% of nursing, psychiatric, and home health aides; 15.8% of clinical laboratory technicians; 14.8% of pharmacists; and 11.5% of RNs.

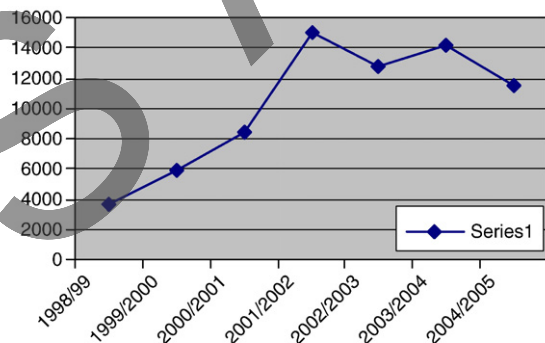

Fig 1. Initial overseas admissions to the NMC register by year.

Furthermore, during the 1990s, immigrant employment grew by 114% in home health care, 72% in nursing care facilities, and 32% in hospitals. The analysis concluded that foreign-born professionals play a crucial role in filling severe shortages within the two largest health care occupations: physicians and nurses.

Interestingly, however, within the United States, concerns regarding internationally prepared nurses (and registration examination pass rates) led the National Council of State Boards of Nursing (NCSBN, recovered 2010) to issue a position statement on international nurse immigration. Their data indicated that in 2001, 47% of internationally educated RNs taking the NCLEX-RN registration examination for the first time passed; this compared with 84% of their U.S. counterparts. Similar disparities were also found in registration examination pass rates for vocational nurses and licensed practical nurses. These examination results led the NCSBN (recovered 2010) to state:

> Safety of the nation's public warrants that all international and domestic nurses be equally qualified to safely practice nursing under the auspices of the laws and regulations of the state of intended practice.

The Canadian Example

Although the current situation in Canada indicates less marked or dramatic increases than the UK or the United States, there are, nevertheless, trends showing an increase in foreign-educated nurses in certain parts of Canada. The number of nurses trained outside of Canada has increased slightly in some provinces and territories, notably British Columbia (BC), Ontario, Saskatchewan, and the Northwest Territories. According to the Canadian Institutes for Health Information (2006), foreign-trained RNs comprised 7.3% (17,633) of the RN workforce in 2003. Most of these were from the Philippines (26%), the United Kingdom (26%), the United States (7%), and Hong Kong (6%). Some provinces rely more on nurses trained elsewhere. Between foreign graduates and graduates from other Canadian jurisdictions, almost

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40% (39.5%) of BC's regulated nursing workforce did not graduate in BC.

The data regarding nurse migration then indicate unequivocally the reality that more and more nurses will be found to be practicing in a country (state, or province) that is not where they undertook their preregistration nurse preparation nor indeed where they "sat" their entry-level nursing registration examinations. What this also unquestionably means is that decisions made by one regulatory body can have a direct impact on the standard(s) of nursing quality and practice in a country on the opposite side of the world. Although this may appear to be a "distant" or "far off" problem, the following case study presented illustrates that this issue has a proximity much closer than one might think.

INTERNATIONAL POLICY TRENDS IN REGULATION: OVERVIEW OF THE BACKGROUND LITERATURE

Far from being esoteric musings, according to Madden-Styles (2005)[4], the role of regulation is critical to what she describes as "profession building." A number of authors have highlighted how there appears to be increased concern regarding protection of the public, and according to Tee and Jowett (2009), this has produced an increase in significance in the role of health care professions regulatory bodies. In 2005, the ICN and the WHO issued a position statement that reiterated how both organizations are committed to supporting and advocating for a nursing profession that is regulated by nurses and focused on providing access to safe, competent care for all members of society. In the same position article, they acknowledge some of the facts already presented in this article, namely, that

> Certain aspects of globalisation have intensified the scrutiny of professional regulation, both nationally and internationally. These include the increasing mobility of professionals; growing trade in health services; ongoing health sector reform and a greater public interest in the quality of health services.

Similar remarks have been offered by Madden-Styles (2005, p. 81), who states that, the internationalization of regulation is occurring as a result of trade agreements, nursing shortages, and other forces.

[4]One of the leading American figures in this area.

This documented shift in regulation as a result of (at least in part) the increased attention to the internationalization of regulation is not exclusive to nursing, with other health care professions (or disciplines) also drawing attention to this trend (see, for example, Baker, 2006; Pearson, Fitzgerald, Walsh, & Borbasi, 2002; Weinstein, 2009). Perhaps, not surprisingly, these developments have stimulated international bodies such as the ICN and the WHO to review their position and on the intent, scope, and nature of professional regulation for nursing.

That limited amount of work that has already been undertaken to examine similarities and differences between professional regulatory bodies indicates that they appear to share broad, underpinning "pillars" or "core principles" but also have significant disparities in the detail of these pillars (Pearson, 2005). For example, professional regulatory bodies for nursing inevitably refer to the following: (a) regulations are underpinned by statute, (b) importance of (requirement for) self-regulation, (c) scope of professional practice, (d) standards of education, (e) standards of ethical practice, (f) competent practice and maintaining competence, and (g) systems of accountability. Nevertheless, the detail or criteria pertaining to these pillars vary from regulatory body to regulatory body. Accordingly, the ICN (2005) made the argument that

> In the nursing profession's future, new, evolving or mature, regulatory systems will grow from the application of core principles.

CASE STUDY—EVIDENCE OF SLIPPAGE IN NURSING REGULATION?

In keeping with Tee and Jowett's (2009) remarks regarding the significance of the role of health care professions' regulatory bodies and the case for greater international regulation, we wish to offer a case study that underscores this argument. The following case study is composed of real events and decisions, although in the interests of confidentiality, all names and places have been altered. However, the substantive facts remain unchanged and accurate (further details please refer to the HPRB website, recovered 2011).

Recently, a student in a psychiatric nursing program with a private (for-profit) college was suspended for a combination of ethical, clinical

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competency-based, and professional conduct-related concerns and several violations of the institution's academic policies. Following a lengthy and thorough investigation by the program's then "program coordinator,"[5] the decision was made that the student had to be dismissed from the program. In accordance with the program policies and procedures,[6] the student requested a Decanal-level appeal of the decision by the then Dean. After another thorough review of all of the evidence and relevant policies, the Dean upheld the decision to dismiss. The extant student policies indicated that this Decanal-level decision was the final level of appeal within the institution; however the student still retained the option of appealing the Decanal-level decision through the accreditation body of that school or a third party (e.g., a lawyer). Not long after this event, the leadership of the program changed, the former program coordinator and Dean moved to other institutions, and a new program coordinator was hired.

Subsequent to this change of leadership, one of the course instructors noted that the student who had been expelled was still accessing some online course material and participating in lessons. This was also noted by several other students who expressed surprise at seeing this student engaging in the course. The instructor subsequently e-mailed the newly appointed program coordinator and informed her that a student who had been expelled was accessing a course in the program. The program coordinator responded claiming that the decision to dismiss had been overturned by an investigation through the accreditation body for the school. The instructor contacted the accreditation body for the school who eventually responded and informed him that this information was not accurate; they had issued no such edict to readmit the student. In accordance with his professional code of conduct, the instructor appropriately contacted his professional registration body, informed them about the improper readmission of a previously dismissed student, and the misinformation provided by the program coordinator. The professional registration body refused to investigate the matter or take any action whatsoever. (Up to the time of writing and revising this article.)

[5]Which included reviewing written testimony provided by three experienced Registered Psychiatric Nurses and one RN.

[6]Which had all been provided in the Student Handbook.

DISCUSSION OF THE CASE STUDY—MATTERS ARISING

As the case study illustrates, just as P/MH nurses have a mandated duty to guard against unethical practice in their peers, the same duty extends to the practice of nurses within regulatory bodies. Otherwise, an argument can be made that we are holding the nurses that work within regulatory bodies to a different set of professional and ethical standards than we do for nurses in clinical practice, education, administrative, or research positions. Indeed, the question can be posed: Why would the P/MH nursing community assume that simply because a nurse works within a regulatory body that he or she no longer requires oversight?

In a perfect world, no oversight of the practice of P/MH nurses would be necessary; however, the accumulated evidence over the years leads us to the inescapable conclusion that such oversight and regulation are required, and thus, an uncomfortable truth has to be acknowledged that we are all imperfect individuals.[7] The regulatory bodies are at least in part composed of the same imperfect nurses that require oversight in other practice settings. Yet, as self-governing bodies, the opportunity exists for slippage within the regulatory body themselves; especially when potential conflicts of interest arise. Further, as the public outcry and dissatisfaction regarding the outcomes of enquiries from other health-related disciplines indicate (UKwirednews, recovered 2010), "circling the wagons" and placing the interests of the professional body above that of the public can occur. Accordingly, P/MH nurses could lead the way in this issue by encouraging the creation of an international oversight body for all nursing regulatory bodies.

As alluded to above, an argument has been made that one element of the public's increasing interest regarding how governments protect consumers from poor or dangerous practice stems from the public's discontent with how some professional regulatory bodies have conducted their intradisciplinary inquiries and investigations (see, for example, Irvine, 1997; Klein, 1998). When there is a sense or the "optic" of cover-up or the professional group placing

[7]See, for example, the monthly reports of nursing regulatory hearings published and made available to the public on the United Kingdom Nursing Midwifery Council Web site, http://www.nmc-uk.org/Hearings/Hearings-and-outcomes/June-2010/.

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the interests of its membership over that of the well-being of the public,[8] then the increase in public distrust of such organizations is understandable, hence the calls for additional transparency.

A significant contribution and effort to advance these issues can be located in Baker's (2006) fine scholarly paper. Baker reports how the UK General Medical Council (GMC) has produced some tables to help inform the public on what is acceptable, unacceptable, and seriously unacceptable medical practice (Dyer, 2005). For example, Baker (2005, p231) captures an example of seriously unacceptable practice, whereby the doctor deliberately omits important information from one or more reports or enters untruthful information.

Baker (2005, p231) continues that the proposed action or response to such an event, according to the GMC, is that the doctor's fitness for practice should be considered.

Although acknowledging that creating and introducing such guidelines would be problematic, the authors of this current article welcome and support the developments advocated by Baker (and the GMC) and contend that such directives might prevent idiosyncratic and "curious" decisions being made by some nursing regulatory bodies. Any decision made by a regulatory body can then be compared with the examples of acceptable/unacceptable/seriously unacceptable practice and their corresponding required responses. As Baker (2005) so eloquently captures the essence of the problem,

> If the regulators are not clear about what is unacceptable, how can patients decide when a doctor should be reported for investigation, and what confidence can they have in medical regulation? (Baker, 2006, p. 230).

In addition to moving toward greater commonality (more standardized?) in decisions from regulatory bodies, the authors would advocate for a second critical development, namely, that of the creation of a genuinely international oversight body. The ICN/WHO have constructed a similar argument when they argue that

> effective communication and diffusion of the vision for professional self-regulation, together with increased congruence and coherence in the development of local, national and international regulatory systems, facilitates coordinated responses to regulatory challenges and emerging issues in the wider international regulatory arena. (ICN, 2005).

An International Regulatory Oversight Body for Nursing

To help make the case for such a genuinely international oversight body for nursing regulatory bodies, there is merit in examining if similar or analogous international bodies exist in other fields. Perhaps, such an example, is that of the Public Company Accounting Oversight Board (PCAOB, recovered 2010). According to the information on their Web site, the PCAOB oversees the auditors of public companies:

> in order to protect investors and the public interest by promoting informative, fair, and independent audit reports. (PCAOB, recovered 2010).

The practice of the PCAOB is underpinned by recent legislation (just as a professional nursing regulatory body is). It is noteworthy that this legislation requires that auditors of United States public companies be subject to

> external and independent oversight for the first time in history. Previously, the profession was self-regulated.

Moreover, information on the PCAOB Web site highlights that this body has a genuine, international mandate whereby any non-U.S. public accounting firm that audits or assists in the audit of U.S. issuers are subject to oversight by the PCAOB. In other words, the PCAOB has oversight of more than 900 non-U.S. audit firms based in more than 85 countries. As a result,

> non-U.S. registered firms are subject to PCAOB inspections in the same manner as U.S. firms. This often raises special considerations.

Interestingly, operationalizing reciprocity and internationality, the PCAOB assists non-U.S. regulators in their inspections and investigations of U.S. firms that are subject to dual oversight (PCAOB, 2010), which leads the PCAOB to state,

> Cross-border cooperation is fundamental to strengthening audit quality globally, and is therefore a priority for the PCAOB. The Board maintains bilateral contact with many countries around the world.

[8] And the authors would argue that there is evidence of this in the case study (see HPRB, 2011).

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A second example for comparison is the International Automotive Task Force (IATF, recovered 2010). According to the information on their Web site, the IATF is a group of automotive manufacturers/trade associations formed to provide improved quality products to automotive customers worldwide. The IATF seeks to develop a consensus regarding international fundamental quality system requirements. Clearly, safety standards and thus (indirectly) the protection of the public (interest) are concerns for the IATF. As a result, a stated goal of the IATF is

> To develop policies and procedures for the common IATF third party registration scheme to ensure consistency worldwide. (IATF, recovered 2010)

In this example, consumers can find reassurance that the product or service(s) they receive in their country, assuming formal association with the IATF, has met international safety standards. The authors find it very interesting that these laudable efforts at oversight have been created to safeguard the public and/or prevent financial impropriety. Yet, where the potential risks to a person's holistic safety and well-being are very real (i.e., as a recipient of formal nursing care), currently no such international oversight bodies exist.

The authors would posit that this may well be the case, at least in part, because some regulatory bodies have yet to come to terms with the fact that we are all operating in a "shrinking world," that we are all connected and part of the global village/community. It is not surprising that nursing regulatory bodies with a more "provincial" perspective (i.e., restricted or limited to local, state/province wide mattes) have paid less attention to global migration trends, increasing internationality, and the concept of an interconnected nursing community (we would argue internationally shared responsibility for the conduct of their members) (Crigger, Brannigan, & Baird, 2006).

In closing this section, the authors offer some preliminary suggestions for what the proposed international nursing regulation oversight body look like, and the authors offer this in the hope that other nurses from various parts of the world will join in and advance this debate (or make refutations of the position advocated by the authors). It seems logical that the international body will require representation that reflects a truly international composition of membership. Given the attention to possible ethical issues, the inclusion of an ethicist would be necessary; as would representation from the four domains of nursing practice: clinical, education, research, and administration. Clearly, the body would require members of the public and, importantly, mental health service user movement representation. Lastly, we would argue that this international body ought to logically be associated with the ICN and thus include a senior figure from that organization.

CONCLUDING REMARKS

In conclusion, the WHO (2004) has drawn attention to the international shortage of nurses and the increasing health care burden in many countries. The data regarding nurse migration clearly indicate that nurses will be practicing in a country (state or province) where they did not sit their entry-level examinations. Therefore, this unquestionably means that decisions made by one regulatory body can have a direct impact on the standard(s) of nursing quality and care in another country.

P/MH nursing has a long history of professional self-regulation. Such nursing regulatory bodies, in many parts of the world, make clear reference to their duty to protect the public. However, the authors would argue as evidenced in the case study, it seems that in some cases at least, the regulatory bodies' purported attempts to safeguard the public have limited legitimacy or credibility. However, the extant literature also indicates the existence of significant disparities between countries and even states/provinces within countries as to the enforcement of professional regulation. Therefore, if we are going to ensure the public safety through self-regulation and being cognizant of the increasingly mobile nursing workforce, then there has to be more consistency in regulation across provinces, states, and countries. Examination of literature emanating from the international nursing academe (and not restricted to a few countries) shows that there is general agreement that these issues need to be addressed.

When there is a sense or the optic of cover-up or the professional group placing the interests of its membership above the safety of the public, which the authors would argue is indicated in this case study, then the increase in public distrust of such organizations is understandable, hence the calls for additional transparency.

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In conclusion, the authors argue that there should be an international oversight body, and although we add our own voice and support to those already highlighting these issues, we recognize that because of the global magnitude and the inherent complexity of the issues, decisive solutions and actions will not be easy and will require the cooperation of governments and organizations to bring about needed changes.

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Include/Notes

Regulatory goals balance national regulation with ethical national and international trade imperatives, and an overarching structure is in place to assist international cooperation and collaboration among regulatory bodies.

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Nursing is appropriately positioned in the global trade and services agenda to shape acceptable and feasible criteria for mutual recognition processes, portability of qualifications and other mechanisms to facilitate movement of nurses and professional services.

Ongoing Contribution of ICN and WHO

ICN and WHO will continue to work together and with all relevant stakeholders to ensure that the regulation of the nursing profession provides a framework within which patient safety can be assured and which enables nurses to respond rapidly and flexibly to changing health needs.

ICN/WHO Statement March 2005

Our Mission

The mission of the College of Registered Psychiatric Nurses of British Columbia is to serve and protect the public. The College of Registered Psychiatric Nurses of British Columbia is responsible, through self-regulation, for assuring a safe, accountable, and ethical level of psychiatric nursing practice. The College is accountable to the public through Regulation.

Our Mandate

The Health Professions Act entrusts CRPNBC with the responsibility for establishing, monitoring, and enforcing standards of education and qualifications for registration; developing and promoting high psychiatric nursing practice standards and the maintenance of nurses' competence; monitoring and enforcing professional ethics; and reducing incompetent, impaired, or unethical nursing practice.In a "nutshell," the mandate of the College is to promote good nursing practice, prevent undesirable practice, and intervene when practice is unacceptable.CRPNBC is committed to helping registered psychiatric nurses carry out this mandate and, by so doing, maintaining public trust in the profession.

http://www.crpnbc.ca/mission.html.

The College is responsible, through self-regulation, for assuring a safe, accountable, and ethical level of psychiatric nursing practice and it is accountable to the public through government regulation under the "Registered Psychiatric Nursing Regulation," which defines the acts registrants of the College may perform. This dual level of accountability ensures the public that those individuals practicing as "RPNs" and "LGPNs" meet the basic educational and practice requirements, are "safe to practice," and subscribe to the recognized standards and ethics of the profession of psychiatric nursing in British Columbia.

http://www.crpnbc.ca/history.html.

"Although prompted by a serious event in the UK, this approach should be considered by regulatory bodies in other countries" (Baker, 2006, p. 232).

SAMPLE