

## **“I am kind of in stalemate”. The experiences of non-EU migrant doctors in Ireland**

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## Chapter 10

# **“I am kind of in stalemate”. The experiences of non-EU migrant doctors in Ireland**

*Niamh Humphries, Posy Bidwell, Ella Tyrrell, Ruairi Brugha, Steve Thomas  
and Charles Normand*

### **10.1 Introduction**

Although historically a source country for health workers, Ireland began actively recruiting health workers internationally in the early 2000s and is becoming the OECD country with the second highest dependency on foreign-trained doctors (OECD, 2010) and the highest dependency on foreign-trained nurses (OECD, 2010). Between 2000 and 2009, 40% of all newly registered nurses in Ireland were from outside the EU (Humphries, Brugha & McGee, 2009). The number of foreign-trained doctors registered on the Irish Medical Register<sup>1</sup> increased by 259% between 2000 and 2010 (Bidwell et al., 2013).

Ireland's increasing dependency on a migrant health workforce drawn largely from outside the EU can be understood in the context of Ireland's economic boom (circa 1995–2007), which enabled increased spending in the Irish health system and necessitated increased staffing levels. Despite recent health cutbacks, the overall numbers employed in the Irish public health system increased between 2002 and 2011 (Department of Health, 2011c): nurses by 8% (Department of Health, 2011b), non-consultant hospital doctors (NCHD)<sup>2</sup> by

<sup>1</sup> The Register of Medical Practitioners collects data on country of training rather than on nationality.

<sup>2</sup> Non-consultant hospital doctors is the term used in Ireland for junior hospital doctors. They may complete initial and higher specialist training to become specialist hospital doctors or GPs or they may work in service or stand-alone posts under the supervision of hospital specialists.

16% and consultants by 45% (Department of Health, 2011a). The expansion of the private health sector generated further demand for health workers.

Ireland's economic downturn had an immediate effect on the numbers of non-EU migrant nurses entering Ireland, with the numbers joining the Nursing Register slowing to a trickle from 2008 onwards, following the cessation of active international recruitment campaigns and the implementation of a public sector recruitment embargo (Humphries, Brugha & McGee, 2012). However, the number of non-EU migrant doctors joining the Register of Medical Practitioners (the Register) continued to increase despite the economic downturn. The number of foreign-trained doctors on the Register increased by 15% between 2007 and 2010 (Medical Council of Ireland, 2013). In 2011, Ireland launched international recruitment campaigns in India and Pakistan to recruit doctors into the public health system. It was noted by Ireland's Health Service Executive that the recruitment campaigns, while costly, would provide an opportunity to reduce overtime and agency costs (HSE, 2011). A total of 285 doctors were actively recruited into the Irish health system as a result of the campaigns (Cullen, 2012). By way of comparison, in 2003, there was an intake to Irish medical schools of 315 Irish/EU students (Medical Council of Ireland, 2003).

The active international recruitment of medical doctors was instigated in response to vacant NCHD posts throughout the public hospital system from 2010 onwards (Healy, 2012). The underlying reason for these vacancies is contested. The Health Service Executive attributes the vacancies to the worldwide shortage of doctors, while the Irish Medical Organisation (the national representative organization for doctors in Ireland) "has repeatedly highlighted that it is a retention rather than a recruitment issue" (Irish Medical Organisation, 2011b). The Irish Medical Organisation cites unattractive working conditions, long working hours, inability to access training and the lack of a structured career path for NCHDs as factors that have led to the attrition of doctors from the Irish health system (Irish Medical Organisation, 2011a).

Health information systems in Ireland do not record where non-EU migrant doctors work within the Irish health system. Recent figures from a variety of sources provide some indication of the workplaces of non-EU migrant doctors: of the 4 639 public sector NCHDs in Ireland in 2008, 55% were non-EU (Postgraduate Medical and Dental Board, 2008); 6% of Ireland's 2 245 consultants were non-Irish (EU and non-EU) as were 5% of Ireland's 2 500 GPs (FAS Training and Employment Authority, 2009). These figures suggest that the majority of Ireland's non-EU migrant doctors work in hospitals as NCHDs.

It is clear from the above figures that Ireland has increased its supply of medical doctors via the inward migration of non-EU doctors. Although international recruitment campaigns have played a part in recent years, most of this doctor migration has been initiated by the migrant doctors themselves. In recent years, Ireland has also sought to increase its supply of medical doctors by expanding medical training via the introduction of graduate entry medical programmes and also by increasing the number of medical places at undergraduate and postgraduate level available to EEA students (HSE MET, 2012): of the 831 medical students in the 2003 intake to Irish medical schools, 516 were non-EU students (Medical Council of Ireland, 2003). By 2011, the proportion of medical graduates from Irish medical schools from non-EU countries had fallen to 40% (Higher Education Authority, 2012). Although on paper it would appear that Ireland trains sufficient doctors to meet demand, many emigrate on graduation, particularly those medical students who originate from outside the EU. That non-EU students tend to leave Ireland after graduation is evident in the profile of the 2010 intern cohort, where 76% (411) of interns were EEA nationals and 24% (131) were non-EEA nationals (HSE MET, 2012). That non-EU students tend to leave Ireland after graduation is evident in the profile of the 2010 intern cohort where 76% (411) of interns were EEA nationals and 24% (131) were non-EEA nationals (HSE MET 2012). There were 350 non-EU medical graduates from Irish medical schools in 2010 (Higher Education Authority 2012). Substantial emigration post-graduation is apparent when the number of medical graduates from Irish medical schools in 2010 – 770 - (Higher Education Authority 2012) is compared with the 542 medical graduates who began their internship in 2010 (HSE MET 2012). In 2011, there were 738 medical graduates from Irish medical schools (Higher Education Authority, 2012) while 542 began their internships in the Irish health system in that year (HSE MET 2012).

While the large discrepancy between the number of graduates and number of internship places can be attributed to the departure of non-EU students who had graduated from Irish medical schools, further large-scale emigration of newly qualified doctors was reported in a recent career-tracking exercise which found "clear evidence that around half of the doctors who completed internship in Ireland in mid-2011, have left the country" (HSE MET, 2012). These data suggest large-scale emigration by Irish-trained doctors (including Irish, EU and non-EU nationals) within one to two years of graduation. Ireland is an illustration of an unusual pattern of health professional migration in that, although Ireland trains large numbers of non-EU medical students, the non-EU migrant doctors working in the Irish health system are, for the most part, *not* Irish trained. A 2007 audit of NCHD posts in Ireland revealed that 48%

(1 134) of respondent registrars and senior house officers had graduated from medical schools outside the EU (Royal College of Physicians, 2007).

To place the experiences of non-EU migrant doctors working in Ireland in context, some understanding of the training and medical career pathways in Ireland is necessary. The Republic of Ireland has six medical schools that provide a five or six year undergraduate training programme; five schools also offer a four year graduate entry programme (Thakore, 2009). Graduates of medical schools in Ireland must complete an internship of one year in order to practise medicine in Ireland (HSE MET, 2011). Successful completion of the internship will result in the award of a certificate of experience, which entitles the holder to apply to the Medical Council for registration (HSE MET, 2011). It also entitles the doctor to apply for initial specialist training, of two to four years in duration. While engaged in this training, doctors are ordinarily employed within the public health service at senior house officer level (HSE MET, 2011). Those who successfully complete their initial specialist training and are awarded a certificate of satisfactory completion of basic specialist training, can become a registrar and compete for a place on a higher specialist training programme, which may take a further two to four years to achieve (Irish Medical Organisation, 2011b). Doctors on the higher specialist training programmes are called specialist or senior registrars and remain at this level while completing their training, which can take up to seven years depending on the specialty (Irish Medical Organisation, 2011b). Doctors wishing to become GPs must complete the higher specialist training in general practice, which involves two years of hospital-based training followed by two years of training under the supervision of a GP trainer.

Following completion of higher specialist training and the awarding of a certificate of satisfactory completion of specialist training, doctors are eligible to apply to be formally registered on the relevant specialist division with the Medical Council. Such specialist registration is a requirement to hold a consultant post within the Irish public health service (HSE MET, 2011). However, completion of higher specialist training and the acquisition of specialist registration does not guarantee doctors a consultant post and it has been noted that “there is no further career progression available within the HSE [Health Service Executive] until such time as they are successful in securing a Consultant post via open competition” (Irish Medical Organisation, 2011b). GPs have an equally complex pathway to achieving a GP principal/partner post following completion of their training.

As of 2011, there were 4 751 NCHD posts within the public health system (Department of Health, 2011c), of which 1 278 were not required for participants in initial or higher specialist training (HSE MET, 2011). Recent

figures from the Health Service Executive note that 910 NCHDs hold service posts (HSE, 2011). Doctors occupying these posts are not part of the career pathway from internship through initial specialist training, higher specialist training to consultant level. They occupy hospital posts at senior house officer or registrar level, sometimes known as stand-alone posts, as the doctors occupying them work as hospital doctors but do so outside the structured training programme. No career progression is possible outside these structured training programmes. NCHDs in stand-alone posts, which are typically in smaller non-specialist hospitals, undertake many of the basic hospital clinical activities that are also done by those in training programmes. However, staffing, supervision and facilities in these hospitals usually fall well short of what would be required in a structured training programme. Recommendations for the phasing out of NCHD posts with limited training potential (Buttimer, 2006) and for all NCHDs to work in recognized, structured training posts (Royal College of Physicians, 2007) have yet to be implemented, despite recognition that having doctors occupy non-training posts has "serious implications for the provision of quality patient care and clinical decision making" (Hanly, 2003).

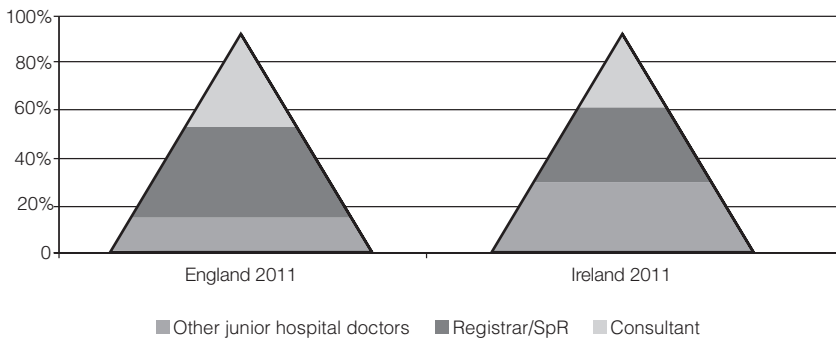
The latest available data (from 2007) suggest that non-Irish doctors are more likely to occupy stand-alone posts: a national audit found that 58% of doctors on basic specialist training programmes were Irish, whereas only 25% of doctors occupying stand-alone senior house officer posts were Irish (Royal College of Physicians, 2007). It has been clearly recognized for many years that holding a succession of stand-alone posts has negative career implications for doctors. Media reports on the experiences of non-EU doctors in Ireland suggests that they disproportionately occupy such "hard to fill" (OECD, 2008) or stand-alone posts that are unrecognized for training purposes. This has resulted in a sense of despair among non-EU doctors who feel that they "are being treated like disposable paper cups" (McDonald & Butler, 2006).

All NCHDs are temporary employees holding short-term contracts (Irish Medical Organisation, 2011b). For the most part, hospital doctors do not achieve permanent contracts until they achieve consultant grade. On completion of their training, GPs face similar uncertainty en route to achieving a GP principal/partner post. The career of an NCHD assumes constant rotation on a basis of three, six or twelve months through hospitals across the country (Irish Medical Organisation, 2011b). As a result, many NCHDs move regularly between hospitals and/or geographic locations, particularly in January and July when the new rounds of NCHD contracts are issued. This biannual national movement of doctors has been likened to wildebeest migrations, with the exception that "the great NCHD migration occurs in every direction" (Culliton, 2009). The rotation system continues until NCHDs achieve a

permanent post, usually at consultant level and not all doctors achieve this grade. The length of time spent as an NCHD can vary considerably depending on the individual doctor, the speciality chosen, access to training programmes and personal/family circumstances. A 2007 audit found that the average age of a senior house officer was 30 and the average age of a registrar was 38 (Royal College of Physicians, 2007). So, although the NCHD rotation system was designed for doctors in their early postgraduate years, it would appear that some doctors, particularly non-EU migrant doctors, spend long periods of time at NCHD level. An example recently cited was of a doctor who came to Ireland after completing his internship in Pakistan and became a consultant 22 years later (Doctor X, 2007).

Despite recent increases in the number of consultant posts, workforce planning has failed to align training places with the staffing needs of the Irish health system. The result is a career structure that has far more doctors in training than it has specialists (Tussing & Wren, 2006). When compared with the structure in England (Fig. 10.1), it would appear that the Irish system relies more heavily on trainee doctors than does the English system, where the ratio of consultant to junior doctors is greater and where a much higher proportion of junior doctor posts are in training posts. These weaknesses in the Irish health system are widely recognized: “too many trainees, too few trained staff – limited availability of senior clinical decision-making, shortages in particular specialities, bulges and bottlenecks in the career structure” (Forum on Medical Manpower, 2001). They have been clearly identified in policy documents from as early as 2001.

**Fig. 10.1** *Medical posts in England and Ireland 2011*



Sources: Department of Health, 2011c; Irish Medical Organisation, 2011b; UK Health and Social Care Information Centre, 2012.

Note: SpR, Specialist registrar.

## **10.2 Methods**

### **10.2.1 Study objectives**

Despite the major contribution of non-EU migrant doctors to the overall medical workforce in Ireland, little is known about them, their experiences of living and working in Ireland and their plans for the future. Minimal data are available to inform health workforce planners as to the specific roles of these professionals within the health system – such as where in the system they work, at what grades and in what specialist areas. Given the extent to which Ireland relies upon non-EU migrant doctors, their experiences and future migration intentions could have serious repercussions for health workforce planning in Ireland if the migration of non-EU doctors to Ireland was to cease and/or if large numbers of those non-EU doctors currently working in Ireland were to migrate onwards. The need to understand the motivations and future intentions of the non-EU migrant health workforce was highlighted by recent research on non-EU migrant nurses in Ireland, which revealed that many non-EU migrant nurses intended to migrate from Ireland, largely because of poor residency and citizenship entitlements (Humphries, Brugha & McGee, 2009, 2012). This chapter draws on qualitative interviews with non-EU migrant doctors in Ireland and seeks to shed light on the factors influencing their migration decisions: their motivations for coming to Ireland, their reasons for staying in Ireland and the factors that might influence their decisions to leave Ireland, either to return home or to migrate onwards.

### **10.2.2 Study design**

Ethics approval for the qualitative research was received from Trinity College Dublin in 2011. In-depth qualitative interviews were conducted with 35 non-EU migrant doctors between November 2011 and March 2012. Interviews were conducted by the research team (PB and NH) and lasted for an average of 35 minutes. Thirty-three interviews were conducted in person and two were conducted over the telephone. Interviews covered a range of topics including respondents' careers and qualifications prior to migration, the decision to migrate, reasons for migrating to Ireland, experiences of working and living in Ireland, ethical issues around health worker migration and the factors influencing their decision to stay and/or their decision to leave Ireland. All interviews were audio-recorded and transcribed in full. Data management and analysis were facilitated by the use of MaxQDA (software for the analysis of qualitative data).

A variety of methods were used to recruit non-EU migrant doctors in Ireland to the study in order to ensure the inclusion of a heterogeneous mix of grades,



nationalities, countries of training and arrival years. The recruitment process involved using the Irish Medical Directory (2010) to access non-EU migrant consultants and invite them to participate in the research. An advertisement was placed in the *Irish Medical Times* seeking respondents and an NGO working with immigrants in Ireland also advertised the research on behalf of the research team. Respondents who had taken part in a previous academic study on non-EU migrant doctors in Ireland were invited to take part. Snowball sampling was used throughout the recruitment process. This is a process of chain referral whereby respondents and gatekeepers are used to refer the researcher to other potential respondents (Atkinson & Flint, 2001; Humphries, Brugha & McGee, 2009).

The complexity of doctor migration to Ireland is reflected in the sample. Although all respondents could be categorized as non-EU migrant doctors, not all had trained in non-EU countries: some had trained in Ireland or elsewhere in the EU. Some respondents had come to Ireland upon graduation; others had come to Ireland as specialists. Not all held non-EU citizenship at the time of the interview; some were naturalized Irish citizens while others held dual nationalities. Unpacking the complexity within the non-EU migrant doctor workforce is an important task for health workforce planners in seeking to quantify the non-EU migrant doctor workforce accurately and assess its contribution to the Irish health system. Some non-EU migrant doctors may be rendered “invisible” within the available data sets because they were Irish trained or because they have acquired Irish or EU citizenship.

### 10.3 Results

Of the 35 non-EU migrant doctors interviewed, 31 were currently working as hospital doctors in Ireland; two had registered with the Medical Council of Ireland and were soon to begin working; one was in the process of registering, and one had recently worked as a hospital doctor in Ireland but had since migrated from Ireland. There were 12 women and 23 men. The largest numbers of participants were from Pakistan (10) and Sudan (9), with participants also from India, Nigeria and Iraq and the remainder from eight different non-EU countries. In terms of grades, most respondents were working as NCHDs, with 25 respondents working at senior house officer, registrar or specialist registrar grades; seven worked as hospital consultants. Most respondents (29/35) had come to Ireland since 2000 while the remainder had arrived during the 1980s and 1990s.

### **10.3.1 Motivations for coming to Ireland**

The primary reason cited by doctor respondents for migrating to Ireland was in order to obtain postgraduate training and to progress their careers (21/35).

I came here for two things: experience and qualification. (Doctor 13)

the fundamental objective to leave [country] and go abroad wasn't looking for easy life or making money, it was for to excel further in our chosen fields (Doctor 2).

Some reported having been dissatisfied with their access to training in their home countries or in other countries to which they had migrated previously. Only seven respondents mentioned either salary levels or a desire for a better life as motivations for their migration to Ireland. These findings immediately challenge the stereotype of a non-EU doctor migrating to Ireland primarily for financial gain. The findings already illustrate two very different perspectives on doctor migration: most respondent doctors came to Ireland to access training and progress their careers, whereas the Irish health system recruits non-EU migrant doctors to fill service posts within the health system (RTE News, 2011). The Health Service Executive (HSE, 2011) explained that active recruitment campaigns were initiated in a 2011 response to difficulties faced by the Health Service Executive in "seeking to attract the quantum and quality of doctors to service related posts to run safe services".

Ireland was frequently selected as a migration destination because of its proximity and perceived similarity to the United Kingdom. Half of all respondents (18/35) had been actively considering migration to the United Kingdom when they decided to come to Ireland instead, sometimes simply because they perceived the registration process to be more straightforward.

Medical Council registration system was a bit quicker than GMC [UK General Medical Council] registration at that time. (Doctor 33).

Other respondents made a "last minute" switch to Ireland in response to changes in United Kingdom regulations regarding access to training for non-EU migrant doctors.

I was thinking about go to the UK, but the UK then changed the policy for the non-EU doctors, that ...non-EU doctors might not get the training posts ... I thought there would be no career progression. So then I decided ... to come to Ireland. (Doctor 7).

The proximity of Ireland to the United Kingdom motivated some respondents to migrate to Ireland, particularly those with family/friends in the United Kingdom, while others noted the similarity of the United Kingdom and Irish

medical systems. Other respondents came to Ireland to reunite with spouses, colleagues or friends who had previously migrated to Ireland. Three participants noted that their migration to Ireland had been prompted by political upheaval in their countries of origin.

### ***10.3.2 Factors influencing the decision to stay***

Only nine respondents planned to stay in Ireland and of those, five were working at consultant grade. Several respondents noted that they felt settled in Ireland and this prompted their decision to remain in Ireland, particularly for those who had children.

I'm very well settled. I think our life is very comfortable. And, well I'm enjoying our presence in this part of the world. Our children are having a good education. We are doing satisfactory job, we are earning reasonable money. (Doctor 15).

I feel very happy here I had a good working conditions. I was fortunate you know, most of the time, I had a good experience I love to work in here. (Doctor 7).

For some, the decision to remain was something that they had not intended; they had planned to remain for five or ten years and return home, but then remained for family reasons.

Going back was looking difficult then I decided to stay when the children go the secondary school, it is very difficult to move then. (Doctor 19).

Other more recent migrants were determined to remain in Ireland until they had achieved the training or career progression they had migrated to Ireland to achieve:

going back home without this exam ... it will not help me at all. So I have to pass the exam and then go there. (Doctor 29).

However, for the majority of respondents, the decision to remain permanently in Ireland had not been made. Most were uncertain of their future, waiting to hear the outcome of a recent interview or training application before deciding whether or not they would remain. Although interested in remaining in Ireland, these respondents felt that their onward migration was almost inevitable.

if something changes I wouldn't ... look for another country. I would stay in Ireland. (Doctor 33).

I'm not really positive that I will get the post. But I'm prepared at this stage to move on. When I finish my fellowship exams I can go ... you cannot get older in a registrar post. So I need consultant post. (Doctor 14).

Even those respondents interested in remaining in Ireland appeared resigned to the fact that they would have to leave. Factors such as career progression and the availability of training opportunities featured strongly in those decisions.

### **10.3.3 Factors influencing the decision to leave**

Respondents' motivations for leaving Ireland hinged largely on career progression and the perceived lack of opportunities for non-EU migrant doctors to access training or progress their careers in Ireland. They spoke of not progressing (Doctor 33), of being stuck (Doctor 17) and of wasting time (Doctor 21) in Ireland. Each of these issues related to the specificities of medical training in Ireland whereby NCHDs, although officially considered doctors in training, can find themselves in posts that are not recognized for training purposes. Respondents occupying these stand-alone posts were frustrated and sought to emigrate onwards to avail of improved training and career opportunities:

I don't want to end my career at this level. (Doctor 16)

it's really tough working ... in a job where you ... want to succeed and progress and you just keep doing the same job over and over and over and over ... it is difficult to stay as an SHO [senior house officer] for 10/20 years but many people are doing that. (Doctor 20).

Those seriously considering onward migration spoke mostly of the United Kingdom as a preferred destination, with a few respondents mentioning Canada, the Gulf States or their home countries as migration options. The overall aim of their migration was to avail of improved training and promotional opportunities.

I need to get training soon. You need to be on a kind of definite pathway. (Doctor 10).

I don't think I have any career prospects – that is why we are planning to move. (Doctor 33).

Respondents recognized the career implications of remaining in medical posts unrecognized for training purposes and felt that they were becoming de-skilled as a result. This was something that they felt would have repercussions for their career progression regardless of what country they were in:

if you are losing your skills you can't work even at home ... And you can't work anywhere else. (Doctor 3).

As well as being frustrated about the lack of opportunities for training and career progression, respondents sought to emigrate from Ireland to achieve

better working conditions. One doctor spoke of an average working week (including on-calls) of 88 hours and noted that

we are just working here, we are not living. (Doctor 33).

Others spoke of the difficulties of the six-monthly rotation system, particularly in relation to family commitments. Respondents sought more stability, either in terms of geography and work location or in terms of permanency and job security:

now my children are here so they are going to school ... I don't want to move around much now. (Doctor 3).

I think I need to find a place to settle down, I think changing the hospital every 6 months I find very hard to adapt and adjust. (Doctor 28).

As was the case with the non-EU migrant nurses (Humphries, Brugha & McGee, 2009), respondent doctors were keenly aware of the opportunities available to them in other countries and comparisons were frequently made, particularly between the United Kingdom and Ireland. The United Kingdom was considered a destination country that was more open to permanent migration.

I've got a strong feeling that a foreign doctor coming in here and applying for a post and staying forever is not favoured, not in Ireland. The UK it is different. (Doctor 14).

The United Kingdom was also considered to have better career progression and career pathways in comparison with Ireland, as this respondent explained in relation to career progression:

same thing you can do in UK in 5 years you do 10 years in Ireland. (Doctor 19).

For the most part, respondents were remarkably philosophical about the perceived differences between the opportunities available to them as non-EU migrant doctors and those available to their Irish colleagues. They appeared resigned to the inevitability of it and planned to work around the system by emigrating from Ireland in order to progress their careers.

they blocked my way at certain point ... they blocked my way but that is how system works. It works everywhere like that. (Doctor 4).

They would like to train their people first then us. (Doctor 14).

Several respondents were at pains to explain that they understood that prioritizing home-trained doctors for training and/or promotions was something that happens everywhere and that similar processes would be in place in their home countries. They were resigned to the fact that they would have to emigrate to

progress their careers, but they were disappointed at having to leave Ireland. Other respondents were angrier about the situation, comparing the position of non-EU migrant doctors in Ireland to "being a labourer" (Doctor 16) and "slave labour" (Doctor 32). These doctors had decided to emigrate from Ireland because working conditions were

very very difficult, prospects were very, very low and supervision was non-existent. (Doctor 32).

## **10.4 Policy implications**

The majority of respondents (26/35) were planning to migrate from Ireland. Motivations for moving on related closely to respondents' initial reasons for coming to Ireland, namely to get access to structured training and progress their careers. The findings demonstrate the importance of aligning the needs of the destination country with those of the individual migrant doctor. The mismatch between respondents' desire for training and career progression and the Irish health system's need for doctors to fill stand-alone or service posts meant that dissatisfaction and frustration for respondent non-EU migrant doctors was almost inevitable. Senior figures in the medical establishment have noted that the Irish health system should be obliged to provide postgraduate training opportunities to those recruited from overseas (RTE News, 2011). Respondents echoed similar comments, adding that where recruitment is into service roles, transparency during the recruitment process is essential. The *WHO Global Code of Practice on the International Recruitment of Health Personnel* recommends transparency and fairness in the recruitment process (WHO, 2010).

Respondents' dissatisfaction with the working conditions in the Irish health system, specifically those attached to the NCHD role, was immediately apparent (Table 10.1) and strongly correlated with the reasons cited by the Irish Medical Organisation (2011b) for the emigration of doctors from the Irish health system more generally. In effect, respondents highlight systems' failures that have not been resolved by the inward migration of non-EU doctors. Although willing to come to Ireland to occupy vacancies in the Irish health system, non-EU migrant doctor respondents appear to have encountered similar barriers to their career progression and drawn similar conclusions to those reported by their Irish colleagues – that emigration from Ireland is necessary for career progression (Irish Medical Organisation, 2011a, b). This is borne out by a recent benchmark survey by the Irish Medical Organisation which found that 80% of NCHDs believed that overseas experience would be essential for them to progress their careers in Ireland (Irish Medical Organisation, 2011a). Kingma's statement

**Table 10.1** Factors influencing non-EU migrant doctor decisions to stay or leave Ireland

	<b>Endogenous (within the health system)</b>	<b>Exogenous (outside the health system)</b>
Reasons to leave Ireland	No access to structured training Poor quality supervision Service posts with poor career advancement opportunities Irish favoured for training/promotions Long working hours 6 monthly rotations and relocation for NCHDs De-skilling (brain waste) No permanency	Instability of frequent moves, particularly for those with families No work–life balance Challenge of being foreign in Ireland
Reasons to emigrate to another country (United Kingdom or elsewhere)	Perception of better training options in the United Kingdom Perception of better career progression opportunities in the United Kingdom Perception of shorter working hours in the United Kingdom Career grade option in the United Kingdom	Perception of better work–life balance in the United Kingdom Perception of more equal opportunities for migrants in the United Kingdom than in Ireland Desire to return home
Reasons to remain in Ireland	May stay if training/promotional opportunities become available Stay until training completed	Naturalization process ongoing Settled in Ireland/children settled Cannot return home because of instability there

Source: Adapted from Padarath et al., 2004.

that “*injecting migrant nurses into dysfunctional health systems – ones that are not capable of attracting and retaining domestic-educated staff – is not likely to meet the growing health needs of national populations*” (Kingma, 2007) is exemplified well in the Irish experience of doctor migration. Non-EU migrant doctors, like their Irish counterparts, want training opportunities, career progression and a clear career pathway. Most non-EU migrant doctors appear to have migrated to Ireland to achieve these goals and will migrate onwards from Ireland if opportunities are not provided within the Irish health system. Non-EU doctors who find themselves working as NCHDs with limited access to training as well as inadequate supervision and poor working conditions, or who emigrate from Ireland because of lack of opportunities, could be considered casualties of the Irish health system, as could Irish and Irish-trained doctors who do not remain working in the health system within which they trained.

## **10.5 Conclusions**

The findings of the study described here illustrate some of the motivations underpinning the migration of non-EU migrant doctors to Ireland and the reasons why they are considering onward migration. If career-tracking data and quantitative data on doctor immigration and emigration can be generated, then combining these with the qualitative results described here has potential to greatly improve our understanding of medical migration and would contribute to better and more efficient health workforce planning and retention in Ireland in the future.

Although this chapter has focused on non-EU migrant doctors, many of the issues they confront are not specific to migrants but rather relate to the structure of the NCHD role and the fact that "many NCHD posts provide no real training" (Tussing & Wren, 2006). Dissatisfaction with the postgraduate training environment for NCHDs has long been recognized as a factor in the "brain drain" from Irish medicine (Buttimer, 2006). Irish doctors emigrate from Ireland because of heavy workloads, pay and working conditions, and because they can achieve a better work–life balance and better training and mentorship in countries such as Australia and New Zealand (Shannon, 2010). Our research has demonstrated that issues of career progression and training structure apply as much to non-EU migrant doctors working in Ireland as they do to Irish-trained doctors.

The need for system-wide reform is self-evident and generally accepted. In the meantime, Ireland has a poorly functioning health workforce system that continues to operate unchanged. Without radical reform, it is likely that Ireland will continue to have both a high dependency on non-EU migrant doctors and to experience the continued high turnover of Irish-trained doctors (non-EU, EU and Irish).

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