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**Am I professional as a nurse in Finland?**  
**Chinese migrant nurses' interpretation of themselves as professionals**

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## ABSTRACT

Under the background of globalization and nursing shortage in Finland, there is an increasing trend of nurse migration from China to Finland. Nurse is a highly professional occupation. Understanding nurses' interpretation of themselves as professionals would lay the foundation for promoting these nurses' professional level, which would improve the quality of care nurses provide to patients, help to retain nurses in the area, and mitigate the shortage of nursing force. Nevertheless, there are currently few studies conducted from the perspective of professionalism of migrant nurses. As a result, I decide to situate my study in this field, and my research question is: *How do migrant nurses from China to Finland interpret themselves as professionals*. To answer this research question, a qualitative research was conducted and nine interviews were done with Chinese migrant nurses that are currently working in Finland.

Studies on professionalism point out that professionalism has been transforming from occupational to organizational, with many occupations losing their control of the profession to large organizations. Legislation, professional associations and hospitals are the three main factors influencing nursing professionalism. Miller with colleagues developed a model evaluating nursing professionalism that was widely used later on. Combining Miller's model with empirical studies on nursing professionalism, I focused on four prominent categories in my research: educational background, continuing education and competency, communicative skills, and adherence to the code of ethics. Two other categories that were rarely mentioned in literature emerged from my data: difference in nursing practice, and respect from patients and colleagues.

This study found out that the shift of these migrant nurses' interpretation is multi-layered. Better chances of further education, being able to pay more attention to each patient, being more respected make the nurses believe that they are professional in Finland; huge language barrier makes them cause damage to their self-confidence as professionals. Differences in the nurses' daily practicing procedures have various influence on their self-interpretation as professionals, while differences in nursing education and training have little influence on the interpretation.

**Keywords:** nursing professionalism, migrant nurses, social policy

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## 1. Introduction

It is not a new phenomenon that people move across borders from one country to another. There were 232 million international migrants worldwide in year 2013, migrating from developing countries to developed countries in most cases, and this number is increasing fast (50 percent from 1990 to 2013) (International Migration Report, 2013). Nurse migration has also been accelerating in the recent decades due to nurse shortages, especially in many developed countries, which has led to international nurse recruitments (Aiken et al, 2004). Nurse migration has attracted much concern worldwide in ethical issues, because it has generated a considerable loss in nursing forces in source countries and caused inequality in health care providing between countries (Stiwell et al, 2004; Humphries, 2012). Furthermore, even though migration is a quick solution to fill nurse vacancies in some developed countries, many of the host countries fail to retain these workers due to lack of relating immigration policies or training systems (Humphries, 2012).

Finland is an emerging nurse migration destination country. Report (Ailasmaa, 2010) shows that the number of foreign nurses started to increase from the 2000s. According to Finnish National Institute for Health and Welfare (2012), health and social services personnel of foreign background has increased from 1.6 percent in 2000 drastically to 4.2 percent in 2012, which is more than 16, 000 persons, and among them, over 10,000 are nurses. This number is foreseen still to rise due to shortage in Finnish health care work force because of the retirement of baby boomers (Välipakka, 2013).

China is relatively new in exporting nurses to the developed western countries compared to the Philippines, South Africa and India, but the trend of Chinese nurses going abroad to work is unneglectable. The trend started from the late 1980s when medical schools started setting foreign-related nursing courses or degrees in the late 1980s (Zhen, 2011). Consequently, it is foreseeable that there will be an increasing trend of Chinese nurses coming to Finland.

Along with the growing flow of nurse migration, researchers have been putting increasing attention in this area. Most studies have focused on the incentives of nurse migration. On the national level, it has been shown that nurse migration is usually driven by the demand of destination countries such U.S. and U.K. (Stiwell et al, 2004), while when it comes down to personal decisions, economic incentive is the most important among other factors (job opportunities, working conditions, funding of health care system and so on). Studies have also listed the most common barriers, including work ethic, persistence, learning ability, language and communication difficulties, cultural-based lifeway differences, and the level of inequality. (Aiken et al, 2004; Zhang, Li and Zhang, 2013; etc).

Compared to the research done on facilitators and barriers of nursing migration, only few studies have been conducted from the perspective of professionalism among migrant nurses. Nurses are the professionals who take direct responsibility of our physical and mental health, and their professional level has crucial importance to their clients. Research has shown that professionalism is going through a transformation towards organisationalism (Evetts, 2011; Olakivi and Niska, 2016), and the common indicators of professionalism in nursing include education background, code of ethics, participation in organizations, academic publications, critical thinking and decision-making abilities and so on (Miller, 1993; Tanaka et al, 2014; Johnson, 2005). However, considering the considerable cultural and social differences, it is likely that these indicators vary from Finland to China, and thus nurses in Finland and China have different professional standards. The Chinese migrant nurses in Finland have different educational background, they may have different understandings of nursing ethics, and they may also possess different critical thinking and decision-making abilities. These migrant nurses face drastic changes in their professional life before and after migration. These changes may influence their understanding of themselves as professionals, which would not only cast influence on the life of these migrant nurses and on their intention of keep working as nurses, but also on the quality of service they provide to the patients. Nevertheless, very few studies have been conducted focusing on professionalism of migrant nurses in Finland or the Nordic countries, or focusing on migrant nurses from China. This study is done to contribute to this area of literature.

As a result, the purpose of this thesis is to investigate, *how do migrant nurses from China to Finland*

*interpret themselves as professionals.*

To achieve the aim of this research, nine interviews were conducted with Chinese nurses who are currently working in Finland, to gain insight into their personal experiences, feelings and attitudes regarding their role as a nursing professional throughout the migration process. Data gathered from interviews was then analyzed, focusing on these nurses' understanding of themselves as professionals in the process of migration. Educational background, continuing education and competency, communicative skills, adherence to the code of ethics, nurses' daily practices and respect emerged from existing literature as well as the data as main indicators influencing these nurses' interpretation of themselves as professionals.

This study finds out that these migrant nurses have complicated understanding of themselves as professional nurses: being able to be more responsible to the patients, better chances of continue education and more respect from patients and colleagues make them to think that they are professional in Finland. Nevertheless, drastic differences in educational content and format, Finnish as a distinct language barrier, and their daily non-medical care providing practices damage their self-confidence as professionals. This study also reveals that the almost compulsory nursing education in Finland is not appreciated by these migrant nurses, and that Finnish policies regulating on nursing education for migrants could be updated or supplemented.

This thesis is structured in seven chapters: In Chapter 2, literature is reviewed on the social interpretation of professionalism, professionalism under the background of globalization, and nursing professionalism. In Chapter 3 more specific information and empirical studies are provided regarding the general nursing system in Finland and China. Chapter 4 is the methodology part, which justifies why this research was conducted as a qualitative research, and outlines how the research was conducted. The findings of the study on how do the Chinese migrant nurses interpret themselves as professionals are presented in Chapter 5. In Chapter 6, I further discuss the findings in relation to previous literature. Conclusion is drawn in Chapter 7, with brief analysis of the possible drawbacks of this study, and suggestions on relevant policies.

## 2. Professionalism

In this chapter I review literature about professionalism. I start from a historical review of the development of social interpretation of term 'profession' and 'professionalism', and then move on to the study of professionalism in globalization. I then discuss professionalism especially in the medical field and nursing. In the end, I review some commonly applied frameworks developed for analyzing professionalism in nursing.

### 2.1 The historical development of term "profession" and "professionalism"

The meanings of terms "profession" and "professionalism" have evolved throughout history. Back in 1950s to 1960s, scholars have been struggling to separate professions from occupations (Etzioni, 1969; Greenwood, 1957), debating over what occupation is "professional" enough to be called a profession. Later on, researchers understood that seeking for the precise definition of profession does little help in understanding the power of certain occupation groups (such as doctors and lawyers), or understanding the new trend of using "professionalism" as a discourse (Champy, 2009).

Professions emerge in the process of social development and labor division. With labor division, profession acts as a social contract between the practitioners and clients. The contract relies on the trust from clients, that they believe the practitioners are practicing within the code of ethics, altruistically for the overall good of the public, and guarantee the quality (Sullivan, 2005). Nowadays, profession is generally understood as "essentially the knowledge-based category of service occupations which usually follow a period of tertiary education and vocational training and experience" (Evetts, 2013, page 3).

The term 'professionalism' derives from the term 'profession'. Back in the 1920s, the concept



“professionalism” was referred to as a counter-force of rampant individualism. It was used to emphasize the altruism and service orientation for some occupations, in order to achieve better stability of social systems. While at the same time, it also stood against the encroaching governmental bureaucracies and calls for professional freedom. From then on, in almost a century, “professionalism” was often interpreted as of high occupational value. It was perceived that a “professional” relationship should be collegial, cooperative and mutually supportive. It is also from then on assumed that the high occupational value should be guaranteed by education and training. (Evetts, 2013). This is usually referred to as the traditional interpretation of professionalism.

With the development of society, the interpretation of professionalism has been changing. Later on, focus has been given to the professionalism as a way of organizing work, as opposed to organizing in institutions or by the market. This new phase of ideology of professionalism means that practitioners maintain the occupational control by themselves instead of relying on organizational regulations and assessments. Freidson (2001) argues that this is important because the real practitioners are the ones who directly understand the needs of work, the procedures, and are responsible for the outcomes. While practicing, the situations can be highly complicated and the practitioners have to do the decision on site and sometimes rely on their professional intentions. This is also why extensive education and training are needed to fully develop practitioners’ expertise. Many cases have been recorded where statutory regulations and the increasing bureaucracy have impoverished the quality of work. In these situations, professionals representing a form of decentralized occupational regulation, with practitioners’ self-regulation, keep providing quality services. (Dingwall, 2008).

Although professionals in different areas have been fighting for their professional autonomy, and tried to maintain the power of occupational control among themselves, it is beyond denial that increasingly more occupations are transforming and institutionalised. Hall is one of the pioneering researchers, sensing the trend of transformation towards organisationalism, back in the 1960s. He did large scale quantitative research on professional and organizational relationships (Hall, 1967), and came to the conclusion that though organizationalization and bureaucratization have led to

conflicts, the single professionals in organizations do not necessarily have to face the conflicts. He argues that the conflicts are normally induced from hiring and promoting processes, and from the changes of degree of professionalism or bureaucratization. Hall insists that while a professional works in a department or organization, his (or her) autonomous professional norms are not necessarily violated, but should be further determined in the detailed situation, seeking the source of confliction. Acknowledging the conflicts between professional individuals and organizations, Henry Mintzberg (2012) portrayed that organizations should be structured according to the nature of professional work, and thus should be occupationally specific. He suggests that in most cases individual professionals operate within organizations “decoupled” from the management structure, and the management structure itself is an order negotiated with the professionals.

Even though organizationalism is not replacing the traditional understanding of professionalism, it is indeed encroaching on the ideology of traditional professionalism in decades of negotiation and struggling. Self-regulatory power of professions is one of the main factors that have been crippled by organizationalism. Some occupational groups remain the power to manipulate the market and set their own rules, such as in medicine and law, while many others have been regulated “from above”, from other higher leveled forces out of the occupational group, such as in social work. (Evetts, 2011; Evetts, 2013). This shows that the traditional understanding of professionalism is transforming to managerialism, with more interests in organizational productivity, and financial efficiency (Olakivi and Niska; 2016, Evetts, 2011).

As a result, it has been argued that coming to the 1990s and later, the term “professionalism” has been more of a discourse of occupational image. It has been used in managerial work to build up work identities, and to attract better working forces (Fournier, 1999). Especially recently, with more occupations institutionalized, the term “professionalism” is changing from “occupational” to “organizational”. Nowadays, most service occupations practice in organizations, and the professionalism is constructed by the employers and managers of the organizations, where the “professionals” work. (Evetts, 2011). In this sense, “professionalism” in discourse is used in delivering a “false impression” of autonomy occupational control, while at the same time it is indeed

facilitating the change of institutionalization. Olakivi and Niska (2016) remain neutral on this issue, and argue that professionals today are normally engaging in 'hybrid activities', balancing in between professionalism and managerialism. Their 'hybrid activities' can often be interpreted from the perspective of the beholder.

There was some time, in the 1970s and 1980s, when professionalism has been questioned and criticized. Back then there was a trend arguing that professionalism aids some professions' monopoly control of the market and has led to market closure. It was also argued, that the practitioners utilize the professionalism way of regulation to pursue their own interests in terms of salary, status, and monopoly power (Evetts, 2013).

In brief, the traditional ideology of professionalism includes the exclusive expertise of knowledge in an area, the power to define problems, and ways and accesses to solve or control certain problems. It also includes collegial work relations of support and assistance, regulations within the professional group, autonomy in making decisions in real practice, and little dependency in outer organizations. However, it is clear that the ideology keeps changing according to different historical and social situations, and currently the seemingly occupational professionalism is more organizationalised in reality. Facing the fact that professionalism is heading towards managerialism, many occupation practitioners are either knowingly or subconsciously balancing their behavior between professional and managerial interests.

## 2.2 Professionalism and globalization

As discussed earlier, professionalization has been transforming from occupational to organizational (managerial), and nation states, as colossal organizations, have come into sight of studies. Burrage and Torstendahl (1990) were the prominent authors, who started arguing that state is playing a

powerful role in shaping the professions in two ways: through controlling access to a certain profession (licensing process), and through controlling regulations within certain professions.

The work by Burrage et al (1990) argues that there are four main actors in shaping professions: the practitioners, the users of service, the states, and the universities that provide knowledge and training bases for practices. They also argue that nation states, in many cases, can be the end-users of services, thus they have especially high power of control over professionals. As states have become prominent actors in shaping the professions, differences among countries have also emerged, as opposed to the studies earlier that professions are more about self-regulation and collegial work (Faulconbridge and Muzio, 2011). According to Burrage et al (1990), the main variations among the nation states lie in the knowledge base of professions (the credentials) and the role of professions in the society.

In the last two to three decades, globalization has drastically changed the labor market and has also changed the role the state plays in shaping professions. The role nation-states played controlling the “two pillars of professionalization” (regulation of access into the profession and regulation within the profession), has been decreased by supra-national organizations such as the World Trade Organization (WTO) and the European Union (EU) (Faulconbridge and Muzio, 2011). The EU has regarded it necessary to create a single market for certain professional services, and has promoted mobility within the EU. A professional qualified to practice in one EU country is able to practice in other EU countries, and the state have little power to regulate over this anymore. Increasing numbers of supra-national organizations have been established (for example the World Medical Association, Association of International Accountants, the International Bar Association and the Council of Bars and Law Societies of Europe), and they have increased their power to control the award of qualifications and certification of competences, the regulation of professional practices, and in providing continuing professional regulation (Faulconbridge and Muzio, 2011).

Along with the huge supra-national regulatory professional bodies, many global professional service firms have also emerged driven by the globalization market (such as accountancy firm PriceWaterhouseCoopers). They employ local practitioners and encourage them to adopt global

standards to work in a global environment, and in many cases, they generate new global practices and norms, promoting global trade. These global professional service firms have also generated new perspectives in education, which seek to provide practitioners with direct qualifications to enter the global market. (Faulconbridge and Muzio, 2011).

Consequently, in the current era, the traditional idea of professionals as a semi-closed self-regulatory group is hardly ever true, and the four main actors in shaping professionalism identified by Burrage et al (1990) have changed. The global client groups that demand goods and services both from home nations and around the globe are promoting the international needs; the practitioners are organized in supra-national groups more than ever; the universities are providing credentials to practitioners, enabling them to enter the global market; and the governance regimes are largely influenced by supra-national institutions such as the WTO and the EU. Besides these four actors, firm has emerged as a new actor, driven by interests in the globalized market, generating new international trade modes and professional practices. (Faulconbridge and Muzio, 2011).

### 2.3 Medical professionalism and nursing professionalism

Nursing as an occupation, started in the early 1900s, was especially for woman and subjected to the social ideal of women at that time, to be “caring, sensible, subservient, and selfless” (Wyne, 2003). Later on, with the development of society and nursing as a profession, nurses sought for a sense of professionalism by emphasizing aspects of “altruism, public service, and a sense of calling” (Wyne, 2003). However, even today, the widespread understanding of professionalism is patriarchal in nature, focusing on “rationalism, scientific standards, objectivity” (Wuest, 1994). This patriarchal orientation to nursing professionals impairs their occupational value, because the caring and nurturing traits in their profession are not recognized.

Just like professionalism in other occupational areas, medical professionals have also gone through a process of organizationalism. Even though the professionals still perform professional decisions as individuals, the medical organizations represent these professional decisions collectively, and act as interfaces between the professional individuals and the society. As in other occupations, the individuals are influenced by joining voluntarily or compulsorily organizations, and conflicts do occur in the process. Individual professionals have little leverage to the current society, by joining organizations they become a part of something bigger and make their voices collectively, but as a result their professional autonomy gets impoverished. On the other hand, organizations are more easily distracted by business and operational concerns. (Egner et al, 2012).

The organizations can broadly be split into two categories: professional associations, and hospitals and clinics. These two categories of organizations have different impact on the professionals within.

Professional associations are unions of professional individuals gathered together, bargaining certain professional rights, and also regulating professional behaviors. For example, the Finnish Nurses Association and the Finnish Association of Public Health Nurses are two major nursing professional associations in Finland. Professional medical associations have huge impacts on medical professionals. Firstly, the associations are influencing medical education, which is the basis for medical professional skills. Professional associations can influence the education either through direct regulation, or by professional meetings and the publications and journals that are published in or after the meetings. Secondly, the associations can issue practice guidelines, which are deemed standards for professional patient care. Moreover, the associations have the power to define ethical norms of practice for its members. They also advocate and shape the ideology of what is the best for patients and society, which in turn influence on the practices of professionals. (Azimova, 2016; Rothman et al, 2009).

Along with the power to promote the industry comes the risks of endangering traditional professional values. It has been argued that professional medical associations in themselves lies on conflicts of interests, as both the association itself and its members tend to receive contributions,

funding, sometimes direct salaries or consulting fees from medicine or medical device industries, which have been demonstrated by multiple studies that has would lead to a bias of choices and decisions. Azimova et al (2016) in their research of low-income and middle-income countries suggest similar issues. Since in these countries the medical associations are more likely to rely on funding of individual donors, the service they provide tends to be influenced by the donors; but on the same time, these countries rely on the associations in medical reformation.

Hospitals (or clinics as many cases for nurses) is another source of organizational impact on medical professionals, and in hospitals, the friction between hospital managers and professionals can be seen on a daily basis. Compared to other occupations, professional autonomy still prevails for physicians and nurses in hospitals. Because of the autonomy power of physicians and nurses, hospitals have to adapt special hospital management strategies, such as transformative leadership and participation of professionals, to invite professionals to change in the way that hospitals want (Wiezorek et al, 2015). The frictions between managerialism and professionalism is multilayered, depending on the corporation level of the medical departments, how the professional teams are organized, and on various medical contexts (Correla 2013). Kristiansen et al (2016, page 55) researched on how the Norwegian nurses face the frictions with managers, and reported their coping method as “increased standardization of professional work”, “creative problem solving”, and “strategic use of documentation”.

Contrasting to many literature focusing on the negative effects of organizationalism and managerialism in medical professionalism, Wyne’s (2013) research indicates that professional organizations actually have positive impacts on nurses, because nurses as members of professional organizations perceive themselves as more professional. These nurses also receive better support from organizations and continue to proceed to become better professionals. Wyne thus propose (2013) to promote professional membership among nurses, starting when they are still students, to help them pursue a better professional career. Starc (2009) in her research in Slovenia also concludes that, to facilitate nurses to be recognized as professionals, organizations should be more innovative in conceptualizing health care and considering nursing as “intellectual work”.

Legislation and regulation is another major actor shaping nursing professionalism. Actually, it lies in the basis of all medical professional associations and hospitals, as they all follow the law and local regulations. Nursing is heavily legislated. The law regulates licensing requirements of nurses, the scope of nursing practice, and in many cases, empower a board to regulate and monitor nursing practice (Grant and Ballard, 2013). The laws regulating nursing in Finland are the Health Care Professionals Act (559/1994) and Health Care Professionals Decree (564/1994) issued by Finnish Ministry of Social Affairs and Health. The relevant parts of these laws will be introduced in detail in Chapter 3.1.

In brief, it can be understood that the perception of professionalism goes hand in hand as the development of professionalism itself. It is also under pressure of organizationalism, and frictions between medical professions and managers exist in various contexts. However, because of the specialty of medical professionals, they do hold a strong autonomous power when practicing. Their practices are guided by national or global laws and regulations, shaped by guidelines made by professional associations, they conform with the requirements by the hospitals or clinics that they work in, yet on the other hand, they do preserve their own control of practicing. Nurses, along with other medical professionals, are balancing their autonomous professional practices with managerial issues daily, to pursue high quality and efficient care. On the same time, nurses as professional organization members tend to receive support from organizations and perceive them as more professional, which leads to better professional practice.

## 2.4 Frameworks evaluating nursing professionalism

Hall has developed one of the first frameworks to interpret and evaluate professionalism, in his research of professionalism and organizationalism, and his framework has been widely employed in various occupational areas (Kim-Godwin, 2010; Wynd, 2003; Hampton and Hampton 2002, etc.).



Hall's model consists of five attributes: a) use of professional organizations as major referents. b) belief in public service. c) self-regulation. d) a sense of calling to the field, and e) autonomy (Hall, 1967, page 170). As we can see, his model corresponds to the traditional understanding of professionalism: focusing on the traditional collegial value within a certain occupation, altruism to the clients, the professional autonomic power, while at the same time he considered influences of organizations and recognized professionals' value to society. Academic and research performances have also long been dominating attributes of professionalism. Factors such as numbers of books and articles published, subscriptions to professional journals, time spent in professional reading and writing for publications and so on have been considered key aspects (Kramer, 1974; Urden, 1990).

In the earlier ages (1970-1990), many studies were conducted using Hall's Professional Inventory (1967) among nursing professionals, when there was not yet an inventory specifically for nurses. Monning (1978) argued that nurses tend to have a lower score in attribute "belief in public service", and that the more years of education a nurse has, the less he or she is likely to have "a sense of calling". McCloskey and McCain (1987) using Hall's inventory found out that nurses' professionalism tend to decline in their first months' of practicing, due to a low work satisfaction level. The degree of organizational commitment also falls. Zagornic's research (1989) using Hall's Inventory shows that nurses working in ambulatory care scored higher in professionalism, compared to others.

However, considering the specialties of nursing, as it is highly service centered, it is rather obvious that the traditional index of professionalism could hardly fulfill the objective of measuring professionalism in nursing. Noticing nursing as an emerging and quickly developing occupation in the 1980s, with lots of empirical studies (Monning, 1978; McCloskey and McCain, 1987; Zagornic, 1989 etc) conducted in the time on nursing professionalism, Miller with colleagues came up with a model depicting the essentials for nursing professionalism evaluation, referring to the Code for Nurses with Interpretative Statements, as well as recommendations and regulations from American Nurses Association (ANA) (Miller, 1993). This model has been the first model specifically for nurses, and has been frequently referred to as a basis for studies in the later decades. Miller's final

model consists nine categories of different behaviors, some are common ones and some are nursing specific. The categories are: 1. educational background. 2. adherence to the code of ethics. 3. participation in the professional organization. 4. continuing education and competency. 5. communication and publication. 6. autonomy and self-regulation. 7. community service. 8. theory use, development and evaluation, and 9. research involvement. (Miller et al, 1993, page 293). Miller herself has done studies based on this model, and many other researchers have utilized this model into their own studies (Adams, 2001, Wyne, 2003), with some revisions, as decades have passed and the nursing situation has changed; yet Miller's model is the one that most researchers refer to as a basis, when they conduct related studies.

Among the nine categories provided in Miller's behavioral inventory for nursing professionals (Miller et al. 1993), some categories are well worth further discussing, because they have complications, and also because they keep developing as the social situation changes.

Education background, as Miller and colleagues suggest, is the first category considered when evaluating professionalism (Miller et al, 1993). It is understandable as professionalism is interpreted as 'of high occupational value', and this expertise is granted by specific professional educations and trainings (Evetts, 2013). This is especially true for nurses, because them as direct care providers, as medical professionals, need to go through all kind of competency-based programs to gain their qualification of working as a nurse. However, as the public need and expectancy to nursing is changing, as the nursing practices is changing, the education needed is also changing. For example, according to Dingwall and Allen, the caring and emotion work in nursing, which was introduced when the occupation of nursing is recognized over a entry ago, is currently under devaluation by society (Dingwall and Allen, 2001). They suggest that nursing is becoming increasingly 'technical' due to real need from medical development, and nurses are expected with real 'technical competences'. As a result, nursing education and training should develop nurses' instrumental skills to prepare them as qualified. Many nurses themselves are also devaluing caring as a nature of their work. Scott suggests (2008) that nursing education currently should also be responsible to ensure that nurses can implement care, as equal partners of clients, without devaluing themselves. Nursing

education and training should always keep up with the development of social and medical developments.

As with domestic nursing education, special education or training is needed for migrant nurses. Nurses need license to practice in another country, and special training for that is provided, normally, in the host countries. However, in some “nurse exporting” countries, such as the Philippines, many nursing schools are actually acting as “migration institutions”. Their goal of education is not merely providing nursing students with relevant techniques and abilities, but also to facilitate their students to migrate (Masselink and Lee, 2010). In a way, the schools have become global professional organizations (Faulconbridge and Muzio, 2010). These schools do provide a simpler way for the nurses who plan to migrate, but on the other hand, while the schools are exceedingly pursuing commercial benefits from nurse migration, the quality of nursing education declines (Masselink and Lee, 2010).

Ethics has always been considered as a core pillar supporting the mansion of professionalism (Hall, 1968; Miller, 1993; etc.). As professionals have superior autonomy power of practice in their own area, their ethics are especially important to maintaining the quality of certain service, and fulfil public expectancy. This goes even further with nurses, when they are care providers directly to humans, body or mind, and our health is dependent on them. However, the professional ethics in nursing keeps changing, and can be understood from different perspectives even at the same time, among different groups of people, in different locations. The more traditional is the ‘medico-scientific’ care work discourse. According to it, care workers’ main responsibility lies in ‘curing the patients’, thus keep the patients in good physical and mental health. While currently the more dominant discourse is the ‘social-scientific’ care work discourse, where patients’ wellbeing is considered as a whole, and special attention is paid to the patients’ social wellbeing, which leads to wider discussion and more variant standards regarding nurses’ practicing ethics. (2016, Olakivi and Niskala).

What's more, the American Nurses Association has recently published the newest edition of the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015), where a new provision is included into this code of ethics that nurses should also be responsible to his or her own health and safety, as well as "preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth" (ANA, 2015).

The third pillar of Miller's inventory (1993), "participation in the professional organization" and the sixth, "autonomy and self-regulation" are counterbalancing each other. As discussed in earlier section, nursing industry has been highly organizationalized, nurses joining organizations feel that they are more professional, they receive support from organizations and other members (Wyne, 2013), while at the same time, their autonomy of practicing power is impoverished. They need to balance professionalism and managerialism, and conflicts are very likely to appear in between (Azimova, 2016; Rothman et al, 2009), but the conflicts can also be smoothed by creative personal skills (Kristiansen et al, 2006). Miller suggests that both "participation in the professional organization" and "autonomy and self-regulation" need to be fulfilled to become more professional, yet as the nature of these two pillars and in the current organizational situations, it is indeed hard to achieve. As Miller points out in the same paper (1993), the inventory can be used to evaluate professionalism, but is more suggested for individual nurse practitioners to evaluate themselves and pursue to be more professional. Considering this two pillars, individual nursing professionals would need to be creative and utilize their interpersonal skills, to keep a balance and score high on both pillars.

The fifth pillar in Miller's inventory (1993, page 293), "publication and communication" is under debate. By "publication and communication" Miller means the academic articles nurses have published on journals, and the communications through journals published. Miller included this pillar into the inventory as a prove that an individual professional is active in the academy. Even though her own result shows that only about 2.5 percent of nurses have published articles on journals, she insisted that "scholarly writing for publication and communication to others must become a requisite for the professional nurse to maintain and promote professionalism in nursing" (Miller,

1993). Miller's insistence can be understood because back in the 1980s and 1990s, academic and research performances were essential attributes for professionalism in almost all occupations (Krammer, 1974; Urden, 1990). Later studies that implements Miller's inventory (1993) also suggest, that the pillar of "publication and communication" is almost irrelevant to nursing professionalism (Tanaka et al, 2014; Bulut et al, 2015). Besides "publication and communication", the eighth pillar "theory use" and the ninth about "research" are both highly academically inclined and hardly ever shown as relevant in later empirical studies.

Communication skills are widely considered as necessary of a professional nurse (Tanaka et al, 2014; Starc, 2009; Johnson, 2015; Apker et al, 2006; etc.). Even though in Miller's inventory (1993) communication was narrowly understood as communicating through academic journals, daily communication skills are deemed essential to nurses' success in career. Miller acknowledged this aspect in her later studies (Miller and Apker, 2002). Communication skills are not only needed by the patient's bedside, as a traditional way of providing care and nurture, but also highly needed within medical teams, when a nurse is interacting with colleagues (Apker et al, 2006; Wade, 1999, Johnson, 2015). As in conflicts of organizational management and autonomy practicing power, good communication skills also provide ways of balancing between the conflicting parties (Wyne, 2013). Apker et al. have revealed four core communicative skills to promote health care interactions within team: collaboration, credibility, compassion, and coordination (Apker et al, 2006).

Apart from the widely used Miller's Inventory (1993), many studies have come up with their own attributes of nursing professionalism, some as complimentary for Miller's inventory.

Tanaka et al. (2014) are one of the many research groups that are still using Miller's model in recent years, in their studies, they have found out that increased length of nursing experience, higher level of education, and position as a nurse administrator are the three main reasons that promote professional behaviors. Apart from the nine categories, they also suggest that nurse managers also act as role models for other fellow nurses and have positive influence on them for achieving better performance.

Johnson (2015) stands out from the other scholars for her way of thinking out of the box. Instead of focusing on the term “professionalism”, she is more direct thinking about nursing practice behaviors, and suggested several indicators other than the traditional ones. She argues that one important factor is competence and judgement, which includes in critical thinking, creative thinking, and clinical decision making. She also states that nurses need communication / interpersonal skills and collaboration to excel in their work, as nurses most often work in teams, and communication with patients is also important. She also suggests that nurses need to be responsible for their work and have pride in their work as well.

As studies have come to factors evaluating professionalism, major nurse organizations have also published best practice guidelines in order to develop professionalism. The Registered Nurses Association of Ontario has published guidelines in *Professionalism in Nursing* (2007), where the focus was laid upon collegial support. Participating in team development meetings, mentorships, interdisciplinary rounds, and actively responding to team members’ challenges were listed as best practices. Mississippi’s’ Council on Advanced Practice Nursing has advocated on awareness of individual nurse as a ‘professional self’, and seek full practice authority instead of dependent upon other nurses (Watkins, 2015). As nursing professionals are most likely engaged in different organizations, professional organizations and hospital or clinic, these guidelines would no doubt influence their understanding of professionalism and their personal means of practicing.

### 3. Nursing System in Finland and China

This chapter is about the nursing system in Finland and China. In this chapter, I provide general information of the nursing system in Finland, with focus on shortage of nursing forces in Finland and policies regulating nursing licensure, especially for non-EU and non-EEA citizens. After introduction of the nursing system in Finland, I also introduce the nursing system in China. Then I provide reviews of empirical studies on nursing professionalism conducted in Finland and China as reference for the later chapters.

#### 3.1 Nursing system in Finland

Finland has been facing a shortage of nurses for long. The shortage is becoming more severe with the aging of the baby boomer generation (born after the World War II). There is also a huge population ageing 65-69 in Finland, in need of care services. In Finland, when older people are in need of care, many move to residential care homes, which is run by municipalities, or by private services purchased by municipalities (Ministry of Social Affairs and Health, 2015). It is estimated that to year 2025, there will be a shortage of 20,000 employees in the field of social and health care (Finnish Ministry of Labour, 2007).

There are three types of nurses in Finland: registered nurses, practical nurses, and nursing assistant. Registered nurses and practical nurses are regulated and licenced by the National Supervisory Authority for Welfare and Health (Valvira). Nursing assistant is not licenced, and doesn't require a corresponding training or education. Registered nurses are in charge of administration of medicine, practical nurses are in charge of assisting and supporting of patients' activities, while nursing assistant is in charge of feeding and cleaning. (Vartiainen et al, 2016).

From the 1950s to 1970s, the shortage of nurses in Finland has normally been filled by domestic Finnish population moving from rural areas to cities (Korpela et al, 2014). While from 1990s afterwards, there has been increasing number of foreign nurses into Finland, especially after Finland joined the European Union in 1995 and signed the Schengen Agreement in 1996. In most cases migrant nurses come from neighbouring countries like Estonia, Sweden and Russia, nevertheless, nurses from farther origins has also started to step into Finland. (Vartiainen et al, 2016).

However, it is not easy for nurses out of the EU to practice in Finland. Currently there are two legislations in Finland relevant to nurses, both issued by Finnish Ministry of Social Affairs and Health, and they are Health Care Professionals Act (559/1994) (referred to as “the Act” later), and Health Care Professionals Decree (564/1994) (referred to as “the Decree” later). The Act and the Decree entered into force in 1994, and went through several amendments in the years after. The Act regulates that, nurses can only have the right to practice and are only entitled to the professional title of a “nurse” after licensing or authorization. If one insists to practice as a nurse or use the title of “nurse” without licensing or authorization, he/she is subject to a fine or even imprisonment.

The Act and the Decree then regulate in detail on what occasion the license and authorization should be approved: According to Section 5 of the Act (amendment 1200/2007), a person has the right to practice and use the title if he / she has completed the training in Finland under a government decree. This means that one is guaranteed the license and title of a nurse as long as he / she completes the training in Finland, whichever nationality he / she may have. Nevertheless, going through the training in Finland is not the only way to acquire licensing. For those non-Finnish nationals, it is possible to get licensed with a foreign diploma. As this study focuses on nurses migrating from China to Finland, I will explain the sections focusing on non-EU, non-EEA nationals in detail. According to Section 13 of the Act (amendment 1200/2007), the National Authority for Medicolegal Affairs may also guarantee license and title to non-EU, non-EEA citizens who have acquired training out of EU and EEA zone, only for special reasons and on special conditions prescribed by the reasons. Besides the special reasons and conditions, it is also required that the applicant must possess adequate language proficiency for managing the work. However, the Act and the Decree



fail to explain further, what can be considered as special reason and conditions. As a result, it remains unclear for non-EU, non-EEA citizens that, in which case one has no need to go through the education and training again in Finland. The Decree further regulates that if an applicant has completed training out of EU and EEA, and the training is considered equivalent as a Finnish training, the applicant would need to further provide evidence of his / her adequate language skills.

In brief summary, for a non-EU or EEA originated nurse who would like to practice in Finland, he / she would have to either complete the education or training in Finland, or have had the training in China that can be considered as adequate from some special reasons and conditions according to Section 13 of the Act. Nevertheless, the “special reasons and conditions” are not explicitly explained in the Act or the Decree. The nurse would also need to prove his / her adequate language skills. According to Valvira (Finnish National Supervisory Authority for Welfare and Health), adequate language skills can be proved by either a satisfactory or higher level of Civil Service Language Proficiency Certificate, or a level 3 or higher of the National Certificate of Language Proficiency test.

### 3.2 Nursing system in China

According to China’s Five-Year Plan (2016-2020) of Development of National Nursing Industry, there were 3.24 million registered nurses in China by the end of 2015. The number seems huge, yet when the numbers are projected to the population of China, there are only 3.2 nurses per thousand people, which is not much compared an average of 7.9 nurses per thousand people in Europe (World Health Statistics, 2013). Due to the severe shortage of nurses, most registered nurses work in hospitals. Care workers in institutions such as residential care homes are rarely registered nurses and rarely have attend corresponding education or training.

The Nursing Act 1994 issued by Chinese Ministry of Health regulates the nurses. According to the Nursing Act, licences are issued by the Ministry of Health after one completes the nursing education and training, and passes the national licensure exam (International Council of Nurses, 2009). There are mainly three levels of education that are considered as adequate: secondary nursing programs, “zhuanke” programs, and baccalaureate programmes. Secondary nursing programs often starts right after one finishes the nine-year mandatory education and consists 2 to 3 years of studies and training; “zhuanke” means “professional training” and can be understood as vocational junior college, which also consists 2 to 3 years of studies and training; baccalaureate programmes often lead to a Bachelor’s degree and consists 4 to 5 years of education and training. Graduates from baccalaureate programmes are automatically granted the licence while graduates from secondary nursing programs and “zhuanke” programs would have to take the National Nursing Licensure Examination to achieve the status of registered nurse. (Xu, Xu and Zhang, 2000). According to a survey conducted in 2017, 53.8 percent of the registered nurses in China hold a baccalaureate diploma (Survey on the development situation of Chinese nurses, 2017).

Similar to the nursing assistants in Finland, there are “hugongs” in China, which doesn’t require any training or education and takes care of a patient’s non-medical needs. The difference between Finnish nursing assistants and Chinese “hugongs” is that in China, “hugong”’s work is normally conducted by patients’ relatives, and they are only hired when the patient’s relatives cannot take care of the patient in the hospital. Non-medical care providing is not considered as responsibility of hospitals or clinics, but of the patient’s own family. “Hugongs” are not considered as staff of hospital, but more as helpers of the patient’s family.

A national survey focusing on all registered nurses in China in 2017 has revealed acute problems Chinese nurses are facing. According to the survey (Survey on the development situation of Chinese nurses, 2017), more than 41 percent of the nurses have encountered aggressive behaviour from patients or patients’ relatives, more than 78 percent of the nurses were hurt by edged tools such as needles within the year, about 90 percent of the nurses expressed that they do not feel respect from the society, about half of the nurses are considering changing to another career. The survey has also

revealed that about 57 percent of nurses have participated in training of professional skills, about 45 percent of nurses have participated in order to achieve specific practicing requirements, and about 39 percent of the nurses have trained to become specialized nurse. Survey shows that there is a huge willing pursuing continue education and training while the training possibilities provided by hospitals are quite limited. What's more, the survey also shows that almost 40 percent of the nurses earn a monthly salary of less than 3000 RMB (about 380 Euros), while the average salary in cities is about twice of that amount. Nevertheless, the nurses are working long hours. The survey reveals that more than 90 percent of the nurses work more than 40 hours per week, while about 10 percent work over 60 hours per week.

It can be concluded from the survey, that Chinese nurses are facing great pressure from long working days, disharmonious nurse-patient relation, disrespect from the public, deficient salary, and rare further education possibilities. This has led to the outflow of Chinese nurses overseas, even though China is suffering from a deficient of nurses.

### 3.3 Empirical studies on nursing professionalism in Finland

Surprisingly, very few studies were conducted on the professionalism in general nursing in Finland. However, the few studies do have indicated some specialties of professionalism in Finland.

According to Papastavro et al (2012), in a quantitative comparative studies of nursing practicing environment, Finland has distinguished among the other countries (Cyprus, Greece, Portugal, Sweden, Turkey and Kansas USA) as less cultural sensitive, mainly because of a comparatively homogeneous patient group. The level of teamwork in Finland is also slightly higher than the other countries compared.

Olakivi very recently conducted a research in Finland on enterprising nursing (Olakivi, 2017). The enterprising nursing policies were published as a response to some older policies such as active recruitment of foreign migrant care workers to make up for the shortage in working force in the area, and implementation of managerial techniques to promote performance of these professionals at work. Because these policies are frequently criticized for exploiting migrant workers, who are in many cases disadvantaged, and also for reducing nurses' professional autonomy and the quality of care that they are providing, the enterprising ideal has been introduced and implemented. It encourages nurses to act as autonomic agencies, who has the 'clarity of vision', 'ability to act' and 'strength to overcome the innumerable obstacles' (Olakivi, 2017). It has been argued that through enterprising nursing, professional autonomy can be better preserved, better quality of care can be achieved, while it is also economically efficient, and goes with governmental goals with proper supervision (Olakivi, 2017). With enterprising nursing as a prominent ideology, nurses are expected to act along with the idea, to establish agencies of their own, and act to fulfill the social expectancies to be considered "professional". Olakivi (2017) did research on Finnish professional nurses' experience and perceptions on enterprising nursing, and found out that major problems exist in three aspects: not having agency, variant interpretations of same occupational issues, as well as conflicts between practicing nurses and their managers. He suggests that many nurses, especially migrant care workers, feel that they are forced to act as enterprising agencies, when they simply do not have the required abilities.

Though few studies have been conducted in Finland regarding nurses' interpretation of professionalism, several were done investigating why do Finnish nurses seek to leave the occupation (Flinkman and Salanterä, 2016; Kankaanranta and Rissanen, 2007). According to Kankaanranta and Rissanen, about 5% of the nursing force were considering leaving the occupation in five years. This trend would lead to severe shortage of nursing force in Finland. Kankaanranta and Rissanen suggest (2007) that wage is a main reason why nurses are leaving, as it is not correspondent to their workload and pressure they are facing. Flinkman and Salanterä (2016) on the other hand suggests that, for younger nurses, suffering from poor nursing practice environment as well as lack of support, orientation and mentoring are the main reasons of them leaving. From a professionalism perspective,

it can be assumed that the wage does not meet up with their self-evaluation as professionals, and that they seek more support from professional organizations. Kankaanranta and Rissanen's research (2007) also suggests that possibilities of further studies and practices for specialisation is a positive factor for the nurses to keep their work, indicating that continue education is a relative important attribute of professionalism for Finnish nurses.

Out of Finland, Arman et al structurally went through the works of three Nordic theorists (Katie Eriksson, Kari Martinsen, and Karin Dahlberg) in nursing care, aims to find out the essence of Nordic tradition of care giving. They concluded that caring science in the Nordic tradition has been highly autonomous, and that the basic of healthcare has always been about life and existence. They argue that typical Nordic caregiving acts include developing self-awareness, being open to the uniqueness of each patient, but considering equally about all patients at the same time (Arman et al, 2015). Aase et al did another research (2016) in Norway, focusing separately on nursing and medical students, revealed that compared to physicians and medical students, nurses and nursing students deem team performance as more important, which correspond to Patastravro et al's research (2012), and consider broader informal communication among team members as an important means to improve team performance.

In brief, it can be concluded from these empirical studies, that nurses in Finland attach special importance on team work and communication, they give special care to each patient while also provide care on a universal equal level. They are aware of themselves as professionals and actively seek future education. In the current Finnish social situation, where enterprising nursing is highly advocated, many nurses do feel pressure of becoming one because they do not yet have the ability required. What's more, a fair percentage of nurses are not satisfied with their wages and working environment, considering themselves as nursing professionals.

### 3.4 Empirical studies on nursing professionalism in China

As in many other areas, studies about professionalism are also highly concentrated from the Western perspective, written by Western scholars, studies done among western participants. In the recent years, not yet many, but increasingly more Asian researchers have been trying to localize the studies in this area, and found out that the dominant western discourse of professionalism does not necessarily apply to Asian countries as to China (Pan et al, 2013; Ho et al, 2011; Jung, 2014 etc.).

Pan et al. in 2013 did a relatively thorough research in China among about 100 healthcare professionals, about their interpretation of professionalism, and nurses were about one fourth among the participants. According to Pan et al, among the nurses, clinical competence is deemed the most important factor, and the following factors are teamwork, accountability and communication. Pan et al noticed that, self-management rarely falls in the framework of professionalism for nurses, but for resident physicians. They also specified a prominent category: humanity. In their research, humanity specifically refers to “humane love” (仁爱) and “public spiritedness” (公心), two dominant Confucian attributes. “Humane love” in Confucianism calls for equal love to all humans, while “public spiritedness” emphasizes on consideration of public benefits.

Ho et al did a research (2011) among medical professionals (not only nurses) in Taiwan, investigating if the western professionalism framework fits in Asian situations. Similar to Pan et al’s research, they found out that while the core attributes such as clinical competence, communication and ethics apply well to the medical professions in Taiwan, two other factors emerged as also dominant, but were rarely mentioned in western frameworks: harmony of personal roles as professional as well as family member, and “self-dignified” or “self-respecting”. They explained both of these two attributes as a result of the underlying Confucian culture, which not surprisingly coincide with the results and interpretation by Pan et al (2013). They have integrated these special Eastern perspectives into teaching curriculums of their institution, in order to facilitate the development of Taiwan medical students to better locally suited professionals (Tsai, 2012). However,

Ho et al failed to separate the participants into occupational groups, and there is no way to know how did the sub-group of nurses comply with their research outcomes.

Similar to Pan and Ho, Leung et al did a research in Hong Kong (Leung et al, 2012). They came to the conclusion that “traditional Chinese thought is embedded, to a significant extent, in our subjects’ (Hong Kong medical professionals) views of medical professionalism.”

Jung (2014) in his research points out that in South Korea, conflicts exist between registered nurses (RNs) and practical nurses (PNs), rooting from the fact that professionalized RNs do not regard PNs as their true nursing partners. The conflict shows in assigning tasks to RNs and PNs, as they have different understandings of their professional abilities, and the law needs further improvement in regulating tasks to RNs and PNs. As most of the migrating nurses have been educated as RNs before migration, their competency is usually not recognized in destination countries because different credentials (educational diplomas, registration exams) are required in the new environment. This is a main way in which globalization has influenced professionalism (Faulconbridge and Muzio, 2011). The drastic change in recognition of identity of the migration nurses, from RNs suddenly to PNs, would have huge impact on their interpretation of themselves as professionals, which will be further discussed in the discussion chapter of this research.

In conclusion, though there were not many studies done specifically in nursing professionalism in China, from the nearby studies in Hong Kong, Taiwan, and Korea, which are all strongly influenced by Confucianism, it is evident that the Eastern culture, often interpreted by Confucianism, has a valid influence on nursing practitioners’ understanding of professionalism. Confucianism as a culture is vast and diverse. Researchers have found out that “humane love”, “public spiritedness” (Pan et al, 2013), harmony and professional relationships, self-dignities (Ho et al, 2012) can be important for Chinese nurses pursuing professionalism. However, since there are currently very few studies conducted on this topic, it is to be aware that other factors induced by Chinese culture or Confucianism may well be documented in later studies.

## 4 Methodology: How Was This Research Conducted

In the beginning of this chapter is an overview of the design of this study. The overview is followed by reasoning of why the study is designed as a qualitative research and why interviews were conducted. I then introduce the recruitment of participants and give general information of participants. After that, I describe how the interviews were conducted, which is followed by ethic issues. This chapter ends with a detailed description of how the data were analyzed.

### 4.1 Design of study

Many professionals migrate under the current trend of globalization. However, among all the professions, nurse is relatively special in that it requires direct contact with clients, and a nurse's daily job – care providing – is highly dependent on the cultural and social norms where the job is situated. There is a trend of Chinese nurses migrating to Finland to practice. Considering various differences between China and Finland, I am curious about how has the nurses understand and think about the changes happened in their professional life. Migrant nurses' self-understanding of professional would have a direct impact on nursing of their clients, while it would also influence on migrant nurses' decision on whether staying in the host country as a nurse or not.

From the above-mentioned considerations, I decide that the research question of this study is: **How do migrant nurses from China to Finland interpret themselves as professionals.**

To answer this research question, literature on professionalism, professionalism under the trend of globalization, nursing professionalism, and empirical studies focusing on nursing professionalism in Finland and China were systematically reviewed. To further gain understanding of migrant nurses'



interpretation of themselves as professionals, contact was made to nine migrant Chinese nurses who were working in Finland, and semi-structured in-depth interviews were conducted with each of them. The data gathered were then analyzed according to indicators derived from literature: educational background, adherence to code of ethics, organizational or autonomic power of regulation, continuing education, and communicative skills. While two other indicators emerged from the data: daily practices and respect from patients and colleagues. The data were analyzed from a comparative perspective, focusing on the differences between Finland and China that research participants expressed in the interviews. The results from data analysis were then further discussed and conclusion was drawn in the final chapter.

## 4.2 Choosing research method

According to Hennik, Hutter, and Bailey (2010), qualitative research is typically conducted for “providing an in-depth understanding of the research issues”. It is useful to explore relatively new topics, to understand complex issues, to explain beliefs and behavior, and to identify social or cultural norms of society. Besides, Hennik, Hutter, and Bailly also point out that (2010), qualitative methods are especially suitable for sensitive topics, as the rapport building in the research process helps the research participants feel comfortable and reveal their real feelings, thoughts, and beliefs. Therefore, qualitative research method fits well with my aim of this study. My aim is to understand how do migrant nurses interpret themselves as professionals. This issue lies in a fairly complicated social and cultural matrix of migration, with innumerable factors in the migration process that could have impact on their understanding of professionalism. As a result, this study is designed to be conducted in a qualitative way.

I decided to use in-depth interview as my method of data collection in this research. In-depth interviews are usually used when a researcher seeks to investigate on “individual, personal experiences” about “specific issue or topic” (Hennik, Hutter, and Bailey, 2010), which fits exactly

my research question of understanding the migrating nurses' personal interpretation of professionalism, as in-depth interviews get "narratives about people's lives", "subjectivity of the interviewee", and "the context in which the interviewee lives" (Wengraf, 2001).

Even though my research question seems to focus on a community of migrant nurses from China to Finland, and they seem to share greatly in common, I didn't collect data using focus group discussions. Focus group discussions tend to see participants as part of a bigger community and seek to collect information on the community perspectives (Hennik, Hutter and Bailey, 2010). While in my research I believe that migration is a complicated process, and the personal feeling before and after migration, on professionalism as well as on other perspectives of life, can be affected by personal experiences, background, working area and environment and so on. Thus each and every migrant is idiosyncratic from that sense. What's more, the perspective of professionalism may seem common in daily conversation, but talking about sense of professionalism can be sensitive among other nurses, or even peer colleagues. Participants may be over modest talking about their professions in front of peer workers, or overconfident, as they may face conflict of interests in work. As a result, in-depth interview is decided to be the method of data collection of this research.

#### 4.3 Recruiting and general information of research participants

Along with the research question, the participants are well defined as migrant nurses from China to Finland. As a result, when recruiting participants, the aim was to reach out to participants that have been working/studying as nurses in China, and they are working/studying as nurses in Finland. However, there was one participant (Participant I) that didn't have nursing training or work experience in China, but only started her career as a nurse in Finland. Her view reveals differences from the other participants and has led to some insights, which is why her interview is included in this study.

Snowball recruitment (“chain sampling”) was used in recruiting the participants, as it is a method specifically suitable for identifying very specific population groups, which “rare experiences” or “hidden” (Hennik, Hutter and Bailey, 2010). Chinese migrant nurses in Finland are relatively hard to reach. As it turned out later in the research, in many cases, when these migrant nurses left school and started working in Finland, it was common that they were the only Chinese nurse in the whole hospital or clinic. I started the recruiting process by getting in touch with two nurses, describing the research topic to them, and asking them to spread the research and my contact information to those that they deem qualified. Those that are reached by these two nurses would then contact me if they are interested in taking part of the research. The potential drawback of the snowball recruitment method is that the participants may all come from the same social network (Hennik, Hutter, and Bailey, 2010). To alleviate this drawback, the process was started from two nurses who don’t know each other.

Nine participants were in the end recruited, considering the workload of conducting interviews and transcription. Some general information of each participant is shown in Table 1 on the next page. As mentioned in Chapter 3, there are three alternatives of education to qualify as a registered nurse in China: secondary education, “zhuanke” education (vocational junior college) (“zhuanke” in Table 1), and baccalaureate education (“University degree” in Table 1). Apart from participant I, who started learning nursing in Finland, all of the participants have achieved to a “zhuanke” or baccalaureate degree. Regarding participants’ education in Finland, all of them hold a degree from a Finnish university of applied science. Participant D’s educational background is quite special among others in that, her school had a co-operation project with a Finnish university of applied science. She studied 3 years in China with teachers from China and also from Finland, and then came to Finland and studied for one year. She got two degrees and was licensed as registered nurse in both China and Finland.

<b>Participant</b>	<b>Gender</b>	<b>Education in China</b>	<b>Work Experience in China</b>	<b>Education in Finland</b>	<b>Work Experience in Finland</b>
<b>A</b>	F	University degree	2 years	Degree from University of Applied Science	1 year
<b>B</b>	F	“zhuanke”	5 years	Degree from University of Applied Science	1 year
<b>C</b>	F	University degree	1 year	Degree from University of Applied Science	2 years
<b>D</b>	F	University degree *	NONE	Degree from University of Applied Science**	7 years
<b>E</b>	M	University degree	2 years	Degree from University of Applied Science	4 years
<b>F</b>	M	University degree	16 years	Degree from University of Applied Science	1 year
<b>G</b>	F	“zhuanke”	1 year	Degree from University of Applied Science	1 year
<b>H</b>	F	University degree	10 years	Degree from University of Applied Science	3 years
<b>I</b>	F	NONE	NONE	Degree from University of Applied Science	5 years

**Table 1. General information of research participants.**

\*, \*\* Participant D’s nursing education is distinct from other participants, as her degree consists of 3 years of nursing education and training in China, and 1 year in Finland. After 4 years of studies, she was granted a University degree in China as well as a degree from a university of applied science in Finland.

#### 4.4 Conduct of interviews

Because I was in China and the participants were in Finland by the time the interviews were conducted, the interviews were done through online-video talking. I required video talk instead of simple phone call to get more information from the participants' facial expressions and body language. However, one of the interviews were done without video as the participant didn't have a functioning video camera at the moment. All the interviews were recorded (sound) with consent of the participants. All the nine interviews were conducted in Mandarin Chinese, as it is the mother tongue of the participants, and will help them elaborate their feelings and understandings in better detail. The records were later on transcribed and coded in Chinese. The analyses was done in English, and the extracts shown later in the analysis chapter were then translated into English from the transcription.

The interviews started with my explanation of the research, the information that it will be recorded, and the statement of confidentiality. Then I started the interview with small talks like "In which city are you currently living and working in Finland?". Small questions with a direct answer that the participants have definitely an answer to help to ease the nerves of the participants and build rapport (Hennik, Hutter, and Bailey, 2010).

Then I moved on to the core questions drafted in my interview guide. The interview was designed to split naturally into two parts - before migration and after – to facilitate later analysis focusing on the difference in China and Finland. Similar questions are designed for both parts like "How was your work when you were in China?" ("How is your work currently in Finland?"), and "What pushed you to decide that you want to move to Finland?" ("How do you now feel about your migration decision?"). As an interviewer, I kept my role as the one asking questions, kept in mind that it is not an open dialog, and my role is to listen and lead the 'conversation', trying to have the least influence on participants as possible. Besides, as in semi-structured interviews, the questions were kept open

and broad, but then I kept asking small and prompting questions like “can you explain?”, “why is it so?” to invite participants to tell more about certain topics.

The interviews varied from 25 minutes to about 90 minutes, depending on the level a participant is willing to talk or have to talk about his or her experience.

#### 4.5 Ethic considerations

Efforts were made to keep the ethical standards in the research. According to Hennki, Hutter, and Bailey (2010), the following principles need to be considered in order to conduct an ethical research: Informed consent, self-determination, minimization of harm, anonymity, confidentiality.

As mentioned before, all the participants recruited acted on free will to participate in the research. Before the interview, they were informed what the interview is for, and that the interview would be recorded. The recording only started after they had consented. No harm was done to the participants, because they were well informed also before the interview, that they did not have to answer to the questions if they didn't feel like to. The interviews were conducted in relative relaxed atmosphere. The participants were totally anonymized throughout the research. Alias were used in the interviews and transcription. As a result of the snow-balling participant recruitment method, even I do not have the name of the participants. The records and transcripts of interviews were safely kept in my personal computer and memory disk, with nobody else having access to the material.

## 4.6 Code developing and categorisation

Hennik, Hutter, and Baily (2010) summarized qualitative analysis into ten broad steps: prepare verbatim transcripts, anonymize data, develop codes, define codes in a codebook, code data, describe, compare, categorize, conceptualize, and develop theory. The data were transcribed and anonymized shortly after interviews. To develop codes, five key factors were derived from existing literature, mainly from Miller's (1993) framework of evaluating professionalism, but also considering implements from empirical studies on nursing professionalism focusing on China and Finland. The five key factors are: educational background, adherence to the code of ethics, participation in organization and autonomy in self-regulation, continuing education, and communicative skills. However, after several rounds of reading through data, it turned out that none of the participants mentioned anything about participation in organization and autonomy in self-regulation, so this factor was left out from coding and later steps of data analysis, even though it is a hotly discussed topic from literature. Two other factors that were rarely mentioned before emerged from the data: nursing practices and respect from patients and colleagues. The coding and categorizing of each of these factors are discussed in detail:

### **1. Educational background.**

Educational background is considered a qualification of competency to enter the occupation, and has long been an essential proof of one's professional level. In my research it refers to the education training in both China and Finland, with only one case as an exception, as the participant (Participant I) only got education from Finland. Keywords such as "Bachelor's Degree", "lectures", "teaching method", "school", "university", "teacher", "study", "diploma" were coded and categorized into this factor.

### **2. Continuing education and competency**

Studies have shown that in Finland nurses enjoy the chance of getting continuing education or training to become specialized in some specific nursing area (Kankaanranta and Rissanen, 2007). How do the migrant nurses think about possibilities of going on continuing education,

what would they acquire from the studies, and how would that affect the level of professionalism for them, is to be discussed. Codes with “keep learning”, “further studies”, “specialize”, “apply to further studies” were grouped into this category.

### **3. Communicative skills**

As discussed in the literature part of this research, communicative skills are deemed essential for being a professional nurse. Communication between nurse and patient, as well as communication among team members are considered in this aspect. Language barrier can be a huge obstacle in these nurses’ daily communication. Data pieces with keywords such as “speaking”, “language course”, “understand”, “communicate” were categorized into this topic.

### **4. Adherence to the code of ethics**

Ethics is an outcome of social norms and behaviors. Ethics is developing through time, and it also differs from China to Finland. As former studies have shown that Chinese nurses tend to be influenced by Confucianism, which includes various beliefs from “public spiritedness” to “self-dignified” (Pan et al, 2013; Ho et al, 2011); while in Finland nurses tend to care under the dome of egalitarianism, yet paying special care to every patient (Arman et al, 2015). Confucianism related topics didn’t emerge from the data, codes with keywords such as “responsible”, “in charge of” were gathered in this category.

### **5. Nursing practices**

Almost all of the participants talked about the enormous difference in the daily nursing practices in Finland and China. The participants argued that they have to also conduct non-medical care services in Finland, which was not part of their responsibility in China. They also argued that they had far more chance to practice medical practices in China than in Finland. This has distinctly led towards a change of their interpretation of the concept of “professional”, thus is considered as a main factor among the others. Keywords such as “giving infusion”, “drawing blood” and “feeding”, “bathing” are coded and categorized into this topic.



## **6. Respect from patients and colleagues**

Another distinct difference between the participants' working experience in China and Finland lies in interpersonal relationships between these nurses and their patients, patients' relatives, co-workers, team leaders, and doctors. They have generally more positive feelings towards the interpersonal relationships in Finland than in China, which can be generalized as more respect from all parts. Sentences and paragraphs specifically about participants' feelings about their relationships with patients, patients' relatives, other nurses, supervisors, and doctors are grouped into this category.

The above six factors were then analyzed in detail, from the perspective of the participants, trying to understand the issue from their eyes and feelings, focusing on the differences they expressed of their work experience in China and Finland.

## 5. Findings: Complex Perspective on Professionalism by Migrant Nurses

In this chapter I present the results I got after analyzing the data gathered through interviews with nine migrant nurses who came from China and are currently working in Finland. The final results are gathered and presented in six categories. Four of the categories were derived from existing literature: educational background, adherence to the code of ethics, continuing education and competency, and communicative skills. Two other categories emerged analyzing the data, which were rarely mentioned in literature. They are nursing practices and respect from patients and colleagues. I will discuss these six categories in detail in the following of this chapter.

### 5.1 Educational background

All of the nine participants talked about education in much detail, both in China and in Finland, a degree is required to get the license to work as a nurse. Most of the participants attained specialized nursing education in nursing in both China and Finland, and interestingly, they have expressed different attitudes towards the educational differences. Differences in nursing education in China and Finland can be divided into two parts: educational methods, and teaching content.

Participants have shown that the educational methods, basically the teaching style is very different from Finland to China. In Finland the teacher would leave more freedom to students, give them a chance to study by discussing with peer students and by searching on topics online; while in China teaching is more hierarchical: the teacher is the provider of knowledge and the students receive the knowledge, and in most cases, would need to remember the knowledge by heart. Many participants

felt that they are “learning nothing” from the discussions on lectures and open question assignments for their courses. As one participant says:

“Lectures here (in Finland) are boring, because I feel like I’m learning nothing. When I go there, the teacher will give us a topic, and we will discuss among students. After the discussion, the teacher won’t tell us whether it’s correct or not. It’s like playing. I haven’t learned anything.”  
(Participant G, 3 years in Finland)

It is noteworthy that this is not a unique phenomenon but rather prevalent among the participants. In most cases, participants don’t think that the Finnish teaching style is more advanced, but more irresponsible to students. They are used to the Chinese way of trying to learn considerably by heart and go through exams and believe that they have learnt more under the Chinese teaching style. As Participant C puts it: “I actually have no idea what I have learnt (in Finland). [laughter]”.

Among the eight participants that have finished a degree in both China and Finland, participant H is the only one enjoying the Finnish teaching style. She took the open questions and freedom allowed as the advantage of Finnish education:

“It’s very different from China. The assignments are different. In China the teacher would assign some questions to answer. But it’s more open here. When there’s an assignment, it’s like writing a long essay, you look for some material online, and, you know, it is just different. You can write however you want, there is freedom.” (Participant H, 5 years in Finland)

Nevertheless, the participants do acknowledge that there is some advantage in the Finnish teaching style. Participants mentioned that they visited residence homes for the elderly people, centers for the mentally ill, and various clinics; they had direct communication with patients and could better understand the patients’ situation and needs after these kinds of field trip, which they had no experience of when they were trained in China. Taking participant C who “had no idea what [she] had learnt” for example:

“We went to a center for the mentally ill to visit. After the visit they introduced to us the activities they do there, and sent a patient to tell us about his/her different mental world. We never had such an experience in China. I feel like I’m closer to the patient.” (Participant C, 4 years in Finland)

Participants have also widely noticed the difference in the content of their education in Finland and in China. The whole nurse education in Finland and China have different emphasis. In China, the focus of studies is in internal medicine, surgery, obstetrics and gynecology, and pediatrics, named as “the four main departments” by several participants, while participants have noticed that in Finland, the focus inclines to mental health care, geriatrics, and hospice care. “The four main departments” are sometimes not even covered, and what is considered to be the basics in China, microbial and biochemical pharmacy, were for many cases not studied at all in Finland.

“In China we focused on the basics: physics, chemistry, internal medicine, surgery. It was very basic, focusing on medical treatment. Here we studied more geriatrics and mental nursing, the other studies, such as gynecology and pediatrics were on the school website, and rarely mentioned in class. Especially the basics, like microbial and biochemical pharmacy, were not covered.” (Participant G, 5 years in Finland)

None of the participant expressed negative feeling towards the special importance that is given to geriatrics and mental nursing, but they take them as a supplement of their former studies in China. However, they do mention that many basic courses that they did in China were not covered or not considered important, and this remains one of their big concerns of Finnish nursing education, and some believe that this is a reason why the Finnish nursing education is not as good as in China.

Nevertheless, no participant showed any traces that, they think themselves less professional after the Finnish nursing education, even though they generally hold a negative attitude towards the Finnish teaching style and content. Many of them actually have picked up knowledge and

experience from this period so that they become more professional, as field trips and direct communication with patients make them “closer to the patients”. Moreover, specialized studies of mental care, hospice care and geriatrics are considered valuable for further career as a nurse in Finland. Though many of the participants blame on the teaching style and contents of “poor Finnish nursing education”, they fail to recognize that they may have these feelings only because they have already had corresponding education in China, and they do possess already a fair amount of knowledge when they are going through the education in Finland. However, the nursing education in Finland that these participants attend, is designed for those that are starting to learn to become a nurse, and no prior knowledge of nursing is required. There is an interesting contrast comparing Participant I’s data with the others, as Participant I had no experience of the Chinese nursing education. She expressed that she enjoyed her education in Finland and had no complaint regarding either teaching style or the content of studies.

Another anxiety for the nurses lies in the title of their universities in Finland. Most of the participants got a degree from a university of applied science (ammattikorkeakoulu) in Finland, while they had already got a degree in China from a medical university. Many of them believe that a degree from medical university is better than a degree from a university of applied science. Participant C made a metaphor in the interview about reading the second degree in Finland: “I’m only stepping on the spot, or even backwards.”

In summary, the difference of education between Finland and China lies in two areas: teaching style and teaching content. Some don’t think that they learned much from the Finnish teaching style, while some enjoyed the freedom. The content of studies is noticeably narrower in Finland than in China, focusing on the elderly and the mentally ill. Participants generally appreciate these specialty studies provided by Finnish universities, but are worried about a lack of general studies. Furthermore, a degree from university of applied science is not well appreciated.

## 5.2 Continuing education and competency

All the participants of my study went through a degree of university of applied science in Finland, and this can be already considered as continuing education and polishing their competency. However, from a comparative perspective of the educational background in Finland and China, the focus of this sector is on comparing migrant nurses' ideas and possibilities of pursuing further education and better competency, when they were working as a nurse in China, and after they graduate from a Finnish nursing degree.

Answers from different participants show that continuing education is considered as a positive factor to their career as professional nurses both in China and Finland, yet data also show distinctly that it is easier to pursue further education in Finland than in China. Participants imply that the possibility of pursuing further education and training in China is largely constrained by hospitals, as hospitals are main institutions providing continuing education and training, and the continuing education and training are mainly provided for the hospital's own employees. Consequently, hospitals in China are indeed controlling nurses' chances to pursue further education. While the working environment is highly hierarchical, chances left for younger nurses are rare:

“In China if you want to go for further studies, it depends on your yearly salary and years of work in a hospital. Say if in your department there were colleagues that started working there before you, but didn't have the chance to go for further studies, the chance would automatically go to them. So I would have to wait for a long time.” (Participant D, 9 years in Finland)

While in Finland, continuing education and training are normally organized by separate educational institutions, which means that nurses can apply to the positions as individuals and of their free will. Several participants have plans already to pursue for further education, usually to become a specialized nurse. As Participant E says:

“I might study and go on to become a specialized nurse (in Finland). I am interested in dealing with wounds, pain, or diabetes. I want to become the one that can run my own clinic. Or there are also nurses that can prescribe medicine in Finland. I have this kind of plan.” (Participant E, 6 years in Finland)

Among the participants there's also Participant I, who was planning to do a master's degree in nursing management. Comparing their experience it is obvious that all participants believe that one is more professional with more education, and more competent, both in China and Finland, and they have always wanted to attain continuing education. But the participants recognize that, it is much easier to pursue continue education in Finland than in China. The difference lies in the way continuing education and trainings are organized in China and in Finland.

Appreciating the chances lying on the interface of China and Finland, one participant (F) utilized his special position on the verge of both countries, and studied to become a Chinese massage therapist, specializing in acupuncture. He is not currently using this specialty at work, but he sees the possibilities. He is a distinct example of these migrant nurses that has become a specially professionalized nurse in Finland, after some further education.

### 5.3 Communicative skills

Interviews reveal that the participants as migrant nurses in Finland, are facing vast communicative problems. As nurses, communicative skills are needed between them and patients and co-workers. As communicative skills can help resolve potential tensions between nurses and patients, also within a team of nurses, these migrant nurses from China are all still in the phase of learning Finnish, trying to understand and trying to express themselves, even after years of studying and working in Finland. Their communicative skills are barely covering the basic needs of communication, resulting in various problems for them at work, endangering their self-confidence as professional nurses.

Communicative skill turns out to be a huge barrier for the participants, starting from the first stage of their career: job interviews. Many participants argued that their employers are also well aware of their technical abilities, but their main concern is the nurses' language skills, which usually led to the nurses working as nurse assistant, even though they are already licensed nurses:

“I didn't work as a registered nurse at that time, even though I have got the license already. The boss said that I needed some time to develop my language skills. He meant that he would take some time and see, if I could manage the language, he would let me do the job of registered nurse. So I started working as a nurse assistant in the beginning.” (Participant C, 4 years in Finland)

Working as nursing assistant though most of the participants have two degrees in nursing and years of practicing experience in China damages their self-confidence, and is a waste of their professional competence.

After learning, training, and practising as intern or nurse assistant, all of the participants got a position as registered nurse. Yet they still face challenges talking with patients and co-workers. Though most of them try hard learning Finnish when they are working, the language barrier cannot be easily crossed, and the participants are anxious about the challenges they are facing daily in communicating. The participants understand that communication, especially with patients, is a core part of their job, thus not being able to smoothly communicate with patients diminishes their self-confidence as nurses:

“Here (in Finland) nurses are with doctors going around the wards, the doctor with his / her computer, and the nurse has another computer. When I go with doctors in wards, I don't understand what the doctor says. Ai... How long would it take for me to reach to that level (of understanding the words of the doctor). If I don't reach it, I can't really be competent as a nurse.” (Participant C, 4 years in Finland)



Even though relatively poor language skill makes the participants feel that they are less professional as nurses, they distinguish clearly language skills as a separate issue from their other technical nursing skills.

“Especially when picking up phones, if it’s urgent, and your Finnish is not good enough to understand, you cannot just tell the one on the phone to speak slower. I am really anxious about that. For now, there’s nothing but Finnish language that makes me anxious.” (Participant F, 3 years in Finland)

Communicative skills turn out to be a huge factor, diminishing these migrant nurses’ self-confidence in their competency as nurses. They faced problems getting a job as registered nurse due to poor language skills, and they still encounter communicating problems daily in practicing, with both patients and co-workers. They themselves are well aware of this problem, and are trying hard learning Finnish language, mostly at work, from co-workers, but some are also taking courses in evenings and weekends aside from work. When we talked further about improving their Finnish skills, they were almost all unsatisfied with the Finnish language courses provided by the university, when they were reading the degree in nursing in Finland, as it was mandatory for them to learn Finnish in the degree, and they had to pass language tests to get licensed. Taking Participant A’s words as an example:

“There were language courses in the university, but they were not enough. Actually, I think they were far from enough. So I want to talk with Finns in everyday life, but they are not very talkative.” (Participant A, 3 years in Finland)

Some participants mentioned that there were only about 3 courses of Finnish language in their degree in Finland, which is far from enough, as they had to practice as interns in Finnish after the three courses, and were severely encumbered with poor language skills. The participants all tried very hard learning from work, talking to colleagues and patients, to improve their skills. Some also took courses out of school:

“I took night classes in Lahti, twice a week. We had Finnish courses at the university, but they were terrible. Our teacher couldn’t explain things clearly, not even to himself/ herself. I don’t understand why the university arranged for him/her to teach us [...] It was fastest to learn by doing. I arrived in Finland in September and was assigned to practice already in October. In the beginning I couldn’t talk at all, so I forced myself to study. I listened and watched every day in hospital. And I had done those things earlier in China, I knew the basics, it was just about changing the language, so I learned fast.” (Participant E, 6 years in Finland)

In summary, all the participants have expressed their anxiety of lacking communicative skills in Finnish, which have resulted in difficulties for them to enter the labor market as a registered nurse, and have caused various problems in communicating with patients and colleagues in their daily work. This has largely impeded their understanding of themselves as professionals. Many of the participants mentioned in the interviews that they are not satisfied with their university’s arrangements of Finnish language studies. Data show that they have tried hard and learnt fast at work. However, even after years of work experience as a nurse in Finland and actively trying to learn the Finnish language, poor communicative skills remain as a major source of anxiety for these nurses.

#### 5.4 Adherence to the code of ethics

Among the participants, ethics of nursing is generally understood as being responsible to the patients, and they deem themselves nursing in Finland as more responsible to the patients from the perspective that a nurse spends more time on each of the patients, providing more thorough care, and paying more attention to individual needs of patients. Words from participants suggest that they were aware of the patients’ needs when working in China. They also wanted to provide more

thorough care. The single problem lies in the facts was that there were simply too many patients to too less nursing force. Participant C gave a very concrete example of contrast of herself:

“I have 3 patients in my room (in Finland), and I can do all their stuff, and it is good. In China it is at least 8 or 9. When I was working in gynecology department, one day there were over 100 patients in the queue waiting, and only 10 nurses at work. I felt crazy.” (Participant C, 4 years in Finland)

The acknowledgement of themselves allocating more time and energy to each patient is consistent among all participants, apart from participant I, who has no experience of nursing in China. The participants consider themselves as more professional through being able to be more responsible. The code of ethics on this aspect is consistent through the participants’ migration process: a nurse should be responsible to patients. While the change of environment has enabled the participants to better fulfil the code of ethics.

No other aspect of adherence to the code of ethics was mentioned in the interviews.

## 5.5 Nursing practices

Huge difference in the nurses’ daily chores appeared from the participants’ experience in China and Finland, and the difference intrigued the participants to think about how do they consider themselves as professionals in China and Finland. Several aspects in the nurses’ daily operation emerged from the interviews:

### 1. Non-medical nursing practices

Almost all of the participants mentioned that, a huge difference in their daily practice of nursing between China and Finland lies in the fact that, in Finland, even registered nurses would need to

take care of the patients' daily life. Non-medical care providing, like bathing, feeding food and water, clothing, is a central part of the participants' job as nurses in Finland. The participants pointed out that in China, non-medical care providing was not part of their job at all, relatives of the patients are the ones that take care of the patients' daily needs. When the relatives of a patient are not able to accompany the patients daily, they would hire a "hugong" (care worker) to take care of the patients' daily needs. Many of the participants expressed discontent because they feel that they are working as a "care worker" in Finland. The comparison of themselves to "hugong" (care worker) in itself shows that the participants consider themselves as less professional, as in China, a "hugong" (care worker) is normally uneducated and self-employed.

“... feeding, changing diapers, bathing. [laughter]. I have never done such things in China. In China my job was very technical, and these are all chores for the relatives. But in Finland the relatives of patients are not around, so practical nurses or registered nurses have to do the job. Like the “hugong” in China.” (Participant F, 3 years in Finland)

Participant F is taking this difference quite casually, when compared to other participants, even though Participant F had 16 years of working experience in operation rooms in China. Participant C said that she felt herself like a “nanny” when providing non-medical care, while Participant B was considering leaving the occupation because she felt that she was not respected to bathe and feed patients after two degrees of nursing and years of experience. Almost all participants considered the non-medical care providing as a highly unprofessional part of their job.

Although most of the participants don't appreciate the non-medical care that they have to provide to patients at work, many of them have expressed that they have learned about “holistic care providing” in Finland and understand that when holistic care is provided, the patient is more likely to recover soon and better. Some of them also believe that since a nurse is taking care of less patients in Finland, the nurse is supposed to be more responsible to each patient, which leads to the result of providing non-medical care. What's more, many of the participants started their career in Finland as practical nurses (“lähihoittaja”), which is more like “hugong” in China and non-medical care was

a bigger share of their daily job. Many participants expressed that they “are used to” or “are getting used to” these non-medical chores, but hardly anyone of them is happy about these chores.

Among the participants, participant I is the only one with no experience of nursing in China. She started nursing education in Finland and has been working as a nurse in Finland afterwards. In the interview she described in detail about her daily work, feeding, bathing, dressing the patients, without any sign of negative feelings towards these daily chores. She was the only one among the nine participants that thought of these chores as normal for nurses, which forms a drastic contrast with the attitude of other participants.

## 2. Technical practices

Many technical operations that requires specific education and practices are required to be performed in nurses' daily work, such as giving injections, drawing blood, and nursing wounds. Many participants expressed that they have better techniques in medical operations than their colleagues. They understand this as a result of Finland's small population, giving the nurses in Finland less chance to practice:

“Transfusions are rare abroad (out of China). They don't do transfusion unless it's fairly urgent. In contrast, in China a patient would get several bottles of infusion in the morning and the afternoon. So the nurses here (in Finland) have fewer chances to practice. So it is normal that a patient bleeds when the nurse cannot prick a needle into the patient's vein for transfusion.”

(Participant C, 4 years in Finland)

Many participants showed strong confidence when talking about their professional techniques. Their expertise in technical operations maintains their level of self-understanding as professionals in Finland, under the huge pressure of language barrier. From words of many participants, it can be seen that they actually feel that they are more professional in Finland than in China, when they consider their better technical skills developed in China. Participant F is very confident in this case:

“They (Finnish colleagues) are far behind me in techniques of drawing blood [laughter]. I’m the “number one” [orig. in English] in Nastola. They come to get me when they cannot succeed in drawing blood from a patient, or when they don’t know how to deal with a wound. I have worked for 16 years; I know it in a glance. I’m the expert in this industry. [laughter]”  
(Participant F, 3 years in Finland)

Participant F has rich experience in operating rooms in China and Finland. He noticed that in some certain areas of practicing, nurses perform procedures that are conducted by doctors in China, and he deems it highly professional:

“For example in China, surgeons sterilize the surgery instruments and spread the sheets on the table, with the help of nurses in the operation room. But these are all done by nurses in Finland. Here nurses do the work that should be done by doctors in China. This looks simple but it is actually not, as it is related to the surgery incision, the area exposed.” (Participant F, 3 years in Finland)

### 3 Autonomy in making decisions

From the former sub-sections it is shown that these participants believe that nurses in Finland would have to provide a lot of non-medical care, and are less experienced in many technical operations like giving injections and drawing blood. These could lead to a broad understanding that the participants would consider a nurse less professional in Finland than in China. In contradiction to that, some participants have expressed that, being a nurse in Finland enjoys more autonomy power in making decisions while practicing in Finland than in China. Below is an extract from participant D for example:

“Here (in Finland) doctors are rarely in the patient’s room, so in case of any situation, like high fever or vomit, the nurse would deal with it by himself/herself. [...] The nurse doesn’t have to call a doctor to the patient hectically, but can make some medical decisions

independently and act as a buffer. I have never experienced this working in China.” (Participant D, 9 years in Finland)

According to the participants, nurses in Finland can make some medical decisions in certain situations, and they also work in a team of nurses and discuss about situations when in need. They would contact the doctor only if the situation has surpassed a certain limit. Otherwise the nurses can deal with the situation on their own and report to the doctors later. However, in China a nurse would always have to follow the orders of the doctors and has no room of making decisions at all. A nurse in China is more like a link between patients and doctors, bringing medicines from doctors to patients, conducting blood draws, injections, and transfusions prescribed by doctors, and reporting the situation of patients to the doctors. Facing this contrast, many of the participants have expressed that they enjoy this new autonomy. None of the participants show discomfort or confusion towards their new right and at the same time, the new responsibility.

In summary, the main difference in daily nursing practice between China and Finland expressed by the participants lies in three aspects: 1. In Finland a nurse is expected to provide also non-medical care to patients while in China it is the responsibility of “hugong” (care workers), who are generally considered less professional than nurses. 2. Nurses in China tend to have better techniques in operations such as drawing blood and giving injections than nurses in Finland. 3. Nurses in Finland enjoys more autonomy in practicing than nurses in China. The attitude of participants shows that having to provide non-medical care to patients in Finland makes them feel less professional, while being able to make some medical decisions on their own makes them feel more professional. In Finland, these migrant nurses do believe that they possess better skills in conducting the medical procedures than most of their colleagues in Finland, so they may feel that they are more professional than the others in Finland.

## 5.6 Respect from patients and colleagues

The participants of this study expressed that they have faced a change in inter-personal relationships of themselves as nurses in China and in Finland. They have experienced changes between themselves and patients, patients' relatives, supervisors, and doctors. Overall, they feel that they are more respected from the former mentioned groups as nurses, which would lead to their understanding that they are more professional in Finland than in China.

The change of the participant nurses' relationship with doctors was described already in 5.5, that nurses in Finland enjoy more autonomy in making medical decisions, while in China nurses only follow the order of doctors. From the perspective of the doctors it can be understood that in Finland, doctors respect more of the specialty and knowledge of the nurses, allowing them more freedom.

Many participants have expressed feeling more trusted and respected by patients and their relatives in Finland than in China. This can be a result of the fact that in Finland nurses are actually making some medical decisions, as Participant E says:

“... , because (in China) patient would think that no measurement can be taken unless there's a doctor instructing. Patients would subconsciously think that nursing staff is not helping much.”

(Participant E, 6 years in Finland)

Some other participants simply understand it from the perspective of culture, they think that in Finland everyone is treated equally and respects each other, while in China a nurse is considered to be on a lower level than the patient.

“... most importantly, men are equal (in Finland). [...] You (as a nurse) can be angry at a patient, you can say that this is not ok, this is beyond my limits. [...] In China you cannot fight back or quarrel with a patient even if the patient starts fighting or swearing. If you swear to a



patient you are either fired or need to pay a fine. But it's OK here (in Finland). I think they treat you as a human here. As a human, one gets sometimes angry, and that is allowed here.”  
(Participant H, 5 years in Finland)

The feeling of respect also comes from the trust from patients and patients' relatives:

“They (relatives in Finland) trust nurses very very much. For example, if you (as a nurse) need to do some operation on a patient when a relative is around, the relative will give you space to do it. They normally won't ask any question; they are just visiting the patient. They trust the nurses a lot.” (Participant G, 6 years in Finland)

Participant G then explains the trust the relatives display stems from the fact that Finnish do everything according to regulations. She explains that in Finland to become a nurse one is scrutinized on all aspects, from techniques to communication skills, and that there's no way to bypass this scrutiny. As a result, the patients and relatives believe that their nurses are all well qualified and know better than the patients and their relatives do in providing care.

Many participants also talked about the relationship between themselves and their head nurses. They expressed that in Finland it is less hierarchical, and that head nurse tends to be more open in listening to and considering the ideas of other nurses.

“. It doesn't feel like she is the head nurse, that she is high above somewhere. I don't feel the huge gap between the boss and the employees. [...] The coffee break is a very good time to communicate. The head nurse would sometime hold a quick meeting during coffee break, for example, he / she would tell us about new policies, we would discuss them, and the head nurse would consider our opinions and decide what to do. [...] In China I felt like I belonged to the head nurse. If he / she said something I had to follow her idea.” (Participant E, 6 years in Finland)

From the words of participants, it is clear that in Finland head nurses pay more attention to each of the nurses, and that the nurses' ideas are listened to. In this way the participants feel that they have a role to play in making decisions on bigger issues, and that they are on the same level with the head nurse, as a result, they may feel that they are more professional.

Participant D mentioned that her head nurse in China didn't give her much attention back then probably because she was too busy, which might be true, as it was mentioned earlier that in China a nurse is in charge of far more patients than in Finland, and it is imaginable that the head nurses in China are also busier than the head nurses in Finland. Nevertheless, it is undeniable that the working culture in China is more hierarchical than in Finland, which can be proved by Participant E saying that she felt like she "belonged to" the head nurse. Participant B also told a story in the interview, where she experienced culture shock at her first job in Finland when the head nurse came to the coffee break room when the room was full, and nobody offered a seat to the head nurse, so the head nurse just stood in a corner. Participant B described the experience as "unbelievable".

To sum up, the participants expressed that they have enjoyed more respect as nurses in Finland than in China, from patients, patients' relatives, doctors, and supervisors. The respect is shown in the daily inter-personal attitude towards the nurses, in the fact that they enjoy more freedom in making medical and administrative decisions, and in the trust from patients, relatives, and doctors. On one hand the respect comes from the fact that in Finnish culture everyone is considered equal, and it is less hierarchical in Finland than in China, while on the other hand the respect also comes from the Finnish system that nurses are educated to make individual and collective decisions without doctors, and that the system with almost no corruption ensures that each nurse is well qualified for the job.

## 6. Discussion: am I professional in Finland?

The research question of this study was how migrant nurses from China to Finland interpret themselves as professionals. In order to comprehend the migrant nurses' interpretation of themselves, I conducted in-depth interviews. When analyzing the data gathered, special attention was paid to the differences shown between China and Finland in the participants' interpretation of themselves as professionals, and efforts were made to seek the underlying reasons of the changes in their interpretation. This study found out that migrant nurses from China to Finland have rather complicated understanding of themselves as professionals, influenced by many factors. The main findings of this study can be found concisely in Table 2 (on page 60).

As shown in Table 2, six categories emerged from the data that have influence on the migrant nurses' interpretation of themselves as professionals: educational background, continuing education and competency, communicative skills, adherence to code of ethics, nursing practices, and respect from patients and colleagues.

In this chapter, I will discuss the findings. Educational background, continuing education and competency are closely connected to each other, and will be discussed in the first sub-chapter together. Then I will discuss the communicative skills and adherences to code of ethics, each in a separate sub-chapter. The two categories that were rarely covered by studies and the literature but emerged from my study - difference in nursing practices and respect from patients and colleagues - will be further discussed in more detail at the end of this chapter.

<b>Categories</b>	<b>Differences Experienced between China and Finland</b>	<b>Influence on participants' interpretation of themselves as professionals</b>
<b>Educational Background</b>	<ul style="list-style-type: none"> <li>- The teaching style in Finland allows students more freedom.</li> <li>- The content of nursing education in Finland is focused on geriatrics and mental illness, subjects that are deemed basic in China, such as microbial and biochemical studies, are not covered.</li> </ul>	<p>No distinct influence on participants' interpretation, because the two periods of studies in China and Finland are often deemed complementary to each other.</p> <p>However, participants have general concerns about the quality of education they received in Finland.</p>
<b>Continuing Education and Competency</b>	There are better chances to attain continuing education and improve competency in Finland.	The participants saw more potential to improve their professional skills in near future in Finland than in China.
<b>Communicative Skills</b>	The language barrier in Finland cause huge communicative problems in participants' daily practices.	The participants doubted their competency and thought of themselves as not professional in Finland.
<b>Adherence to Code of Ethics</b>	Nursing practices in Finland are considered more ethical because nurses are more responsible to patients.	Being able to be more responsible to patients makes participants feel themselves as professionals in Finland.
<b>Nursing Practices</b>	<ul style="list-style-type: none"> <li>- Nurses in Finland provide non-medical care.</li> <li>- Nurses in China tend to have better medical technical skills.</li> <li>- Nurses in Finland enjoy more autonomy in practicing.</li> </ul>	The participants believe that they are professional as a result of their better technical skills compared to colleagues and the autonomy in practicing, but non-medical care providing seriously hurt the belief.
<b>Respect from Patients and Colleagues</b>	The participants received more respect from patients, colleagues, head nurses, and doctors in Finland than in China	The participants believe that they are professional in Finland.

**Table 2. Main factors influencing migrant nurses' interpretation of themselves as professionals**

## 6.1 Nursing education: compulsory training and possibility of further studies

Educational background and continuing education are related to each other. As nursing is a highly specialized profession, specialized education and training prepare nurses for the skills they are required to have before entering to the profession, and also assure the public that the nurse can be trusted (Scot, 2008; Evetts, 2013). As a consequence, the better education and training a nurse receives, the better knowledge and skills s/he possesses, the more competent s/he is, and the more professional.

Education is required by corresponding laws and policies as a pre-requisite to acquire a license to practice as a nurse in both China and Finland. In China, nursing education could be either secondary education, “zhuanke” (occupational junior college) education, or baccalaureate level education, while in Finland education and training at a university of applied science is required. According to the Health Care Professionals Act (559/1994), non-EU and non-EEA citizens can also apply for licensure without Finnish education and training, but only for special reasons and on special conditions prescribed by the reasons, which are not specified. Consequently, for the target group of this research, almost all of the migrant nurses went through another 2-4 years of Finnish education and training just to acquire the license of registered nurse in Finland. As most of the participants went through “mandatory” education and training in both Finland and China, these periods of education were categorized into “educational background” and compared.

The result of this study shows that most of the participants are not satisfied with the Finnish education they had to go through. They hardly believe that they are learning much from the Finnish teaching style, which gives students “too much freedom”. The participants are also concerned about the lack of basic studies such as microbial and biochemical pharmacy in Finland. Nevertheless, even though the participants are not satisfied with the quality of Finnish education, it is not such a concern to them that it would diminish their confidence in their professional levels. On the contrary, the

drawbacks of Finnish education in their eyes are in a sense reminders of their “better” education the participants have had in China, as most of the participants did have corresponding education before moving to Finland. At the same time, their former educational background could be the reason of their dissatisfaction towards the Finnish nursing education, yet the participants hardly noticed this. Most of the participants acknowledged that the Finnish education had enriched their skills in nursing the elderly and the mentally ill, but they felt the gain was hardly worth it when compared to the cost of time and money spent on a 2 to 4-year degree.

One exception in the participants is Participant D, who attained degrees and licenses in both China and Finland through a co-operative nurse training project between China and Finland. She spent 3 first years of the education in China, where Chinese teachers taught in the Chinese style and there were also Finnish teachers teaching in the Finnish style. In the fourth year she was in Finland studying and practicing in clinics. Compared to the other nurses, she had saved 2 to 4 years in education and training, while the quality and content of education she got was similar to the others. This could be a nice example to follow for Finnish educational institutions who would like to attract more Chinese nurses to Finland, and also for Chinese educational institutions, who are aiming to export Chinese nurses overseas.

“Continuing education and competency” is another category that emerged from the data, that is related to education and training. Studies have shown that continuing education and training is a way of promoting one’s competency and becoming more professional, consequently, experience of continuing education is commonly considered as an indicator of how professional one is (Tanaka et al, 2014; Miller, 1993). In this study, continuing education and training refers to the education and training the migrant nurses receive after getting licensure in China and in Finland, as the education for licensing is discussed as “educational background”.

Analysis from the data gathered show that all participants acknowledge that further education and training would enable them to become more professional, and they have always tried to pursue so. However, they feel that it is distinctly easier to attain further education and training in Finland than in China. One of the participants have found the gap of demand and supply of Chinese medicine in

Finland, and he studied Chinese massage and acupuncture in China to become more professional in Finland. Consequently, it can be concluded that some participants interpret themselves as more professional as a result of the continuing education and training they attained in Finland or in the migration process, and many more think that there are better chances to become more professional from continuing education and training in Finland than in China.

The difference between China and Finland lies in the way continuing education and training are organized. In China it is normally organized by hospitals, for the employees of hospitals. As a result, hospitals are in the controlling position, deciding what kind of continuing education and training is provided, and provided to whom. Nurses in China could normally attend the education and training provided by their own hospital, yet in a highly hierarchical society, the chances normally go to senior nurses. The survey on the development situation of Chinese nurses (2017) reveals that 30-50 percent of Chinese nurses have gone through various continuing education and training, yet considering the ways continuing education and training are organized, it is highly possible that those who receive the chances are in senior positions, in bigger and better hospitals that organize such education and trainings. There are also master degrees of nursing in China, but the application includes tests that normally take months to prepare for, and competition is fierce. Considering the working load of nurses in China, the application and studies of such degree programs are difficult to attain. On the other hand, in Finland when the migrant nurses talk about continuing education and training, they refer to education and training purely organized by educational institutions. They may apply to study either alongside with their work or while they are not working, but they apply as individuals and are not controlled by their employers. Data gathered from the interviews also show that most participants feel positive about their chances of getting places for further studies if they apply to.

## 6.2 Communication skills: a huge language barrier

“Communication skills” is another main factor influencing migrant nurses’ understanding of themselves as professionals. Originally in Miller’s (1993) model for evaluating nursing professionalism, communicative skills were narrowly understood as techniques to communicate through academic journals and publications, as back then the study on “professionalism” was still highly academically inclined. Later, studies focused on the communicative skills needed at the patients’ bedside, and then focus was also given to communication between team members of nurses, and between nurses and doctors (Apker et al, 2006; Johnson, 2015). This “modernized” interpretation of communicative skills is the basis of data analysis in this category.

Not surprisingly, the main issue that arose from the interviews is the problem of the language barrier. All participants face severe language barrier problems because of their Finnish language skills. Many participants (from different Finnish universities) complained about insufficient Finnish language courses during their degree, and all of them are anxious regarding their Finnish language abilities at work, which shows in their daily communication with patients, and also talking with team members and doctors. The participants have been in Finland for 3 to 9 years, but none of them could reach Wyne’s (2013) level of communication to balance conflicting parties, or Apker et al’s (2006) level to promote collaboration, credibility, compassion and coordination within teams. Most of the participants still struggle with understanding others and being understood, and undoubtedly the language barrier has harmed their self-interpretation as professionals. Some participants even consider themselves as “incompetent” when talking about communicative difficulties.

The language barrier is a well-known obstacle in the process of migration, and it is a major concern of my participants. In consequence, they have tried to catch up with their language skills in order to become more competent as professional nurses. As the courses provided by their university in Finland could hardly satisfy their need of language learning, they turned to night schools, individual tutors, and possibilities of practicing the language at work. It is very hard to reach the level of native speakers, but the communicative needs in nursing practice are highly demanding. The self-



confidence in the migrant nurses is continuously challenged when they face daily communicative obstacles with patients, and also with colleagues. This explains why many migrant nurses choose English speaking countries as their host country. However, for those who choose Finland and want to remain in Finland, it would help them greatly if they could get more support in learning the language, such as through more Finnish courses at university, more possibilities of learning the language out of university, financial assistance to help them hire private tutors. Hospitals hiring migrant nurses could also consider supporting Finnish language learning of their migrant employees, which would not only benefit the migrant nurses, but would also improve the quality of their work, and smoothen communication in the nursing team.

### 6.3 Spending more time with each patient is ethical

“Ethics” has always been a key factor of professionalism. The level of adherence to the code of Ethics is considered a pillar from the first inventory evaluating professionalism by Miller (1993), and is widely tested in various studies (Tanaka et al, 2014; Ho et al, 2011). According to Sullivan (2005), ethics of professions in general refers to working altruistically for the overall good of the clients, and is a guarantee of quality. In nursing professionalism, the understanding of ethics has been changing from being medical-scientific centered towards being social-scientific centered (Olakivi and Niska, 2016), which is to say that nurses are more expected to take care of patients’ social wellbeing. Research conducted in China and adjacent areas (Pan et al, 2013; Ho et al, 2011) suggest that Confucianism has influenced nurses’ understanding of nursing professionalism, giving importance on “humane love” and “public spiritedness”.

In this study, the only topic that emerged in the category of adherence to the code of ethics is that these migrant nurses believe, that they are more responsible to patients in Finland than in China. They sense the need of taking care of the patients’ social needs instead of simply providing medical care. They communicate more often with patients regardless of the language barrier, getting to know

them, and they feel that they are more professional in doing so. Nevertheless, they are also aware that the code of ethics hardly changed from China to Finland, they are more adherent to the same code of ethics simply because they are in charge of fewer patients in Finland than in China. Data from the Five Year Plan (2016-2020) for the Development of National Nursing Industry show that the number of nurses per 1000 people in China is still scarce compared to western countries, and that the number of nurses compared to the number of doctors is also small. Empirical studies (Zhang and Zhang, 2013; Zhen, 2011; Zou and Ma, 2015) show that huge work pressure is a main factor of why are the Chinese nurses migrating to other countries to nurse. It is not that nurses in China are not willing to provide better care to their patients, it is simply that they have little time and energy to do so. After coming to Finland, these migrant nurses are in charge of less than half of the patients that they had to care for in China. The migrant nurses are also influenced by the Finnish custom of providing “holistic care” to the patients. As a result, they spend more time with patients, providing not only physical care but also caring for the patients’ social needs, and these migrant nurses believe that they are more ethical as professional nurses in Finland.

#### 6.4 Nursing practices vary considerably from China to Finland

“Nursing practices” is a factor that studies have rarely discussed in nursing professionalism. Through my study of migrant nurses from China to Finland, the participants expressed huge differences in their daily nursing practices, which were hardly noticed before, and these differences have influenced the migrant nurses’ interpretation of themselves as professionals without doubt.

One main aspect of the difference is that in Finland the nurses are expected to provide holistic care to the patients, which includes non-medical care such as feeding and bathing, which in China is not in the responsibilities of nurses at all. Many nurses are not comfortable with this change. They acknowledge that they were educated of “holistic care” in school in Finland, and they understand that holistic care is beneficial to patients. They also consider themselves as more ethical as

professional nurses in Finland, as they can spend more time and energy with the patients. Nevertheless, they do “feel like a ‘hugong’” or “nanny” when conducting the non-medical procedures. This general negative feeling towards non-medical practices results from the change, that similar chores were conducted by “hugong” in China, which don’t require any education or training, and are not employed by hospitals or clinics but by patients’ families. As discussed in the category of “ethics”, participants understand, that the code of ethics of being a nurse is changing from medical-scientific to social-scientific (Olakivi and Niska, 2016), which infers that it is ethical to take care of patients’ non-medical needs. Yet the negative feelings from themselves working like “hugong” or “nanny” is so huge, that none of the participant realized that they are acting more ethical while providing non-medical care to patients. As a result, participants interpret themselves as far less professional when they referred themselves as “hugong” or “nanny”, because they think these occupations as less professional.

On the other hand, participants noticed that they have better practical technical skills in medical procedures such as drawing blood or making injections. They developed the skills from practices in China. While in Finland, the need of such procedures is relatively small, and nurses do not have much chance to practice. Because of the contrast in technical skills to other colleagues, participants interpret themselves as more professional in Finland. Apart from the poor technical skills of nurses in Finland compared to these migrant nurses, some participants found that there are procedures conducted by nurses in Finland but by doctors in China. Being able to perform work that used to be done by doctors makes them feel more professional in Finland.

One other distinct aspect of the difference is that the participants have enjoyed more freedom in making decisions as nurses in Finland than in China. The autonomy of making decisions enables the participants to feel more professional, as autonomy power has long been considered as a key factor of professionalism (Hall, 1967; Egner et al, 2012; Wiezorek et al, 2015). It is to be noticed that this autonomy power is different from the sixth pillar “autonomy and self-regulation” from Miller’s inventory (1993). In Miller’s inventory, the autonomy power is understood as the power to regulate a profession, like nurse, from individual professionals, as against the regulating power from

organizations such as hospitals. In this study, Miller's interpretation of autonomy didn't show up as clearly there was no autonomic self-regulatory power among these migrant nurses, but they were simply employees and under regulations of the Health Care Professionals Act, the Health Care Professionals Decree, and regulations of hospitals. No participant recognized this as an issue, so organizationalism and self-regulatory autonomy power is not discussed here.

## 6.5 Nursing is more respected in Finland

Another finding of this study is how "respect" would influence migrant nurses' understanding of themselves as professionals. Interviews with participants revealed a change in the nurses' relationships between each of them and patients, patients' relatives that come to visit, co-workers, head nurses, and doctors. Literature have hardly mentioned that inter-personal relationship would cast influence on one's professional level, while this study shows that it has at least influence on one's self interpretation of one's professional level. Participants mentioned in the interviews that they faced more positive inter-personal relationships from many aspects after moving to Finland: Patients and patients' relatives that come to visit have more trust in nurses in Finland as they follow the nurses' instructions with no queries; head nurses pay more attention to each of the nurses and listen to their ideas and suggestions; doctors also have more trust in nurses in that the nurses are allowed to make medical decisions to some extent, which was not even imaginable in China. All of these changes in inter-personal relationships can be understood as more respect to the nurses, and the respect comes from a trust of their competency and importance, which leads to the participants believe that they are more professional in Finland than in China.

The reason lying behind the difference of inter-personal relationships that the participants are facing can be multilayered. In Finland, the trust for nurses from all parties comes from the trust that the nurse is competent of working on the position, which is guaranteed by the education and training a nurse must go through in order to get licensing. However, the competency of nurses can hardly be

guaranteed in China. Some education and training are required, but not as the requirement of a degree from university of applied science in Finland, secondary education and “zhuanke” levels are also allowed. Actually, Xu et al. argue that almost any kind of nursing education is accepted in China (2000). Considering the corruption on the side, an unqualified nurse may get licensing or/and a position in hospital with illegal procedures, it is understandable that nurses are not as trusted as in Finland. On the other hand, as Werde suggests (2008), Finland is a highly egalitarianised country, and the egalitarianism extended social recognition to groups like nurses, before which whose job gained little appreciation; while China is more hierarchical and nurses are not on a high level of the hierarchy, which also explains why these migrant nurses feel that they are more respected from all parties in Finland than in China, and has led to their self-awareness of being more professional in Finland than in China.

## 7. Conclusion

This study is conducted under the background of an increasing trend of nurses migrating from China to Finland. Nurses' understanding of professionalism not only influences on the respect and appreciation of their own job, but also casts huge influence on the care they provide to their patients. Professional standards of nursing can be drastically different between China and Finland, yet there are few studies conducted on nursing professionalism focusing on migrant nurses, and even fewer focusing on Chinese migrant nurses in Finland. From the considerations mentioned above, I decided to investigate the understanding of professionalism among Chinese migrant nurses in Finland, and my research question was: **How do migrant nurses from China to Finland interpret themselves as professionals.**

To answer the research question, a qualitative research was conducted. After reviewing literature on nursing professionalism and many empirical studies, especially focusing on China and Finland, I conducted nine semi-structured in-depth interviews with Chinese nurses who were working in Finland, trying to understand how they understand themselves as nursing professionals.

In the end, I would like to make some suggestions.

My study finds out that migrant nurses' interpretation of themselves as professionals from China to Finland is multilayered. After moving to Finland, being able to be more responsible to each of patients, having better technical skills than most of their colleagues, enjoying more autonomy in practicing, and more respect from patients and colleagues make them interpret themselves as professional in Finland; while on the other hand, language barrier, and having to provide non-medical care to patients are the two main factors damaging their confidence as professionals; moreover, there are better chances of continuing education and training to promote their competency and become better professionals in Finland. This study also finds that most of the migrant nurses had to go through another nursing degree in Finland to be licensed as registered nurse even though

they had corresponding education and training in China, and the format and content of this degree in Finland is not satisfactory.

It is to be noted that my study finds two categories that have influence on nurses' interpretation of professionalism, but were rarely mentioned in literature. The first category is that the differences of nursing practices among countries (in this case, China and Finland) can be huge, and the differences in nursing practices would lead to migrant nurses' various interpretation of themselves as professionals. Between China and Finland, the difference of nursing practices are that nurses in Finland provide non-medical care to patients (and nurses in China do not), and that nurses in Finland enjoy more autonomy in practicing than in China. The other category is that the attitude towards nurses can also influence a nurse's self-interpretation as professional. The main attitude difference between China and Finland is respect. Nurses in Finland are generally more respected from all parties than in China, making the Chinese migrant nurses in Finland feel that they are more professional. I would recommend further studies on migrant nurses consider these two factors.

In the following of this chapter, I would discuss some possible drawbacks of my study, and then give some suggestions to policy makers about nursing migration.

### 7.1 Possible drawbacks of this study

One possible drawback of my study lies in the validity of data gathered. My data were gathered through nine in-depth interviews, however, because the nurses were in Finland and I was in China by the time of data gathering, the interviews were conducted as on-line video talks. The validity of data gathered through in-depth interviews is determined by the 'rapport' building: the more comfortable participants feel talking in the interviews, the more valid is the data (Alasuutari, 1998). This was considered when I was conducting the interviews, but the level of 'rapport' is hard to

measure for the interviews, and it is possible that participants were not totally honest in their answers, or may have avoid certain aspects that they didn't want to talk about in the interviews.

Another drawback is the relative small number of participants. Nine interviews were conducted for this study. To mitigate the possible drawback from small number of participants, I started the "snowball" process of recruiting participants from two nurses that didn't know each other. Among the nine participants, five had work experience of less than two years, and only two participants had experience of over 5 years in Finland. Result can be different if more participants with longer experience in Finland were recruited. But since the time of working in Finland was not considered as criteria when recruiting the participants, I believe that the distribution of working experience in Finland represent the general situation of Chinese migrant nurses in Finland. Nevertheless, if the study was conducted on a larger scale, the result can be more convictive.

## 7.2 Policy suggestions

In both China and Finland, it is legislated that nurses have to finish certain education and training to be entitled to practice. This means that migrant nurses have to finish some compulsory education also in the host country. However, this education and training period seems not so efficient if the migrant nurse has gone through similar education already from the original country. As in this study, many participants showed that they are unsatisfied towards the education and training years that they had to went through. They argued that they "didn't learn much" because most of the studies were already covered when they were studying in China. Participant D stands out from the other participants in that she was the only one that didn't have to complete a whole 2 to 4-year degree in Finland. Her school in China was in cooperation with a Finnish school, and she studied three years in China and one year in Finland to get licensed in both China and Finland.



The experience of Participant D seems highly efficient when compared to the other participants. Health Care Professionals Decree (564/1994) of Finland regulates that, for a non-EU or non-EEA citizen to be entitled as registered nurse in Finland, one has to either go through mandatory nursing education in a university of applied science, or to be considered fitting for “special reasons and on special conditions prescribed by the reasons”. From my interview with Participant D, it is hard to decide whether her licensing was issued based on her education in Finland, or that her situation is considered fitting for “special reasons and on special conditions prescribed by the reasons” regulated by the Health Care Professionals Decree. But either way, it would be remarkably beneficial to Chinese migrant nurses if the Finnish Ministry of Social Affairs and Health would further clarify in the Act or the Decree, what could be considered feasible for “special reasons and on special conditions prescribed by the reasons” or reveal some case examples. Chinese individual nurses, education and training institutions, or migration agencies would then have better possibility to facilitate the nurse migration process according to the Decree, reaching the level of competency required in Finland more efficiently. This would also mitigate the concern for some migrant nurses, that they have to finish a degree of university of applied science, even though they may already possess a degree from a medical university, which is considered superior to universities of applied science.

Another suggestion is regarding the language skills, as it turns out to be a main harming factor for migrant nurses’ interpretation of themselves as professionals. In order to get licensed as registered nurse, Valvira (Finnish National Supervisory Authority for Welfare and Health) requires either a satisfactory or higher level of Civil Service Language Proficiency Certificate, or a level 3 or higher of the National Certificate of Language Proficiency test. Participants have unanimous opinion that the Finnish language courses provided by their universities in Finland is not enough to prepare them for the tests, nor for daily communication needs as nurses. I suggest that promoting the language skills of migrant nurses should be considered as a more important goal of universities that provide nursing education for migrants. More Finnish language courses shall be arranged, and possibilities of practicing shall be provided. Institutions that facilitate nurse migration in China should also be

well aware of the potential huge language barrier before sending nurses to Finland, and facilitate the nurses of language studies.

One other concern is about the outflow of nursing forces in China. China is in dire shortage of nursing force, with only 3.2 nurses per thousand people (The Five Year Plan (2016-2020) of Development of National Nursing Industry), yet the trend of losing nursing force is non-negligible. This study shows that participants feel better as nurses if there are better possibilities for further education and training, if they receive more respect from patients and colleagues, and if they have more time to care for each patient. This finding goes with abundant existing literature (Zhang et al, 2013; Zhen, 2011; Zou and Ma, 2015) that inter-personal relationships between nurses and patients and between nurses and colleagues, possibilities for personal career development, and high working pressure are among the top reasons why Chinese nurses choose to work overseas. It won't be easy to change the current situation of nurses in China, and how to better retain nursing force in China is not and cannot be covered in this study, but China should pay more attention to retain the nursing force in China, or educate and train more nurses to satisfy the dire need.

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