Producing Transnational Nurses: Agency and subjectivity in global health care labor migration recruitment practices

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Introduction

Globally, healthcare worker shortages are increasing, giving rise to a need for a migratory healthcare labor population (Buchan 2006; Choy 2003; Kingma 2006; Ross, et al. 2005; Võrk, et al. 2004; Zulauf 2001). Countries such as India and the Philippines have long-term experience with this practice, often operating state-run placement services to place nurses in countries such as the United States, United Kingdom, and Saudi Arabia. Recently, new origin countries have entered the global market. Healthcare workers from Central and Eastern Europe are being recruited for this work and are increasingly discovering the opportunities available to them as in-demand, mobile professionals. However, entering this labor market is not simple and workers often need recruitment firms to mediate the complex process of transnational skilled labor. Negotiating between the different labor and cultural environments, these staffing firms must ensure that the laborers they represent will be successful on the job market. They train them accordingly, essentially "producing" migrants. This article uses the Czech Republic as a case study to explore this phenomenon.

Currently, two firms that specialize in medical staffing exist in the Czech Republic: Care4U and Nursematch.[1] Since 2001 they have sent abroad a combined total of over 600 healthcare workers, chiefly nurses but also physical therapists, midwives, and lab technicians. The primary destination of these healthcare workers is Saudi Arabia, a country that imports almost 90% of its nursing force (Luna 1998:9). The Saudis have a constant demand and, according to recruiters and former migrants, prefer European nurses over workers from East or Southeast Asia. As part of a nation-wide labor importing effort, the Saudi Ministry of Health accepts Czech nursing licenses as valid in its country. With a steady demand and bureaucratic processes in place, all they need are viable job candidates, who they find through recruitment firms.

Healthcare recruiters work as entrepreneurs, relying on their expert knowledge of market demands in order to supply the desired product—nurses—with a *specific* skill and knowledge set or competence. Competence is a key component of healthcare migration and, therefore, a major component of the migrant production process. Along with confidence, compassion, conscience and commitment, competence is an attribute of caring and is essential to the nursing profession (Roach 1984). It includes the knowledge and skills necessary to "respond to the demands of [one's] profession and responsibilities" (Beck 1991:21). However, migrants need more than clinical competence to be successful in their new work environment. They also require social and cultural competencies suitable to success in a globalized society. In her work on baby food production in Poland, Elizabeth Dunn states that East European workers needed to be transformed from the "supposedly passive and unthinking bodies of Fordism to active, thinking subjects" in order to be successful in a global, capitalist economy (Dunn 2004:19). The case of migrant-nurse production is no different. Czech recruiters claim that Czech nurses do not have the full range of competencies and confidence needed for this success. The recruiters have told

me that "being in a non-English speaking country we have to actually 'make the people.' They are 70% ready but we have to add the 30%, which is usually English." In other words, recruiters must transform nurses into culturally competent and confident global healthcare professionals. English, the common language of Saudi healthcare, is the primary focus of migrant transformation or production and is intimately tied to levels of competencies and confidence, which require and are informed by a minimum level of communication skills.

In order to "make" successful migrants, then, recruitment firms offer extensive training courses and resources in Medical English, as well as interview preparation and information regarding cultural and practical aspects of the destination countries. Moreover, much of the remaining "30%" is the crucial component that is outside the purview of easily assessed skills. Fluency in English can be assessed through various exams, but comprehension of the ideology of a different environment is not assessed. Czech nurses not only have to learn a language but also the social and cultural intricacies, or competencies, of life in another country and work environment. Additionally, it is more than medical, cultural, and language skills that will make Czech nurses successful on the global job market; Czech nurses need to embrace an ideology of modernity and globalization that is presumed absent in their current perspective, as well as adopt an associated sense of self and belonging in that global arena.

Therefore, the recruitment process is not merely ensuring that nurses have appropriate language and medical skills. Rather, through a training regime that instills both skills and ideological concepts, it is producing candidates who have the various competencies and the confidence needed to be successful in the foreign hospital environments. To do so, nurses must first submit to the *migrant production process* of various training seminars. Upon successful completion of the training and probation periods (in the new workplace), nurses should have the capability or agency to take full advantage of the global market and its opportunities. Dunn's work demonstrates that the workplace is one of the primary locations in society where subjectivity and identity, as well as agency, are produced (Dunn 2004). *How* nurses gain these competencies through this production process, is the focus of this article.

Methodology

This article is part of a larger project regarding the full context of Czech nurse migration as facilitated by recruitment firms. From November 2008 to October 2009, I was based in Prague, Czech Republic and collected the principal data.[2] I used traditional ethnographic research methods of interview and participant observation and have data from 40 individuals who play a variety of roles in the migration process, including return migrants, first-time migrants, and recruiters. I recruited approximately 75% of research participants at recruitment firm events; the remaining 25% are personal contacts found via networking. Additionally, I interviewed representaives and clients from different Czech recruitment firms and for 10 months I held the position of Education Coordinator at one firm. This position allowed me access to a wide variety of participant observation opportunties. I observed monthly informational sessions and training classes and took part in mock interviews as a native English speaker. On three occasions, I was able to interact with and observe hospital representatives on recruitment visits, where they present their job sites to potential employees and then conduct interviews.[3] Finally, I was able to observe the organizational strategies that the recruiters utilize in their practices by attending staff meetings and observing daily activities. At the time of publication, I am

maintaining communication with research participants via electronic media and am collecting daily life experiences regarding life abroad.

The "Finished Product"

Hospital representatives select candidates with strong medical and English skills, as well as the ability to think for oneself and the desire to work in a foreign environment. Therefore, from the perspective of the recruitment firms, the most successful job candidates are those that speak very good, if not fluent English, can easily adapt to changes, and have confidence in their abilities. In other words, a successful nurse-migrant is one who has the appropriate skill set that will enable her to pass her three-month probation period, which enables the recruiters to collect their finders' fee.[4] Through experience, recruiters have learned that Czech nurses have the basic medical skills on which they will build abroad and have developed training programs that will provide the remaining essentials. Although the recruiters claim that English is the "main problem," I argue that it is embodied competencies - clinical, cultural, and social – along with confidence, that enable nurses to successfully perform, both in the interview and in the foreign workplace. English is the critical base on which these characteristics stand. The next section reviews the three types of competencies and how they impact candidate success both on the job market and in the new workplace, justifying why recruiters find it necessary to instill these characteristics into their candidates.

Clinical competence

Clinical competence is the bringing together of "a range of general attributes, such as knowledge, skills, and attitudes, in such a way that these specifically address the needs of the practitioner" (Watson, et al. 2002:422). In this case, they are not only the medical but also the language skills that are necessary to do one's job. Hospital applications include checklists of nursing duties and require applicants to list their level of experience and expertise in each. During interviews, hospital representatives will often provide the candidate with a job description listing the various clinical competencies affiliated with the position, asking her whether or not she could perform each duty.[5] Interviews are conducted entirely in English. Although most patients will speak only Arabic and need translators, Czech nurses are not expected to speak any Arabic upon arrival, but are expected to have a level of "very good" or "fluent" English. In addition to English exams, which require minimum scores to pass, hospital representatives rely on local recruitment firms' recommendations and candidate performance during interviews to assess English speaking and comprehension levels. Candidates who may not be as proficient as desired in English but show potential as quick learners, or have an especially needed specialization like midwifery or neonatal care, are often hired with the understanding that they will improve when immersed in an English-only environment. Nurses who do not have a minimum level of English at the end of their probation periods are dismissed and recruitment firms do not receive fees for them.

Cultural competence and capital

I consider social and cultural competencies components of cultural capital (Bourdieu 1986). Cultural capital in both the embodied and institutionalized states equates to an

understanding of specific knowledge which is "recognized as legitimate competence," such as academic qualifications (Bourdieu 1986); in medicine, the primacy of academic and legal qualifications makes cultural capital dominant (Rischel et al. 2008:514). It includes clinical competence in nursing, as well as language skills appropriate for the environment; linguistic competence is part of both cultural competence and capital (Leininger 1988:155; Siegal 1996:376). "Cultural competence" has a special meaning in nursing and is taught globally as part of nursing curriculums (i.e. institutionalized cultural capital). It is not merely having knowledge about various cultures from which the nurse and patient come. Cultural competence is an embodiment of working within the cultural context of the patient, integrating cultural awareness, knowledge, skill, encounters and desires (Campinha-Bacote 2002). Madeleine Leininger's cultural care theory states that care and culture are "inextricably linked," and that care should be founded on cultural beliefs and understandings (Leininger 1988:153). Cultural competence generally should be second nature in care work and is an essential part of the cultural capital needed for international healthcare work.

Social competence and capital

Social capital and competence do not correlate in the same way as cultural competence and cultural capital do. Social capital is the "aggregate of the actual or potential resources which are linked to…membership in a group, which provides each of its members the backing of collectively-owned capital" (Bourdieu 1986:248)—in other words, networks. Social competence, on the other hand, is socially appropriate behavior, which can in fact lead to increased social capital. In the migration arena, social capital is the networks which connect candidates to employers (often personified by recruitment firms); social competence is an understanding and deployment of the appropriate behavior of the destination site, or "good behavior" and comportment. I suggest that clinical, cultural, and social competencies fall under the scope of cultural capital. Therefore, in this article I concentrate on cultural capital, specifically the areas of social and cultural competencies that nurses must learn before they can enter the global market.

Confidence

I pair competencies with confidence. Confidence can be defined as "an acquired attribute that provides individuals with the ability to maintain a positive and realistic perception of self and abilities" and is directly linked to competence (Evans et al. 2010:335). During nurse education, it is engendered by trust and respect between student nurse and instructor (Beck 1991:21), and recruiters attempt to emulate this bond through their own training programs. Confidence continues to foster trusting relationships in the work environment (Roach 1984:23). In addition to having confidence in her own abilities, a nurse must perform care in a manner which instills and maintains the patient's trust in her (Roach 1984:24). Cultural capitals such as clinical competence, location-specific language skills, and cultural knowledge or competence support confidence.

Although limited literature exists regarding confidence in relation to new environments (Evans et al. 2010:335), my research indicates that first-time and recently-arrived migrants experience a decreased sense of confidence regarding their abilities to perform their jobs well. Sandra, a 31-year-old nurse, despite having worked in the UK for six months and having

excellent English, is still nervous about what will be expected of her on the job. "[The recruitment firm] taught us that nurses have more responsibility [in Saudi Arabia] than here and I am afraid about this," she commented. Světla, 34, worked as a nurse in Saudi Arabia for three months. At the end of her probation period, the hospital terminated her contract because she still did not speak English well enough to perform her duties. When reminiscing about her time there, Světla says that she suffered not from culture shock but "work shock," and when she was in the hospital "felt very bad, and I cried and it was very difficult for me. But when I had a day off I felt very fine. Okay, this is a good holiday. I wasn't homesick but the job was awful for me." She also describes not being able to understand and complete medical documentation due to the different forms and terminology:

> First was the documentation. I didn't know the terminology. For example, when I had to describe the wound in English the first time, I didn't know the words and it was terrible for me. And when I had my first admission. I had a preceptor for eight shifts and I was working with her when I had to do my first admission and my preceptor told me 'you must do this documentation alone' and I told her 'but I don't understand this paper' and she said 'no, you must do it alone because you must learn it.' And I cried because I didn't understand this word and what it is and later when I repeated the admission process, it was better. It got better but this first time it was very shocking.[6]

Světla also describes having to get used to the "chaos" of the hospital, as well as working around large groups of visiting family members, which is a common cultural practice in Saudi Arabia but very different from Czech practices. Světla compares herself to Filipino nurses in her ward who she describes as "hardworking," implying that she was not hardworking, or at least unable to work hard due to her lack of necessary competencies and inability to adapt quickly enough to the system. Světla's level of competence gave her a negative perception of herself and her abilities to perform the job in that environment.

Autonomy also plays a central role in the level of nurses' confidence (Evans et al. 2010:337) and is particularly salient for Czech nurses. Primarily, for the 40 years of communism, when the profession of nursing was developing abroad and granting nurses more autonomy and professionalism (Zulauf 2001:99), nursing in Czechoslovakia was "understood as an assistant role…the nurse being accepted as the doctor's assistant." Nursing was, and still is to many extents, considered a practical activity, not a scientific discipline in the Czech Republic (Tóthová and Sedláková 2008:34). This attitude has not changed in the 20 years since the fall of communism. Nurses today still complain that many doctors treat them with little respect, not valuing their medical opinions. Saudi hospitals operate on the model of autonomous nursing, where nurses have more responsibility to make decisions. Světla states that she had more responsibility in the Saudi hospital, as well as more accountability for mistakes.[7]

Understanding the cultural rules and norms of a unit and feeling accepted there are necessary to feeling confident (Evans et al. 2010:336). Overall, Czech nurses are very confident in their abilities to perform their jobs in the Czech medical system. Upon returning to the Czech Republic and work in a Czech hospital, Světla says that "now in my job I feel very good. I am happy that I can work in a Czech hospital, I am very happy." Her sentiment of happiness, when viewed in contrast to her unhappiness in Saudi Arabia, correlates to feelings of confidence. However, when faced with the challenge of dealing with a foreign environment, Czech nurses

voice concerns and apprehension. Most of this is based on their levels of English and their abilities to communicate in the workplace. Other worries concern their lack of support group and distance from home. Although natural, I suggest that the lack of confidence in foreign environments relates to a lack of a sense of belonging in these same environments. Twenty years after the end of communism, some Czechs are still finding it difficult to consider themselves a credible member of the broader global community.

In order to feel confident, and therefore be successful on the job market, Czech migrants need to feel as if they have a right to work in a non-Czech work environment. Marginalized within their own country, nurses draw on the market demand as a way to bolster their sense of belonging both at home and abroad.[8] However, they need to perform successfully, employing appropriate levels of competence, in order to prove their legitimacy and right to belong. Therefore, they rely on other Czechs who are, and have been, successful abroad as a conduit to their own success. It starts as a process of interpellation in which recruiters target healthcare workers as subjects for the global healthcare market. Nurses, subsequently, do not only recognize recruiters as individuals who understand the ideology of the market, but also accept the "hailing" of themselves as subjects (Althusser 1971).

The migrant production process

The migrant production process, as described earlier, is more than interview training and preparation. It is a long-term process, lasting from three months to years, through which a nurse becomes a candidate and finally a migrant. It is a process during which a nurse transforms herself not only into someone who has the outward and verifiable skills necessary for work in her profession and/or specialization, but also the more implicit characteristics of a person who will successfully fit into a global environment. Recruitment firms manage the migrant production process through a variety of mechanisms, which I will outline here.[9]

Once a nurse accepts herself as a candidate for the global healthcare market, she agrees to cooperate with a recruitment firm. Until this point, she may have answered the recruiters' call as having potential on the market, but does not accept it for herself before she has the necessary information regarding the foreign work environment and migration channel (from the websites and informational sessions) and how she is individually positioned within that channel (from the personal interview). After speaking individually with a recruitment consultant, a nurse decides whether or not she is willing to make the investment of time, money, and self that is required of migration. Money is the easiest component. Nurses who do not have the available funds will either save money and prolong the training period, borrow from family members, or borrow from the recruitment firms.[10] Self, however, is the more difficult component. The work of "self-improvement" or the acquisition of cultural capital takes an effort that presupposes an investment in oneself, including time and sacrifice (Bourdieu 1986:244). Embodied capital, which is intimately linked to the self, cannot be transmitted directly but must become an integral part of the person. Cultural capital must become part of one's practiced worldview or ideology.

Ideology functions by transforming individuals into subjects through *interpellation* or "hailing;" accepting the hailing transforms the target into a subject (Althusser 1971:174). Simply by entering the recruitment firm's doors and recognizing that they are the people being targeted or "interpellated" by marketing tactics, a nurse becomes a subject of the ideology of globalization. Furthermore, by cooperating with the firm, nurses recognize the "existing state of affairs"(Althusser 1971:181) and that they must be obedient to the recruiters in order to take

advantage of the opportunities available to them. As a set of practices that provide conditions in which nurses become subjects but at the same time allow for more fully-developed agency, the migrant production process falls under the rubric of "agential subjectivation" (Mahmood 2005:154). Both public and private discourses call nurses, who are agents, to recognize themselves in terms of the global healthcare market and measure themselves against its demands (Mahmood 2005:32). Furthermore, if a nurse does not subject herself to the migration production process, she will never gain the necessary competencies which will enable her to act as a member of the global healthcare labor population.

The ideology of globalization is the foundation for the entire migration process. Based on freedom of mobility, the ideology of globalization is necessitated by an increase in the transnational production of goods and services (Carnoy and Castells 2001:3). A decrease in the global healthcare work population influences the healthcare component (Kingma 2006). Recruiters utilize this ideology to recruit and produce labor subjects in order to perpetuate it. Globalization, and the resultant global healthcare market, characterizes a set of ideas and beliefs that migrants and recruiters use to "figure out how the social world works [on a global scale], what their place is in it and what they *ought* to do" (Hall 1985:99, emphasis in the original). Additionally, recruiters use expertise in the field as a means for legitimizing this particular ideology (Poulantzas in Carnoy and Castells 2001:9).

Through the reproduction of its specifically skilled labor power, the migrant production process is a key component to the perpetuation of global healthcare migration. Nurses typically enter the migration chain with a minimum secondary school education and nursing license, which has been accepted by the Saudi Ministry of Health as the minimum to work in Saudi Arabia.[11] However, the social and cultural competencies, as well as the clinical competence of English, described above must be added in some way in order for Czech nurses to be labeled as part of this particularly skilled labor population. Recruitment firms have developed as the mediators, or the ideological apparatus, through which the skilled labor power of migrant nurses is reproduced.[12] It is only through the process of the production of healthcare services that reproduction of the labor force is realized and training is complete. The ideological apparatus of healthcare migration operates by teaching language and reiterating freedom of mobility, nationalism, and individualism in the work place. The ways in which the system is organized and classes are run are founded on the familiar ideological apparatus of education (Althusser 1971:156). Recruiters utilize the same techniques by employing instructors who have experience in Saudi or Western hospitals and who reiterate their own experiences in the employment destinations. Migrant training is the "practice" of these ideas related to globalization and through which the ideology of globalization is "inscribed" on the migrants as subjects to its system of beliefs (Hall 1985). The migrant production process has two primary training components—English and special skills—through which are infused ideological messages, which nurses absorb along with other forms of cultural capital.

Training components

The two training components of the migrant production process are English and special skills such as interview training, including mock interviews, intercultural training, Basic Life Support (BLS) or other specialized medical training. All courses, except intercultural training, are taught in English. The purpose of these training programs is not only to provide knowledge and skills to candidates, but also to provide practice in English-language interactions, as well as

to inscribe attitudes and values that are part of the globalization ideology. Some courses are required by the recruitment firms, while others are optional. Additionally, recruitment firms may provide specialized programs for candidates who lack the basic level of English and need accelerated training. Overall, the goal is to produce successful candidates for the migrant labor pool.

English training

English is the most important part of the training. Žaneta, a recruiter, says that "Saudis are waiting for me to supply, supply, supply and I'm not supplying because English is the problem. The main problem. Otherwise, like skill-wise or professionally, they are okay. But the language barrier is too high. [It is] the main cause for not being successful as a candidate." While discussing candidate preparation with his staff, Vilem, another recruiter, often talks about motivating the nurses and building their confidence, usually through participation in their various training courses, which help to improve language skills.

The emphasis on English training positions this skill as a core element to candidate success rates. As the common language in the Saudi healthcare system, candidates must have a minimum level of "very good" in order for recruiters to forward their files for consideration. Politically, English is emerging as the new second language of choice in the Czech Republic due to the variety of opportunities available at home and abroad. Not only is it less threatening than other languages such as German and Russian which symbolize the oppression of past regimes, but English represents cosmopolitanism, globalization, and even modernity (Bilaniuk 2005:182). English schools in Prague advertise English as "sexy" and show hip, modern, young people having fun in billboards and posters. Hana spent two years in London because she wanted to learn English, saying "it's an international language and I think it's quite important. I like traveling, so I need English as well. In a lot of countries I can speak English." Knowledge of English represents belonging in a broader world than the Czech Republic, but as part of the migrant profile, English works as not only an opportunity or motivator, but also a barrier.

English as motivator

In mock interviews, candidates often list learning English as either a challenge to be faced in the foreign work environment or a motivator for working abroad. Tamara, a 29-year-old lab technician from Moravia, currently has no opportunity for advancement at her job. She wants to work abroad so that she can improve her English in order to get a better job, outside of healthcare, upon her return. "Maybe teaching English or as a pharmaceutical representative," she says. When questioned why she wants to go abroad in order to learn English, nurses often offer a vague answer that alludes to a future in which the knowledge of English will provide some sort of benefit as cultural capital. Barbora is a midwife in her mid-twenties and wants to go abroad "mainly for my English because I want to speak English very well. I know that when I can speak English I can travel around the world and I can work in European states." However, asked specifically whether being able to speak English directly benefits them in the workplace, such as a raise or promotion, nurses respond in the negative, often justifying the need due to an increased number of international patients in Czech healthcare facilities. Žaneta claims that:

> English is connecting people, right? And to be able to work in foreign countries - not only in foreign countries - foreigners come over here too. You've got to be able to communicate with them. Accidents do happen. You work in the surgical department, they bring the accident victim and he speaks only English so there you are.

Kristen Ghodsee describes such strategies of skill development without a clear or present purpose as adjusting their "portfolios" of capital as a response to institutional, and I add, societal changes (2005:79). English provides not only opportunities to work abroad but to travel more freely and to engage in a fuller sense of global belonging.

English as barrier

As a barrier, the challenge of English can be an added stress to the migration process, especially for those who struggle with it. For example, although Helena has over 20 years of experience and a master's degree in the much-sought-after field of midwifery, she was not immediately successful on the job market; her English is not good enough. Věra worked with a recruitment firm for over four years, laboring to learn English, before she was offered employment. She had been told by hospital representatives during interviews that her English skills were the only thing lacking, and after many failed interviews, the recruitment firm did not consider her a top candidate. Her boyfriend had been pressuring her to learn English so that she could go abroad and earn enough money for them to buy a house and start a family when she returns. At 32, she was feeling pressured by the situation. Ironically, when Věra was finally offered a job in Saudi Arabia, it was based solely on her application; she did not interview. Věra says that she "was sure, that my study of English was already useless and now suddenly success comes." Věra refers to the usefulness of learning English as part of the necessary component to success in the job market. Her long-time struggle to transform herself into a successful candidate for the global market is directly related to her ability to prove competence in English skills.

English courses

English, therefore, is the foundational block on which success stands. Recruitment firms offer three types of English preparation: courses, intensive study with a tutor, and work or study abroad. Built into the courses are other non-language forms of training; English classes are not just language classes, but one more way in which recruiters inscribe ideologically-based attitudes and other forms of cultural capital onto their candidates. For example, Care4U's website describes their Medical English courses as "Practical preparation focused on different kinds of work approaches in foreign hospitals (following the US standards) such as dosage calculation and document processing. Strategy of filling in the documents which is essential for the recruitment process. Preparation for a job interview." The course is in English and discusses medical work, hence, the title "Medical English." Nursematch states that their English courses are "tailored to help you adapt in foreign hospitals in the language, as well as professionally," and that "the aim of this course is that you have lost your shyness and learn a basic conversation on familiar topics." Confidence and cultural capital in the forms of specialized knowledge regarding hospital practices and interview skills, as well as losing one's shyness, are just as

important to the goals of Medical English classes as are the actual lessons in the English language.

Other training

Recruitment firms also offer courses in specialized medical "training." Care4U offers courses in actual medical training which "make participants familiar with the educational system (according to the US standards)," preparing them for the certification courses they will need to pass once they enter the foreign workplace, like Basic Life Support (BLS). These courses are designed and taught by experienced healthcare providers and utilize kinesthetic teaching techniques such as practicing on resuscitation models in life support training. However, the actual efficacy as medical training can be questioned. Světla stated that "you do BLS here and there is no certification and then when you get to Saudi you have to do it again," but followed by stating that it was useful to have the experience with the different system before she left.[13] At Advanced Cardio Life Support (ACLS) training one month, the instructor failed to arrive due to illness. I observed that the students were not as concerned about missing the medical information as they were about missing the chance to practice English for a full day. Ida, a 38-year-old nurse and returning migrant who had worked in the Middle East before, told me that she would not take the optional courses, like ACLS, because it was "a little expensive."[14] However, when I saw her at this class a few months later, I asked why she changed her mind. Ida responded that the courses were "very helpful because it's important to listen to English and speak English. I can hear it at home every day but I need to speak it." At other times I observed students laughing nervously about how much they were not understanding because everything is in English.

Cultural knowledge about the destinations is also a part of the migrant production process; a primary concern for candidates is lack of information about the destination site of Saudi Arabia. While Nursematch offers information on its website in the form of letters from nurses working abroad, Care4U actually requires its candidates to complete a one-day Intercultural Training that includes "socio-psychological aspects of cultural changes and how to handle them…[information] about particular destination, [and] discussion with healthcare specialists with experience in the particular country." Hana states that a benefit of the courses is that they provide "information about places where you would like to go."

Courses also provide a space for candidate networking, and a base for emotional support. Eva, a 42-year-old nurse, states that a benefit from the courses is the "support from other workers - like psychological support. When I speak with nurses from Prague, Ostrava, [they say] I'm afraid, you're afraid…" She continues, saying that "I think it is very important because the style of the work abroad is different from my work and when we speak English in these courses, my hearing gets used to this language. Because I must meet with workers abroad, it's very important for my own experience." Eva's need for emotional support references the decreased confidence of first-time migrants. In her hospital interview, Eva was very nervous, which affected her English use and comprehension. However, once the hospital representative asked Eva about her hometown and current job, she physically straightened and performed much better. Once she was able to discuss something with which she was familiar, Eva's competence and confidence returned.

Finally, the training that illustrates the culmination of candidate transformation into global laborers is interview training. Both firms offer courses, claiming that candidates who

have taken the interview skill courses have been far more successful than those who have not. One website claims that "some graduates of the course were so successful that they have received two to three job offers!" During interview training, candidates learn how to formulate answers to common interview questions and are instructed how to dress and behave professionally.

Both English and other training courses are vital components to instilling competencies and confidence in candidates. By means of training classes, recruitment firms attempt to teach candidates clinical, cultural, and social competencies through embodiment; by practicing nursing language and documentation, and applying critical thinking skills in mock hospital settings and circumstances, candidates inscribe English skills with bodily practice. Through these embodying actions, the nurses are working to transform themselves into subjects of globalization or members of the global labor population.

Scaffolding of practices

As I stated previously, it is only through submitting to the migrant production process and transforming themselves into successful migration candidates, or embodying the norms, skills or competencies expected of them, that nurses can gain the agency needed to take full advantage of the global opportunities available to them. Migrant training is the "practice" of ideology related to global healthcare migration and the means through which it is "inscribed" on migrants as subjects of the system (Hall 1985). Once nurses embody the appropriate ideology, they not only *can* but are *impelled to* act in accordance with their new beliefs and attitudes (Althusser 1971:168). Therefore, migrant production is a "scaffolding of practices" that provides not only the conditions for subordination but also agency (Mahmood 2005:154). In this regard, migrant production is even more salient in the post-socialist context. It is through this mechanism of migrant production that recruiters are able to transform passive, doctors' assistants into competent and confident global healthcare professionals. At the same time, while post-socialist freedom of mobility engenders agency, it is only through meeting the ideals of the foreign employers that nurses have the opportunity to employ this agency.

Conclusion

In conclusion, Czech nurses are in a unique position among Czechs. Despite their marginalized position within Czech society, nurses have opportunities not available to the large population. Due to their professional membership in a globally, in-demand labor population, nurses have potentiality for foreign employment that is not open to other professions. However, they only have the capability to fully capitalize on this possibility through coordination with recruitment firms. This means submitting to migrant production processes that help position them as members of the global professional network. Through the migrant production process, nurses are taught not only to embrace, but also embody, the competencies – clinical, cultural, and social – that when employed with confidence, transform them into transnational nurses and successful migrants. It is only by subjecting to these "scaffolding of practices" that allows them to transform into global subjects, that Czech nurses become agents of migration activities and actors with global potentialities.

Notes

[1] "Nursematch" and "Care4U" are pseudonyms for Czech recruitment firms.

[2] Research was funded by a Fulbright-Hays Doctoral Dissertation Research Abroad grant and analysis has been aided by participants of the 2010 Junior Scholars Training Seminar (co-sponsored by the Woodrow Wilson International Center for Scholars and NCEEER).

[3] Hospital representatives are employed as recruiters by hospitals and are the primary contacts between hospitals and recruitment firms. In this paper, the term "recruiter" will refer to those from independent firms. When referring to recruiters who are employed by hospitals, I will clarify them as "hospital representatives."

[4] Staffing firms typically can earn up to an equivalent of 10-15% of the candidate's yearly salary if she completes the three-month probation period of a one-year contract. It is their primary source of income and is paid by the hospital.

[5] The majority of Czech nurses are females, as are the potential migrants.

[6] Preceptors act as a combined trainer and mentor for new employees.

[7] Czech nurses often refer to autonomy and more responsibility as a proxy for respect and the status of nurses in the medical field, relating these concepts to how much they are valued as members of a healthcare team instead of merely carrying out assigned tasks.

[8] Nurses are marginalized as members of a feminized profession who receive low financial and social reciprocity for their work. Attitudes toward nurses position them as low-educated, often sexualized, "semi-professionals," subordinate to the higher medical field.

[9] Other parts of the process are marketing and interviewing, which precede and follow, respectively, the training period.

[10] Recruitment firms will often offer loans to candidates. Care4U, for example, offers its candidates the option to pay for the 2nd half of their processing fees three months after they have started working abroad, for an additional 10%.

[11] Some may be lacking the two years working experience required by Saudi hospitals and therefore must simply wait until they have gained that experience.

[12] Ideological apparatuses are "distinct and specialized institutions" through which the reproduction of production is realized (Althusser 1971:143).

[13] Saudi hospitals practice American method of BLS, whereas Czechs practice the slightly different European method.

[14] ACLS cost 1800 čK or approximately 100 USD. In the Czech healthcare system, the average national salary for hospital nurses in 2008 was just over 24 000 Czech crowns or approximately 1340 USD per month (ČTK 2009).

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