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MANAGEMENT | RESEARCH ARTICLE

The cultural adjustment of self-initiated expatriate doctors working and living in Ireland

Eimear Nolan^{1*}

Abstract: Understanding how expatriates adjust to the various aspects of the host environment has been a focal point of research within international management literature for several decades. Many healthcare systems throughout the world are heavily reliant on internationally trained doctors to fill vacancies in their health services arising from the fact that significant numbers of homegrown doctors seek opportunities abroad. As self-initiated expatriates, little is known about their adjustment to working and living while in their host culture. This paper examines the cultural adjustment of internationally trained hospital doctors working in Ireland. Three hundred and sixty-nine respondents working across 34 public hospitals completed a questionnaire relating to their experience of living and working in the host culture. The results indicate that international trained doctors are somewhat adjusted to working and living in Ireland, but there is a clear lack of organizational support for these doctors while in the host culture. Health care policy makers must focus on the development and implementation of robust policies and supports to facilitate internationally trained doctors' adjustment to their host culture.

Subjects: Business, Management and Accounting; International Business; Public Health Policy and Practice; Healthcare Administration and Management

Keywords: Self-initiated expatriates; internationally trained doctors; cross-cultural adjustment; organizational support

1. Introduction

Cross-cultural adjustment has been a focal point of enquiry in research for many decades and this is likely to continue for the foreseeable future. With increased levels of globalization in recent years, the Organization for Economic Co-operation and Development (OECD) has reported a rise in

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the number of expatriates travelling abroad for work. Organizations want to select employees who will best meet the demands of the job, adapt to the environment, and remain loyal and committed to the firm. Because of this, research continues to investigate factors that are associated with expatriate success or failure when adjusting to the new host culture and organization (e.g., Black et al., 1991; Festing & Maletzky, 2011; Kristof—Brown et al., 2005). The World Health Organization estimates that there will be a global shortage of 12.9 million doctors by 2035 (WHO, 2013). The Association of American Medical Colleges estimates that the United States alone will have a shortage of 120,000 doctors by 2030 (Dall et al., 2018). This can be attributed to a number of factors including health workforce staff retiring, leaving for alternative professions, and the lack of sufficient personnel entering the occupation or being adequately trained to fill the vacant positions (Chojnicki & Moullan, 2018). Ireland employs more internationally trained doctors per capita than most developed countries. The Irish Medical Organisation (IMO) announced in December 2017 that 41.6% of all doctors working in Ireland were internationally trained, comparing, for example, to 3.1% in France. Currently, Ireland is experiencing challenges not only in retaining internationally trained doctors (ITDs), but also attracting and recruiting new ones into the country due to the poor working environment (Nolan & Liang, 2022). Research indicates that many home grown doctors are leaving Ireland upon qualification for increased pay, career opportunities and better work-life balance (Humphries et al., 2019). Should this issue persist, Ireland will be seeing more ITDs leaving the country than entering, an issue that is unsustainable for the health care system in the long term (Nolan, 2018).

Expatriates can be described as individuals who live and work outside their home country, generally on a temporary stay (Nolan & Liang, 2022). Research highlights two main types of expatriate workers; conventional expatriates and self-initiated expatriates. The difference between these two types of expatriates is that conventional expatriates are sent by their home organization to a host organization, while self-initiated expatriates decide to relocate to another country and seek work independently of a home organization (Myers & Pringle, 2005). ITDs are classified as self-initiated expatriates (Nolan & Liang, 2022) as they are individuals who themselves make the decision to move and work abroad. However, ITDs face all the conventional adjustment challenges posed by moving abroad to work and live in a new culture. Research indicates (Nolan & Liang, 2022) that it is increasingly important to look at the adjustment of different cohorts of self-initiated expatriates as their adjustment to working and living abroad is likely to differ depending on their occupation, therefore a blanket approach to managing self-initiated expatriate adjustment is not optimum. Coupled with this, more research is needed on the expatriation of medical professional (Nolan & Liang, 2022; Varma et al., 2020) and their adjustment to working and living in the host culture. In furthering our understanding of the adjustment of self-initiated expatriate ITDs, this research explores two key questions : 1. How are ITDs adjusting to working and living in Ireland? 2. How is the host organization supporting ITDs cultural transition to working and living in a new culture? The findings from this research contributes to both theory and practice. First, this study responds to the call for more research to be conducted on self-initiated expatriate adjustment, in particular that of medical doctors. Understanding how ITDs adjust to working and living in a host culture can provide valuable insight into the challenges faced by ITDs when moving aboard. ITDs are often working and living in a diverse cultural setting to their own, thus there is a need to understand any difficulties they are experiencing, not only from a medical administration perspective but, also from a personal perspective. Second, the findings in this study can be used to assist in the development and implementation of supporting policies to enhance ITDs cultural adjustment to their host culture and to aid policy reform and organizational change within the Irish Health Care System, and indeed across Health Care Systems more broadly that rely on the recruitment of ITDs.

The remainder of the paper is structured as follows. Firstly, the concept of adjustment is introduced, outlining the importance of this construct to ITDs working and living abroad. The methods and measures employed in the study are then described, and the main findings of the

research are presented relating to ITDs cultural adjustment. Finally, the key aspects of these findings are discussed, and implications for various facets of theory and practice are highlighted.

2. Cross-cultural adjustment and organizational support

2.1. Cross-cultural adjustment

Cross-cultural adjustment refers to the degree of psychological comfort individuals perceive concerning a new situation or culture (Black, 1988; Nolan & Morley, 2014). It can be described as a learning process through which individual's attain the new skills, cultural norms, and appropriate behaviors to adjust to the host culture, both inside and outside the working environment. For ITDs to adjust, they must reach both cognitive and emotional levels of satisfaction with the values, norms, and attitudes of their host culture, in this case Ireland. This enables them to integrate to the cultural assumptions of their new environment by adapting to differences that exist in the physical, psychological and communication environments. Assumptions that ITDs have about everyday encounters in Ireland may differ from their home culture, which can lead to increased ambiguity. It is essential that they can reduce these uncertainties by appreciating the contours of Irish culture and acquiring the necessary knowledge and social skills to perform their job effectively. The acquisition of these key competences aids their ability to negotiate everyday social interactions with Irish citizens, which in turn facilitates knowledge exchange within and outside the hospital setting and increases trust (Mumtaz et al., 2020).

Historically, cross-cultural adjustment in general, and particularly expatriate adjustment, have been conceptualized as unitary constructs (Okpara, 2010). Past theories of cross-cultural adjustment like Lysgaard's (1955) U-Curve theory, Oberg's (1960) Culture Shock, and Gullahorn and Gullahorn (1963) W-Curve theory offer insight into the cross-cultural adjustment process. However, such approaches merely examine the cross-cultural adjustment process by assessing the expatriate's self-reported adjustment. They fail to examine and understand what exactly the expatriate must adjust to, in other words the environment itself. Black and Stephens (1989) argue that many models are simplistic in nature. Black (1988) conceptualized cross-cultural adjustment as the degree of psychological comfort an individual has when living and working abroad, proposing a multi-domain model whereby individuals must adjust to their general, interaction, and work domains.

Within this framework, *general adjustment* can be conceptualized as the degree of comfort and familiarity ITDs have with their general living conditions in Ireland, including non-work factors like food, housing, and culture. ITDs not only have to make sense of the hospital's facilities, but also the surrounding socio-cultural context in which they find themselves. This may include a different political and monetary system, different language, norms, values, and behaviors to those of their home culture. *Interaction adjustment* refers to the degree of interaction ITDs have with host country nationals (HCNs) and the comfort they feel in interacting with supervisors, peers, and patients in Ireland. Interaction adjustment is considered the most challenging aspect of adjustment as differences in mental maps and rules (perceptions, beliefs, and values) are revealed when expatriates interact with HCNs (see, Fee & Michailova, 2020; Mumtaz et al., 2020). Different cultures generally have certain norms that guide the proper functioning of individuals within the society. As a result of these differences, ITDs can experience conflict and misunderstandings with HCNs. For them to adjust successfully it is important that the uncertainties they may experience are reduced. HCNs are an important source of information regarding appropriate behaviors that can increase an ITDs efficiency in communication with others (Ang & Tan, 2016; Ali et al., 2019; Aycan, 1997; Mendenhall & Oddou, 1985; Vljacic et al., 2019). Consequently, ITDs who acquire new social and cultural skills (e.g., new language skills, communication skills) decrease uncertainties, which in turn aids their interaction adjustment. Thus, it is hardly surprising that language ability and relational skills can aid interaction adjustment among expatriates (Bhaskar-Shrinivas et al., 2004). Decades of research indicates that expatriates host country language ability impacts on their communication with HCNs and aids their adjustment (Zhang & Harzing, 2016). While ITDs

language ability is screened prior to recruitment and many have English as their first/second language, little is known about ITDs ability to understand the host country accent. If ITDs are finding it difficult to understand the new accent in the host country, then this is likely to impact on the ease at which they communicate with HCNs (their colleagues, the patients they are treating and the patient's family), which results in increased levels of uncertainties and reduced levels of interaction adjustment. The final key domain aspect of cultural adjustment relates to *work adjustment* which concerns itself with the degree of psychological comfort ITDs experience with various aspects of the work environment e.g., managing authority relationships, job responsibilities and working conditions while in Ireland.

According to Black and Gregersen (1998), this is the easiest dimension of the three cross-cultural domains mainly because it is aided by the similarities of the role in the home culture.

2.2. Organizational support

An extant body of research in international management literature highlights the importance of perceived organizational support (POS) in the pre- and post-expatriation process (e.g., Malek et al., 2015; Shaffer et al., 2001). POS has been linked to increased levels of expatriate cultural adjustment (Kraimer et al., 2001), expatriate organizational commitment (Malek et al., 2015), and expatriate intent to remain on the contract (Shaffer et al., 2001). POS can be defined as the degree to which expatriates believe that the organization cares about their wellbeing, their career and values their contributions to the company. Organizational support theory proposes that expatriates deduce the level of POS they are given from the organizational policies and practices in place and the way they are treated by the organization (Eisenberger et al., 1986; Kraimer & Wayne, 2004).

One way in which organizations support their expatriate employees is to provide them with cultural training (Varma et al., 2020). Pre-arrival training comprises of information relating to the host culture (e.g., established norms and values of the host culture), along with more practical elements such as accommodation and location information, banking systems and general life information pertaining to the host culture. Information is also provided relating to the expatriates' new job role and responsibilities to prepare them for the transition. Once they arrive in the host culture, post-arrival training commences which is designed to support and facilitate the expatriate's adjustment by answering any questions they may have thus reducing their uncertainties. In both the pre- and post-arrival training, expatriates may also be connected with others working in the host organization and living in the host culture. The aim of this connection is to facilitate knowledge exchange and reduce uncertainties. The administration of cross-cultural training (pre- and post-arrival) has been widely used by companies to ease expatriate transition, thus aiding overall cultural adjustment (Okpara & Kabongo, 2017).

Relocating across borders for employment can have substantial and sometimes unexpected effects on ITDs. While immersed in the host environment ITDs become aware of the differences that exist between the host and home culture, leading them to become more susceptible to the variety of challenges such as culture shock and inability to interact effectively with the various HCNs (e.g., supervisors, peers, patients). Lack of adjustment to a new culture in the management literature is viewed as one factor which accounts for some of the failure that occurs in international assignments (Black, 1988; Grainger & Nankervis, 2001; Selmer & Leung, 2003). Therefore, cultural adjustment is of significance to both the host hospital and to the ITDs themselves.

3. Methods

3.1. Context of the study

The last two decades has seen Ireland becoming increasingly dependent on ITDs to service its public health care system (Nolan & Liang, 2022; Bidwell et al., 2013). The Working Time Directive introduced in Ireland on August 1st, 2004 saw a restriction on the number of hours' doctors could work. As a result, it was estimated that Ireland would need to recruit an additional 2,500 junior

doctors to ensure coverage post the implementation of the Directive. In addition, 2005 saw Ireland with the second lowest ratio of doctors per thousand and in order to combat this it was estimated that the country would need to increase the number of doctors by 41% ($n = 3754$). In February 2011, the HSE reported the vacancy rates of junior doctors were at a critically high level (HSE, 2011). While Ireland is training enough doctors to meet the demands of the Irish health system, the majority of the students (60%) are non-EU nationals and most of these doctors leave Ireland after graduation. The Irish Medical Council's workforce report released in August 2014 noted that there was an annual relative increase of 23 per cent in the number of Irish medical school graduates (aged between 25–29) leaving Ireland for international positions. This means that almost one in ten (9.7%) newly qualified doctors left Ireland in 2013 to work abroad. Bidwell et al. (2013) linked this trend to Ireland's inability to retain and train sufficient doctors. Additionally, qualitative research found that ITDs who came to Ireland seeking career advancement and training were both disappointed and frustrated with their experience (Humphries et al., 2013; Nolan, 2022). A study by the IMO (2011) found that 80% of ITDs wished to leave Ireland and a key reason for their desire to leave was the lack of career advancement and training. Coupled with this, the IMO (2011) indicated that there is a shortfall in the number of consultant posts available to ITDs after their training. It seems that the attractiveness of Ireland as a host location for ITDs has decreased but need for them remains high. The IMO report published in August 2016, indicated that 60% of newly qualified doctors who undertook their medical training in Ireland plan to emigrate and Ireland is to see further doctor shortages in the years to come. It therefore is essential that the adjustment of these ITDs is addressed and understood, so that more informed managerial decisions can be implemented moving forward to aid retention rates along with attracting more ITDs into the Irish health care system.

3.2. Sampling procedure and response rate

43 public hospitals in the Republic of Ireland were included in the research. Of the 43 hospitals contacted, 34 hospitals agreed to participate in the study. Questionnaires were then administered to the entire sample of 1,610 ITDs in the 34 hospitals. A total of 369 usable questionnaires were returned yielding a response rate of 23%.

3.3. Demographics and measurements

Basic demographic information was collected from ITDs such as age, gender, nationality, marital status, medical registration, and length of time in Ireland. ITDs were also asked about their previous international work experience and for those that were married, if their spouse accompanied them on their relocation to Ireland. It has been well documented that both previous international work experience and spouse accompanying the expatriate in the host culture aids expatriate adjustment (Bhaskar-Shrinivas et al., 2005; Eroglu & Rahman, 2017; Okpara, 2016).

Another important factor to consider when looking at expatriate adjustment is to establish if ITDs received any organizational support in relation to inter-cultural training prior to departure and post arrival. It is widely acknowledged in international management research that pre and post cultural training significantly increases the level of expatriate adjustment (Eroglu & Rahman, 2017). In order to establish if ITDs received any inter-cultural training prior to departure and post arrival, ITDs were asked two questions: 1. Did you receive any inter-cultural training prior to departure; 2. Did you receive any inter-cultural training post arrival in Ireland. Those that responded yes to either of these questions were then asked who provided the training.

ITDs were also asked about the ease to which they understood the Irish accent, and if they had difficulty understanding HCNs, and if so, how long did it take for them to understand the Irish accent. Effective communication (language ability) between the expatriate and HCNs has been linked to increased levels of cultural adjustment as the information and social cues shared by HCNs can reduce expatriate uncertainties (Fei & Le, 2020; Laurant & Selmer, 2010; Rodsai et al., 2017).

To establish the degree to which ITDs felt adjusted to working and living in Ireland the research used Black and Stephens (1989) adjustment model consisting of three dimensions; general, interaction and work adjustment. The scale comprised of 14 items on a seven-point likert scale with anchors ranging from 1- very unadjusted to 7—very adjusted. General adjustment items included food, health care facilities, entertainment, living conditions, cost of living, shopping and housing conditions. Interaction adjustment items included interacting with host country nationals outside of work on a day-to-day basis, and socializing with host country nationals. Work adjustment items included performance standards and expectations, supervisory responsibilities, and specific job responsibilities. The mean for each dimension was established to identify the degree of ITDs general, work, and interaction adjustment.

4. Results

4.1. Data analysis

Data analysis was carried out through SPSS. Univariate descriptive frequencies and statistics were used to examine the data. Both the mean and standard deviation were checked and approved for plausibility. All data in this research fit the criterion of normally distributed data. Factor analysis using varimax rotation was employed in the analysis to validate Black and Stephens scale of adjustment.

4.2. Demographics

4.2.1. Gender

Table 1 highlights the gender of respondents categorized by nationality. The majority of respondents who completed the questionnaire were male 72.6% (n = 268) with females accounting for 27.4% (n = 101).

4.2.2. Age

The average age of respondents fell between 31–40 years of age (38.8%), while 37.7% (n = 139) were between the ages of 20–30. Respondents between the ages of 41 to 50 accounted for 23.6% (n = 87) of the responses. No respondents were above the age of 51 in the research. Table 2 shows that significantly more females 68.3% (n = 69) were under the age of 30 compared to 26.1% (n = 70) of males. In addition, significantly less females 5% (n = 5) were over the age of 41 compared to 30.6% (n = 82) of males.

4.2.3. Nationality

Table 3 breaks down the respondents' nationalities using the 7-continent model (Africa, Southern Asia, South America, North America, Australia, and Europe) categorized by gender. Results relating to gender were broadly similar for both males and females. The majority of respondents were from Africa 46.3% (n = 171) mainly Sudan and Nigeria. Asia (more precisely Southern Asia) accounted

Table 1. Gender (Categorized by nationality)

Gender	Total		Nationality					
	N	% of Respondents	Africa		Asia		Other	
			N	% of Respondents	N	% of Respondents	N	% of Respondents
Male	268	72.6	132	77.2	113	74.8	23	48.9
Female	101	27.4	39	22.8	38	25.2	24	51.1
Total	369	100.0	171	100.0	151	100.0	47	100.0

Table 2. Age (Categorized by Gender)

Age	Total		Gender			
	N	% of Respondents	Male		Female	
			N	% of Respondents	N	% of Respondents
20–30	139	37.7	70	26.1	69	68.3
31–40	143	38.8	116	43.3	27	26.7
41+	87	23.6	82	30.6	5	5.0
Total	369	100.0	268	100.0	101	100.0

for 40.9% (n = 151) and respondents were mainly from Pakistan, Malaysia, and India. Europe accounted for 7.6% (n = 28), with respondents mainly from Poland and Britain. North America accounted for 3.3% (n = 12) and respondents were mainly from Canada and America. A very small proportion of the sample 1.1% (n = 4) were from South America and Australia 0.8% (n = 3).

4.2.4. Marital status

Respondents were asked about their marital status (Table 4). In total, 66.1% (n = 244) of the sample were married and 33.9% (n = 125) were single or separated. Breaking this statistic down further shows that only 1.4% (n = 5) were separated. A higher percentage of females (55.4%) were single or separated compared to only 25.7% of males. Of the respondents who were married, it was important to ask if their spouse was with them on their assignment as this can influence cross-cultural adjustment. Out of the 66.1% (n = 244) of respondents that were married, 55% (n = 203) stated that their spouse was with them on their assignment in Ireland. A small number, 11.1% (n = 41), stated that their spouse was not with them on their assignment.

4.2.5. Medical registration

Respondents were asked what type of medical registration they had while working in Ireland. Table 5 presents the type of medical registration held, categorized by gender. The majority, 48.8% (n = 180) had specialist or general registration. Over 30% (n = 111) of the respondents were trainee specialists and 20.1% (n = 74) were interns at the hospitals. A further 1.1% (n = 4) stated “other” but did not clarify what type of registration “other” was. Interestingly, 36.6% (n = 37) of females

Table 3. Nationality (Categorized by gender)

Continent	Total		Gender			
	N	% of Respondents	Male		Female	
			N	% of Respondents	N	% of Respondents
Africa	171	46.3	132	49.3	39	38.6
Southern Asia	151	40.9	113	42.2	38	37.6
South America	4	1.1	1	.4	3	3.0
North America	12	3.3	5	1.9	7	6.9
Australia	3	.8	2	.7	1	1.0
Europe	28	7.6	15	5.6	13	12.9
Total	369	100.0	268	100.0	101	100.0

Table 4. Marital status (Categorized by gender)

Marital Status	Total		Gender			
	N	% of Respondents	Male		Female	
			N	% of Respondents	N	% of Respondents
Married	244	66.1	199	74.3	45	44.6
Single/separated	125	33.9	69	25.7	56	55.4
Total	369	100.0	268	100.0	101	100.0

were on an internship in Ireland compared to only 13.8% of males. The 58.2% of males (n = 156) had specialist or general registration compared to only 23.8% (n = 24) of the female respondents.

4.2.6. Length of time working in Ireland

Respondents were asked about the length of time they had been working in Ireland. Table 6 presents the length of time the respondents had been working in Ireland categorized by gender. The majority of respondents had been working in Ireland for over three years 56.9% (n = 210), 24.4% (n = 90) had been working in Ireland between one and three years and 18.4% (n = 68) had been working in Ireland for less than one year. The length of time spent so far in Ireland is approximately the same for both genders.

4.2.7. Previous international work experience

71% of respondents (n = 262) did not have international work experience prior to working in Ireland, while 29% (n = 107) indicated they did have international work experience. Of those that had international work experience, 18.2% (n = 76) had 3 years plus international work experience, 4.1% (n = 15) had between 1–2 years' work experience, and 6% (n = 22) had less than a year's international work experience prior to coming to Ireland.

4.2.8. Difficulty understanding the Irish accent

Respondents were asked if they experienced any difficulty understanding the Irish accent while on contract in Ireland. Table 7 presents the results categorized by gender. The findings of this question were very interesting, with 62.1% (n = 229) of the participants stating they had difficulty understanding the overall Irish accent. This was further broken down into the following: difficulty understanding Irish doctors 1.6% (n = 6), difficulty understanding Irish patients 13.6% (n = 50), difficulty understanding Irish people socially 14.6% (n = 54), difficulty understanding Irish doctors and patients 1.4% (n = 5), difficulty understanding Irish patients and Irish people socially, 4.3% (n = 16) and yes to

Table 5. Medical registration (Categorized by gender)

Medical Registration	Total		Gender			
	N	% of Respondents	Male		Female	
			N	% of Respondents	N	% of Respondents
Internship	74	20.1	37	13.8	37	36.6
Trainee Specialist	111	30.1	73	27.2	38	37.6
Specialist/General	180	48.8	156	58.2	24	23.8
Other	4	1.1	2	.7	2	2.0
Total	369	100.0	268	100.0	101	100.0

Table 6. Length of time working in Ireland (Categorized by gender)

Length of time working in Ireland	Total		Gender			
	N	% of Respondents	Male		Female	
			N	% of Respondents	N	% of Respondents
under 1 year	68	18.4	40	14.9	28	27.7
1–3 years	90	24.4	60	22.4	30	29.7
3 years +	210	56.9	167	62.3	43	42.6
Total	368	99.7	267	99.6	101	100.0
Missing	1	.3	1	.4	-	-

(1 individual did not state how long they have been working in Ireland)

all of the aforementioned 26.3% (n = 97). Over 36% (n = 135) stated that they had no difficulty understanding the Irish accent. A further 1.4% (n = 5) did not answer this question. Following from this, respondents indicated the length of time they felt it took to fully understand the Irish accent. Table 8 presents the results categorized by gender. A total of 84.1% of all respondents indicated that it took a degree of time to understand the Irish accent. Over 53% of the respondents took less than six months to get used to the Irish accent. It took 16% (n = 59) of all respondents between 6–11 months, 9.8% (n = 36) between 1–2 years and 4.9% (n = 18) over two years to understand the Irish accent. An additional 3.8% (n = 14) specified that they never got used to the Irish accent, however 10.3% (n = 14) reported never having issues understanding the Irish accent.

4.2.9. Realistic preview of Ireland prior to departure

ITDs were asked if they received a realistic preview of what working and living in Ireland would be like before they arrived. 55.8% (n = 206) stated they did not have a realistic preview of what life would be like working and living in Ireland, while 43.9% (n = 162) noted that they did have a realistic preview. When asked if they came to Ireland to visit prior to their move, 26.6% (n = 98) did travel to Ireland to see what the Country was like before their moves, however the vast majority of ITDs did not travel to Ireland prior to their relocation 73.2% (n = 270).

4.2.10. Pre and post inter-cultural training

When asked if they received any inter-cultural training from the hospital prior to their departure, the vast majority noted they did not 95.4% (n = 352). ITDs were also asked upon arrival in Ireland if they received any inter-cultural training from the hospital. Again, the vast majority (96.7%,

Table 7. Difficulty understanding the Irish accent (Categorized by gender)

Difficulty understanding the Irish accent	Total		Gender			
	N	% of Respondents	Male		Female	
			N	% of Respondents	N	% of Respondents
yes all	97	26.3	72	26.9	25	24.8
doctors and patients	62	16.8	36	13.4	26	25.7
patients and socially	70	19.0	55	20.5	15	14.9
no	135	36.6	100	37.3	35	34.7
Total	364	98.6	263	98.1	101	100.0
Missing	5	1.4	5	1.9	-	-

(5 individuals did not indicate if they experienced difficulty understanding the Irish accent)

Table 8. Length of time it took to fully understand the Irish accent(Categorized by gender)

Length of time to understand the Irish accent	Total		Gender			
	N	% of Respondents	Male		Female	
			N	% of Respondents	N	% of Respondents
Under 6 months	197	53.4	140	52.2	57	56.4
6–11 months	59	16.0	46	17.2	13	12.9
1–2 years	36	9.8	23	8.6	13	12.9
2+ years	18	4.9	14	5.2	4	4.0
Never	14	3.8	8	3.0	6	5.9
NA	38	10.3	30	11.2	8	7.9
Total	362	98.1	261	97.4	101	100.0
Missing	7	1.9	7	2.6	-	-

n = 357) stated they did not receive any inter-cultural training upon arrival in Ireland from the host hospital.

4.2.11. Realistic preview of working in Ireland prior to departure

ITD were asked if they felt they got a realistic preview of their job role in Ireland prior to the departure. 62.6% (n = 231) noted they did not get a realistic overview of the job role in Ireland prior to departure, while 35.2% (n = 130) felt they did get a realistic insight into their new job.

4.3. Cross-cultural adjustment

Adjustment was measured using one of the most tried and tested models of adjustment, Black's (1988) model of adjustment. In this study the 14 items were divided into general adjustment, interaction adjustment and work adjustment for analysis. The reliability (Cronbach Alpha) for general adjustment was $\alpha = 0.81$, for interaction adjustment was $\alpha = 0.89$ and for work adjustment was $\alpha = 0.81$. The combined reliability of the three items, referred to as overall cross-cultural adjustment, yielded a Cronbach Alpha of $\alpha = 0.91$. The mean for general (4.88), interaction (4.10), and work adjustment (5.07) indicate that ITD reported they are somewhat adjusted to general and work adjustment. ITDs were close to somewhat unadjusted in relation to their interaction adjustment (4.10), Table 9.

One small, positive, statistically significant, relationship exists between general adjustment and interaction adjustment ($r = 0.121$, $p < .05$). A large, positive, statistically significant, relationship exists between general adjustment and work adjustment ($r = 0.701$, $p < .01$). Drawing from these

Table 9. Means, SDs and correlations

	Mean	SD	1	2	3
1. General Adjustment	4.88	1.05	-		
2. Interaction Adjustment	4.10	0.86	.122*	-	
3. Work Adjustment	5.07	1.15	.711**	.097	-

Note: * $p < 0.05$, ** $p < 0.01$

**Correlation is significant at the 0.01 level (2-Tailed).

findings, it is clear that ITDs are not fully adjusted to working and living in the host culture. Indeed, this finding is likely influenced by the lack of organizational support ITDs receive when transitioning to working and living in Ireland, their difficulty understanding the Irish accent, the lack of career advancement opportunities available to them working in the Irish Health Care System all of which is likely to hinder the adjustment to working and living in Ireland. A detailed discussion of these points is presented in the following section.

5. Discussion

Decades of research acknowledges that the transition to working and living in a new culture can be a difficult one (Bhaskar-Shrinivas et al., 2004; Black et al., 1991; Harrison & Shaffer, 2005). While much research has been conducted on conventional expatriates (generally sent by their home company to a host subsidiary), little is known about that self-initiated expatriation of medical doctors (Nolan & Liang, 2022). ITDs coming into Ireland need to adjust to their new job role and the organizational culture, along with the broader national culture. This research aimed to answer two research questions. 1. How are ITDs adjusting to working and living in Ireland? 2. How is the host organization supporting ITDs cultural transition to working and living in a new culture?

5.1. Cultural adjustment

In answering question 1, this study finds that ITDs are only somewhat adjusted to working and living in Ireland. ITDs reported a degree of general, interaction and work adjustment while working in Ireland. They reported less interaction adjustment when compared to general and work adjustment. However, the results are surprising, while it was expected that these three domains would be related to a small degree, it was not anticipated that the relationship between general and work adjustment would be highly correlated. This suggests that ITDs could not differentiate between their general and work adjustment. Long working hours and the considerable amount of time ITDs are “on-call” results in limited exposure to life outside the hospital which could account for the finding. It would appear that ITDs are regularly scheduled to do two 28-hour and one 24-hour shifts in a six-day period. The IMO survey conducted in 2019 indicated that almost half of the doctors reported working shifts over 24 hours, sometimes consecutive 26–27 hours (Reilly, 2020). This significantly reduces their time for family or personal life due to work pressure. This finding is disconcerting as it has been documented that overworked doctors are likely to experience burnout, which can result in serious personal problems such as broken relations, problematic alcohol use and suicidal ideation, along with negatively impacting patient care (Shanafelt et al., 2012). Hayes et al. (2017) in assessing doctors wellbeing in Ireland found that one-in-three doctors are suffering from burnout. Health service policy makers and hospital management in Ireland need to take urgent action to protect ITDs from burnout, in the interest of ITDs and their patients. While it may be difficult to prioritize self-care of doctors within the current system with high patient-staff ratios and stressful working conditions, the health service needs to respond in a way that values and protects the doctors and their patients (Crowe & Brugha, 2018).

5.1.1. Communication difficulty

Over half the ITDs admitted having difficulty understanding the Irish accent upon arrival, with the biggest difficulty occurring whilst trying to understand other Irish doctors and patients. Just over half the ITDs said it took less than six months to understand the Irish accent, 95 ITDs stated it took between 6 months and two years to understand the Irish accent and a small amount reported that after two years they still did not understand the Irish accent. Research indicates the critical role of expatriate socialization in the development of trust and intercultural communications between expatriates and HCNs (Mumtaz et al., 2020). However, this socialization is limited when ITDs experience difficulties in understanding the accent of HCNs in the country. Without a clear understanding of what HCNs are communicating, ITDs will struggle to develop such trust and intercultural communications in the initial year in the host culture. In addition, if ITDs are having difficulty understanding the accent of the patients they are caring for, it is likely that this will impact the doctor-patient relationship. Such issues need to be addressed by the host hospital and support and training needs to be given to ITDs to overcome such difficulties.

5.2. Organizational support

Past research indicates that organizational support is a key factor in the successful cross-cultural adjustment of expatriates (e.g., Kraimer et al., 2001; Malek et al., 2015; Shaffer et al., 2001). Some organizations put considerable time and resources into creating and developing pre- and post-arrival cultural training programmes for their expatriate employees, as such courses reduce uncertainties, thus aiding overall adjustment and retention of staff. Providing these cultural training programmes is a key practice in human resource management development when attempting to reduce expatriate uncertainties. Training expatriates about the host culture promotes an inclusive working environment (Zaman et al., 2021), thus strengthening workplace harmony which can lead to increased productivity (Sharma, 2016).

The second research question aimed to establish the degree to which the host organization was supporting ITDs cultural transition to working and living in a new culture. The findings suggest that ITDs receive little organizational (hospital) support on their transition to working and living in Ireland. They arrive in a culturally diverse country and must navigate their working and general life without the necessary organizational support. This finding is troublesome for several reasons; without a clear level of organizational support these ITDs are less likely to adjust to working and living in a new culture, compared to those that receive cultural training. While it is not unusual for certain self-initiate expatriates (e.g., those that find work while already living in the host culture) to receive little organizational support on their cultural transition, these ITDs are being directly recruited by the host country hospitals in their home country and therefore it seems plausible to expect that they would be given a degree of organizational support while transitioning to the host culture. ITDs are working in hospitals and are interacting from the first day of their arrival with host culture patients. Without sufficient pre- and post-arrival training, the cultural dissimilarity between ITDs and the patients they are treating is likely to be vast and potentially destructive for both parties. For example, the results of this study show that the majority of ITDs are coming from cultures that have a high degree of power distance (Hofstede, 2021), where authority is not questioned. Therefore, within the hospital setting where doctors would be considered to be in a powerful position, these ITDs in their home country are less likely to experience patients questioning their diagnosis. Ireland, however, has less power-distance (Hofstede, 2021) and individuals are more likely to question a doctor's diagnoses. This is something that may be new to ITDs, thus they need to adapt their cultural mindset to fit in with the new cultural setting. Such issues are vital to cover in pre-training courses to ensure that ITDs transition to working in a new culture goes smoothly. Hospitals should be providing pre-training courses on issues surrounding cultural differences: norms, values, beliefs, communication methods, housing, food, political systems, banking, transportation, language etc in a bid to reduce uncertainties and ease ITDs cultural transition. The lack of commitment from the hospitals in Ireland to provide ITDs with appropriate cultural training is worrying. It is important to highlight here that not only is it likely that ITDs feel the negative consequence, but that patients, and indeed the hospital itself are negatively affected when cultural training is not provided for ITDs.

5.2.1. Limited career advancements

The majority of ITDs in this research stated that they did not have a realistic preview of what their job and life would be like in Ireland prior to coming. Of the ITDs who had received a realistic preview of working and living in Ireland, they mentioned that the information was supplied from friends already working in Ireland and not by the hospitals. It has been noted that ITDs reach a glass ceiling where it is near impossible for them to get promoted (Kelly, 2010). Kelly acknowledges that there seems to be two training systems in Ireland, one for ITDs and the other for Irish doctors. He describes it as the elephant in the room which must be resolved to boost the enrolment and retention of ITDs. Fairness issues revolving around pay, training opportunities and benefits as key building blocks of a satisfactory and sustainable employment relationship lie at the heart of retaining this pivotal talent pool of healthcare professionals (Nolan, 2018). The naturally occurring exchange of information between ITDs and local colleagues regarding current terms and conditions, along with future career advancement prospects may in situations where there are

perceived comparative inequalities result in demotivated behavior. Hospitals need to address the issue of realistic job and career advancement opportunities by devising and implementing strategies to ensure that such opportunities are offered to ITDs. It is especially important in relation to securing future health care reforms, as research indicates that in order for such reforms within the health care system to take place, support for professional development is vital (Blacklock et al., 2014).

With limited organizational support, there is a clear glass ceiling in place for ITDs—limited access to training and career progression opportunities- it is not surprising that Ireland is having difficulty attracting and recruiting ITDs to service its nations hospitals. Clear managerial reform needs to occur to ensure that the ITDs are being offered organizational support at work and expatriate cultural training, which has long been considered a fundamental expatriate requirement within the international management field of research.

6. Limitations

This study is not without limitations. First, the research used a quantitative approach, we advise future qualitative explorations into the nuances of ITDs cultural adjustment and organizational support within host cultures. Second, the ITD sample was drawn from a single host country, it would be valuable to explore other countries that use high levels of ITDs to service their country, thus creating a comparative analyses.

7. Recommendations and future research

It is clear from the research that reform needs to happen within the Irish health care system in order to improve the attraction, selection, and retention rates of these doctors. The first, and possibly the most important, recommendation from this research is the need for equality among ITDs and Irish doctors taking up similar positions in the country. These doctors need to be offered organizational support in relation to their adjustment along with equal training and advancement opportunities to those of their Irish equivalents, in order to increase their job satisfaction and decrease their intent to quit and discourage others from taking posts in Ireland. Secondly, more regulation is needed regarding the long working hours of ITDs. Their inability to differentiate between general life and work life in Ireland is troubling and is clearly indicative of an imbalance in work-life domains. Regarding future research, this study adopts a cross-sectional research design and examines the opinions of ITDs at one point in time. A longitudinal study following ITDs on their contract in Ireland to determine the difficulties they experience and when they most commonly occur would clearly be beneficial.

8. Conclusion

The international migration of health care workers has become a focal point of debate in global health care policy (Okeke, 2013). This research joins the conversation through studying the cultural adjustment of ITDs working in Irish hospitals, the results of which can be taken into account within the global development of health care worker migration support strategies. Our findings illustrate that ITDs working in Ireland are only somewhat adjusted to working and living in the country. This result is likely influenced by the clear lack of organizational support from the host hospitals in relation to ITDs pre-arrival and post-arrival cultural training. The study also found that ITDs find it difficult to separate between their general and work adjustment, which could be largely down to the amount of time they spend working and on call in hospitals. These long working hours are likely to negatively impact on ITDs cultural adjustment, and are also likely to result in ITDs burnout, a result that is detrimental for all parties involved. ITDs in Ireland are also suffering from a lack of career advancement opportunities, that is likely to impact on the recruitment and retention rates within the sector in Ireland.

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