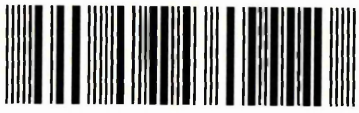

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Indian Physiotherapists' Global Mobility: A Grounded Theory Journey of Professional Identity Transformation

Kate Grafton

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Abstract

In the last decade over a thousand Indian physiotherapists have travelled to work or study overseas. Published literature investigates the global mobility of doctors and nurses but there is no literature that considers the global migration of physiotherapists from developing countries. The purpose of this study was to understand the motivations and aspirations underpinning the Indian physiotherapists' global mobility. Nineteen Indian physiotherapists were interviewed in English individually or in focus groups. The data was collected and analysed using constructivist grounded theory methods.

The findings suggest that Indian physiotherapists travelled overseas for professional development, they sought knowledge, skills and experience that they perceived were not available in India. Many sought experience of autonomous physiotherapy practice. They aspired to a better life, through better professional practice, increased respect and pay. Indian societal values amplified the importance of pay and respect for male physiotherapists, whereas females prioritised professional development. All aspired to professional autonomy and planned to return to India once their travel objectives were met. Behind the motivations for travel was a discourse of challenge and turmoil for physiotherapy in India, where they have no legal professional recognition.

The grounded theory constructed posits that the Indian physiotherapists' global mobility is a journey of professional identity transformation that consists of four stages 'forming', 'storming', 'transforming' and 'returning'. Identity formation occurs through professional socialisation during their degree training. 'Storming' occurs as they transition into work and experience a disjuncture between their nascent physiotherapy identity and the workplace role expectations. This leads to frustration as they aspire to autonomous practice and an autonomous professional identity; they hear that physiotherapy is different overseas. Transformation occurs through overseas professional development and experience of autonomous practice. Successful return to India is dependent upon returnees transferring and integrating their new professional identity back to the Indian physiotherapy context.

Candidate's Statement

I declare that the work in this thesis was carried out in accordance with the regulations of Sheffield Hallam University and is original except where indicated by specific reference in the text. No part of this thesis has been submitted as part of any other academic award. The thesis has not been presented to any other educational institution in the UK or overseas.

Any views expressed in the thesis are those of the author and in no way represent those of the university.

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Contents

List of Tables

List of Figures

List of Appendices

1. Chapter One: Context of the Research

Over the last decade a substantial number of Indian physiotherapists have sought to work and / or study overseas. Between 2002 and 2012, 3514 Indian physiotherapists applied for registration with the, then, UK Health Professions Council (HPC); 2286 were subsequently registered, which is 27% of overseas physiotherapy HPC registrants (HCPC 2013). The UK is just one destination country for globally mobile Indian physiotherapists. The USA, Canada, Australia and New Zealand are the other principle destinations for study and work but many also travel to the Gulf states seeking employment. Many Indian physiotherapists who travel to the UK, first enrol on a masters degree and then seek to work overseas upon completion of their study. Anecdotal reports suggest that they form a significant portion of many universities' international physiotherapy student cohorts and are important contributors to the financial viability of masters physiotherapy post-graduate programmes in some UK universities. The numbers of Indian physiotherapists coming to study in the UK have reduced due to recent UK visa changes and the increased challenges of obtaining a post-study work but there has been no indication of a reduction in numbers leaving India for other overseas destinations.

This research uses constructivist grounded theory methodology to offer an explanation as to why Indian physiotherapists seek to study and work overseas. It also examines the challenges associated with their return and how their mobility might impact upon physiotherapy practice and profession development in India.

1.1. Background and Literature Review

This chapter introduces some key considerations that form the background associated with the migration of Indian physiotherapists. The Indian health care context is outlined, along with the governance and challenges of physiotherapy within the Indian healthcare system. Most of the literature published explores

mobility issues from the general perspective of highly skilled workers. The literature presented here outlines the issues and knowledge associated with skilled labour migration and mobility and identifies the key conceptual analysis of such mobility, 'brain gain', 'brain circulation', push and pull factors. There is some literature that discusses the mobility of doctors and nurses, much of it conceptually based upon an epidemiological context; some empirically explores factors underpinning mobility. The main focus of the literature is on movement from developing to developed countries, and particularly in health, is often from a work-force planning policy perspective. There is very little published that focuses upon the allied health professions collectively and nothing published that specifically explores the factors underpinning physiotherapy mobility.

The literature presented in this review reflects the starting point and sets the context for the research but, as constructivist grounded theory is an emergent research methodology, the research has followed the direction that emerged from the interview data. Therefore new literature will be introduced throughout the chapters to illuminate the findings and the theory.

1.1.1. Global Mobility and Migration

The terms mobility and migration are used interchangeably in the literature with few attempts to define them. Kingma (2001) considers that 'migration is moving from one place to another, and international migration is moving from one country to another'. A dictionary definition of mobility as "quality or power of being mobile; freedom or ease of movement" (Chambers 2002), suggests fewer constraints and more flexibility. A World Confederation for Physical Therapy (WCPT) published paper concurs that mobility is borderless. It is also described as 'the extent to which a worker is able to move from one country or jurisdiction

to another and to gain entry into a profession without undue obstacles or barriers (Glover-Takahashi et al 2003).

Population mobility is leading to greater internationalisation of the labour market and this is generally considered to have a positive effect on global economies and humanity (Winkelman 2002; Bhagwati 2004; GCIM 2005; Leeder et al 2007; Friedman 2006). Bhagwati (2004) considers that in India the out migration of professionals is an opportunity and not a threat, as India has a huge capacity to generate skilled professionals. There is evidence to suggest that migration is less likely to be permanent and long term, with the twentieth century classical 'settler' migration less dominant (Glass and Choy 2002). Many Organisation for Economic Co-operation and Development (OECD) countries are changing migration policies in order to facilitate the mobility of highly skilled (this includes health professionals and students) foreign workers on a temporary basis, so that specific skill shortages can be met (OECD 2002).

1.1.1.1. Migration patterns and statistics

It is difficult to make meaningful comparisons of population mobility. There are no universally agreed definitions of 'international migration' or the various subsets, and statistics are variably recorded based upon local national definitions (Nonnenmacher 2008). The international labour force represents approximately 3% of the global workforce; approximately 33% and 10% of the UK's doctors and nurses respectively are from developing countries (OECD 2008b). Available reports document migration statistics that illustrate the movement of doctors and nurses between various countries (Dumont et al 2008). However, none clearly identify the movement patterns of physiotherapists or members of the other allied health professions. What can be seen from the statistics on doctors' and nurses' mobility is that the movement of health care professionals is complex. It is not just from developing to developed

countries, and 'south to north' flows, as much of the literature that expresses concerns regarding the effects of nurse migration might suggest (Chikanda 2005; Kingma 2006). There is also movement of professionals between developing countries 'south to south' (20,000 Cuban doctors work in other developing countries (Solimano 2008)) and movement between developed OECD countries. The USA obtains 20.2% of its immigrant nurses from Canada and 8.4% from the UK (Brush 2008). It is clear from the literature that the UK is a source country for Canada, USA, Australia and New Zealand (Forcier et al 2004), as well as a destination country. What is less clear is whether the UK acts as 'hub' country for migrants. Additionally, there is little consensus about the extent to which health profession mobility is a temporary or permanent phenomenon. Policy makers have attempted to ensure that professional migration is a temporary rather than a permanent state and therefore try to facilitate migrants, with their developed skills, to return to their home country (Buchan 2004; OECD 2004a; 2008b).

Despite trade agreements facilitating the movement of nurses and other health professionals within the EU, little movement of nurses occurs due to language barriers and the absence of substantial economic or educational motivators (Aiken et al 2004). Buchan and Dovlo (2004) reported work permit statistics which suggest a significant upward trend in the flow of physiotherapists to the UK from South Africa, Australia, New Zealand, Zimbabwe and India. Table one shows that India is the source of more overseas HPC registrations than any other country. The numbers peaked in 2005 and have been reducing since 2007. This reduction reflects the shortage of jobs for physiotherapists and the subsequent changes to the UK visa system with the removal of the post-study work visa. Australia is the other key 'sending' nation but, unlike India, it is also a receiving nation, dependent upon migrants from English speaking nations (including India) to staff its health workforce (Hawthorne 2012).

Table 1: Top Five Overseas Countries for Physiotherapists on the Health Professions Council Register 2002 to 2012

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
India	15	121	416	599	360	167	92	132	105	147	132	2374
Australia	271	250	302	200	204	114	127	130	121	106	149	2057
South Africa	138	109	173	80	68	39	46	35	7	14	14	728
New Zealand	66	93	75	72	75	60	57	24	47	37	34	657
Poland	5	2	4	14	35	42	44	44	24	27	44	320

In summary most published reports focus on doctors and nurses migration and there is little information on physiotherapists migration. The UK HPC statistics (HCPC 2013) and Hawthorne's (2012) report suggest that Indian physiotherapists have been significant players in the global migration of physiotherapists over the last decade.

1.1.1.2. Global mobility and education

The demand for higher education globally is growing, with the number of students worldwide doubling in the last twenty years (OECD 2008a; van der Wende 2003). The result is a growing internationalisation of education systems and increased student mobility (Tremblay 2002; Vincent-Lancrin 2008). In 2011 4.5 million tertiary students enrolled outside their country of citizenship which represents an annual average growth rate of 6% over the last decade (OECD 2013). Most mobility occurs to OECD countries, with the USA and the UK respectively being the first and second choice destinations; over 27,000 Indian students studied in the UK in 2007/08 (Fearn 2009). It is suggested that student migration is a form of migration of qualified labour, or certainly a precursor to it (Tremblay 2002). Motivational factors in students applying to study overseas

include employment and residency opportunities and the quality of the 'student experience' (OECD 2013). In the labour market, migrants who possess a degree from the host country are at an advantage over migrants whose degree is from a foreign education institution (Cobb-Clarke 2000). Students will travel internationally for a specialist education that is insufficiently provided in their home country; this may assist their home country through the transfer of technical and cultural knowledge (Vincent-Lancrin 2008).

Global mobility is proposed to be important for transmitting the tacit element of knowledge globally. Tacit knowledge is dependent upon a social context and physical proximity and so is not easily disseminated through academic papers, conferences and lectures (OECD 2008c). Physiotherapy practice is considered to be underpinned by the codified and tacit dimensions of knowledge (Higgs and Titchen 1995). It is the contact with colleagues, chance meetings and social networks with 'co-located' associates and organisations that are important factors in the diffusion of knowledge, and as the proximity to colleagues reduces, so does the knowledge transfer or 'spill over' (Agarwal et al 2006). There is a lower level of mobility in certain professional disciplines due to regulatory issues (Tremblay 2002), this is the case for physiotherapy. However, increasingly physiotherapy graduates, especially from India, have sought masters and PhD level education in the UK and other OECD countries but little is known specifically why they seek to study overseas.

1.1.2. Global Mobility Conceptual Frameworks

Various conceptual frameworks have been articulated to analyse the different facets that underpin the global mobility of skilled workers. The most commonly described are 'brain drain' and 'brain circulation', which encapsulate the effects of mobility at a country level; and 'push and pull factors' which focus upon aspirations and drivers at an individual's decision making level.

1.1.2.1. Brain drain or brain circulation?

'Brain drain' refers to 'the migration of professionals and technical personnel to other countries, resulting in a perceived loss of real and potential human capital to their home country' (Sparacio 2005). When the concept is applied to health professions it raises emotive issues and ethical concerns that have been extensively discussed in the literature (Buchan and Calman 2004; Ollilo 2005; Mensah et al 2005; Buchan 2006; McElmurry et al 2006).The loss of productive labour and the fiscal cost of educating health professionals is a key concern, which must be balanced against whether they could have found productive employment at home; this in turn is dependent upon the extent to which the source country have planned their workforce requirements effectively. Nurses and other health professionals in sub-Saharan Africa would undoubtedly find meaningful employment at home and any international mobility will clearly exacerbate any country shortage (Aiken et al 2004; OECD 2004b; Chikanda 2005). However, it cannot always be assumed that they would have been retained within the public health sector (Bach 2006), as many move to the private sector in their own country, thereby creating an internal 'brain drain' (Wilbulpolprasert 1999). Further impacts of 'brain drain' are the increased workloads and low morale of those who remain (McElmurry et al 2005). There is also a reduced ability to deliver education and training for the health workforce, which in turn makes the source country more reliant on an inflow of specialist workers (Bach 2006).

To offset the effect of 'brain drain', the governments in some source countries have policies of training more doctors or nurses than the country needs. This encourages migration without damaging the local healthcare provision (Kaukab 2005; Bach 2006), for example 85% of Filipino trained nurses work overseas (Aiken et al 2004). The economics of such policies are based upon the contribution of remittances to the country's economy and the percentage of the country's gross domestic product (GDP) that it accounts for (OECD 2008b). It

has been estimated that remittances are worth US$401 billion to developing countries, and US$69 billion to the Indian economy and US$24 billion to the Filipino economy (The World Bank 2012). Remittances are an important source of income for many low and middle income households in developing countries (OECD 2008b) and individual nurses report sending over 25% of their salary home (ICN 2007). However concerns have been raised that as it goes to families it will only contribute to the economy through an increase in private consumption but will not contribute to the healthcare system (Oberoi and Lin 2006; Bach 2006). No literature has been published that identifies 'brain drain' to be a result of the global movement of physiotherapists, although in the context of the significant healthcare needs identified in India, it might be perceived that their overseas migration is indeed 'brain drain'.

The concept of 'brain circulation' has recently entered the literature. Various mechanisms have been articulated, through which it is contended that global mobility may contribute to the circulation of knowledge and skills. Emigration possibilities encourage the development of skills by attracting talent to the profession (Bach 2006) and will increase the incentives to study and obtain a higher level education to help facilitate the migration (Khadria 2004; Kaukab 2005). Professionals will weigh the costs of acquiring skills against prospective market rewards both at home and abroad. The assumed higher returns for further education or education abroad create an incentive for the professional to up-skill to increase their human capital. This increases the stock of education in the country, as only a proportion with the accumulated skills will ever be lost to migration (Mountford 1997; Beine et al 2001).

There is an increase in the global stock of knowledge. An individual employed in an overseas workforce may produce better and different knowledge than they would have if they had not travelled; this accumulates human capital faster and

improves productivity. Therefore there is an increased potential for a return flow of knowledge (OECD 2008c). Networks and diasporas are important to facilitate the circulation of knowledge. Professionals working abroad can act as a conduit for flows of knowledge and information back to their home country (OECD 2008c).

Increasingly professionals are returning home, taking the knowledge they have gained with them. Many OECD countries have policies implemented to encourage either a temporary or permanent return of health professionals to their home country. However for a return to have an optimal effect on knowledge circulation they must enter the work force at an appropriate level, into a job that effectively uses the skills that they have acquired (OECD 2008c). This is often difficult in African countries (Bach 2006) and also in Pakistan (Kaukab 2005); as hierarchical promotions based upon time served in a health care system predominate. Post return it is suggested that networks overseas are maintained therefore facilitating a continued knowledge exchange.

Most of the publications cited refer to theoretical and anecdotal aspirations around the effect of migration on knowledge flows and there is little published empirical evidence in relation to any profession. A survey of overseas doctors in the UK in 2002 (Kangasniemi et al 2007), explored the notion that skilled migration created incentives for obtaining training and increased the net supply of skilled labour if two conditions were met. Firstly, that migration opportunities sufficiently affected decisions to take medical training and secondly, that migrants were not screened by the host country. This second condition was not adequately justified in the paper and does not directly link with Beine et al's (2001) supposition that rationing is a key factor in seeking further training. It was concluded that neither of their hypothesised conditions were met and so the notion was rejected. However, the authors did concede that entry and training

requirements had changed in 2005, which suggested that the latter condition would now be met. The paper also identified that remittances and return migration were beneficial to the sending country.

1.1.2.2. Push and pull factors

Factors that 'push' a professional to emigrate have been identified to be context specific for individual migrants, with commonalities for the country of origin. They mainly focus on pay, working conditions, management and governance issues, and personal safety. The exposure to HIV/AIDS is an important consideration for health professionals in Africa (Buchan and Dovlo 2004; Chikanda 2005; Oberoi and Lin 2006; Bach 2006). It has been suggested that 'push' factors play a greater role than 'pull' factors (Oberoi and Lin 2006).

'Pull' factors that affect the selection of the destination countries are commonly identified as work-force shortages in the destination country and active recruitment (Bach 2006). However, the picture for health professionals would appear to be more complex. The role of wage differentials between developing and developed countries is variably reported but the overall consensus is that it is not the main driving factor (Kingma 2001; Ross et al 2005). A study that explored wage differentials adjusted for purchasing power parity demonstrated that there is little difference between the source (Australia, India, Philippines, South Africa, Zimbabwe) and the UK as a recipient country (Vujicic et al 2004). However, as the actual differences in wages are large, this may lead to false expectations. The literature exploring the motivations of doctors and to a lesser extent nurses suggest that access to higher education and opportunities for professional development are key 'pull' factors (Kingma 2001; Khadria 2004).

Moran et al (2005) used an 'e-survey' to explore the perspectives of thirty four international health professionals (of which a third were physiotherapists) on

working in the UK. The survey found that travel, money and career opportunities were the primary motives for working in the UK; they also reported that career development opportunities were better in the UK and there was a wider variety of specialisation. The source countries were Australia, South Africa, New Zealand and Ireland, and the respondents had most commonly entered the UK on working holiday visas; hence their perspectives may be those of a holiday maker and may not be generalisable to health professionals from other countries. The paper did not provide a breakdown by nationality and profession, and so it is not possible to identify any perspective that may be unique to a particular profession or country. There was a consensus of opinion that their home country would benefit upon their return, as they had gained a much broader skill base, knowledge of a different health care system, and had learnt from a vast array of good and bad experiences; hence this paper supports the notion of 'brain circulation'.

Khadria's (2004) study explores the motivations of Indian doctors (n=34) and nurses (n=40) emigrating from Delhi. The study has clear methodological limitations with regard to sampling, the questionnaire and data presentation, but it does provide an interesting suggestion of the different motivating factors between Indian doctors and nurses in emigrating. The role of overseas friends, and family and friends in India were identified as being important in the decision making process for both doctors and nurses. The nurses (who were older than doctors) were more likely to find their mobility limited by family ties in India. The doctors' intended purposes of going overseas were aligned with the motivating factors they identified, all educationally and professionally focused as shown in table two. However, for the nurses there was a paradox between the educational and career focused purpose for going overseas, and the more socially focused motivating factors. Unfortunately the paper does not give any indication as to the import of each of these factors in relation to each other; it just presents the frequency with which each was identified by the respondents.

A study of Ghanaian health professionals identified similar differences between doctors and nurses in their motives for emigrating (Mensah et al 2005).

Table 2: Doctors and Nurses Reasons for Moving Overseas to Work
(Compiled from data described by Khadria 2004)

	Doctors	Nurses
Purpose	to get jobs with better training opportunities	access to better training opportunities
	to ensure more rapid progression in medical profession than would be possible in India	access to a specific kind of training
	to get specific training not available in India	to progress faster in their profession
	to get good employment opportunities	
Motivating Factors	access higher education opportunities	better income prospects
	the availability of experts in the host country	better quality of life
	higher income	better infrastructure facilities
	better quality of life	education for children
	an overseas experience being of value in India	valuable experience
	increasing employment opportunities	access to higher education overseas
	better professional infrastructure	increasing employment opportunities

N.B. List orders based upon frequency of reason cited

Khadria's (2004) Indian survey also suggested that both professions identified that overseas experience would be highly valued upon return to India; the

importance of feeding back their overseas knowledge; and that in order to dissuade them from travelling overseas better careers, education and training facilities, and remuneration were required in India. A key difference between the doctors and nurses appears to be the intended duration of their stay. Only 15% (n=5) of the doctors identified permanent settlement in the host country as an aim but they were sceptical about future professional growth in India. Whereas the 35% (n=14) of the nurses appeared to wish to stay overseas permanently, with 63.3% (n=25) wanting to stay abroad for more than four years. This is in stark contrast to a similar sample of information technology (IT) professionals who wish to gain overseas experience and then the majority to then return to India within two years.

A comprehensive cross-sectional study used both quantitative and qualitative methods to explore factors underpinning Lebanese nurse migration (El-Jardali et al 2008). It identified that educational support, managerial support, better working conditions, utilization of best nursing practices and autonomy were key factors underpinning why the Lebanese nurses sought to work overseas. In contrast a study by Akl et al (2007) identified that the reason for doctors migrating was due to the oversaturated Lebanese job market and the role of training to increase their competitiveness in the market. It was identified that there was a culture of expectation within the medical academic communities to progress their study overseas, even for just a few months. The study was conceptually rigorous and used grounded theory to explore the factors underpinning the 23 Lebanese medical students desire to migrate. The push and pull factors identified were similar to those in Khadria's (2004) study; however Akl et al (2007) also identified 'repel' and 'retain' factors that operated in parallel to the 'push' and 'pull' factors. 'Repel' factors worked from the recipient country and included personal worries, such as raising children in a different culture; concerns regarding lack of social support, cultural differences; and political based issues. 'Retain' factors were based in the source country

and included issues such as a partner unwilling or unable to travel; a desire to stay close to family and local community; and for single women a pressure not to travel.

In summary, the factors underpinning individual mobility patterns differ across different countries (OECD 2008c), the Lebanese and Indian research both suggest that there are key differences behind the motivations for doctors and nurses mobility. There are also clear commonalities across the developing countries within each profession.

1.1.3. Global Health Professions

There is a global shortage of nurses that is projected to become worse with changing demographics; the ageing population, the ageing health workforce, increasing demand for healthcare, increased patient expectations (Sparacio 2005; Dumont 2008). It is not unreasonable to assume that these same factors will increase the global demand for physiotherapists and the demand for physiotherapy in developing countries. Developed countries face the challenge of how to respond to the predicted increase in demand for health professionals over the next 20 years (OECD 2008b) in the context of globalisation and the increasingly mobile health work force. The underpinning issues are complex and the debate polarised. At one end of the continuum the literature highlights many positive aspects of globalised health services, the benefits for individuals in enhancing career and earning opportunities, and at the same time the source country benefits from remittances and components of knowledge transfer (Leeder et al 2007). At the other end of the spectrum are the effects on the source country, especially where professionals are moving from a poor country with a developing health care system (Bach 2006). However, the free movement of labour is considered to be a fundamental right of an individual (Buchan and Calman 2004).

The strong influence of regulatory frameworks may act as facilitators or blockers to mobility and therefore makes the mobility of health professionals distinctive from the mobility of other highly skilled workers (Kingma 2006; GDC 2007; Hawthorne 2013). Governments and professional regulatory bodies, control training standards, levels and numbers, recruitment and often deployment of professionals. The purpose of regulation to protect the public is fundamentally the same across the world. However, it is also increasingly being used to protect the profession and workforce that it regulates (Kingma 2006). Arguably mobility ease is partially determined by registration ease, the more similar the education and healthcare systems of different countries' are, the easier it is to gain registration and therefore be mobile, with some countries having reciprocal registration agreements to ease the flow of workers (Glass and Choy 2001).

In some developing countries it has been suggested that altering the curriculum and reducing the length of the training period required for doctors and nurses would hasten entry into the workforce and deter out-migration of the graduates, as they would find it difficult to register to work in a country other than the one in which they trained (Bach 2006). Similarly there is a lobby for physiotherapy in developing countries to develop a technician level, as this would meet local health needs. These moves are being challenged by those aspiring to set global standards for medical and physiotherapy education (Wojtczak and Schwarz 2000; WCPT 2013a). The current WCPT focus is on raising physiotherapy globally to at least a degree level profession, and setting global standards. Many developed countries are moving to master's and in the USA to a doctorate level entry qualification in order to develop and enhance physiotherapy's standing as an autonomous profession (WCPT 2013a). It could be argued that reducing the level of training in some countries long term will hinder the development and the effectiveness of physiotherapy and ultimately the health of the population in those countries. Firstly, there would be less development of the cognitive skills required for advancing practice and

secondly, there would be reduced knowledge transfer opportunities that global mobility theoretically affords. However, in an African country a technician level physiotherapist is preferable to no physiotherapist. There is a clear mismatch between the aspirations of physiotherapy as a global profession and the health needs of local countries. It is not known whether physiotherapy mobility contributes to knowledge transfer and ultimately practice and profession development. If the physiotherapy workforce were more globally mobile, would we see a better diffusion of knowledge and hence enhanced practice? An enhanced and valued profession would attract people into it. It could be suggested that ultimately a global health workforce could increase the standard of health globally.

1.1.4. Disability Rights and the Impact on HealthCare Professions

The Convention on the Rights of Persons with Disabilities (UN 2006) has influenced the way in which disability is conceptualised, particularly in developing countries. The legislation adopts the societal model of disability and recognises the interaction between the environment and the influence upon disability. Disability is politicised into a human rights issue and is perceived as primarily a social problem, rather than a healthcare problem. Attention to impairment needs is seen as an entitlement and an established right in the convention. Specifically Article 26 'Habitation and Rehabilitation' of the convention determines that persons with disabilities will be supported "*to attain maximum independence, physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life*". The article indicates that states should develop services across health, employment, education and social services to ensure a multidisciplinary approach based upon individual needs and strengths. Support should be inclusive and locally based, and assistive devices and technologies should be promoted. Training should be provided for professionals and staff working in these services. India is a

signatory to the legislation and given the scale and rural predominance of its population the convention presents significant challenges.

The Community Based Rehabilitation (CBR) model of provision was introduced in the 1970's to rural communities in developing countries as a part of primary healthcare programmes. It has evolved over the years according to changing agendas and the growing disability activism, resulting in increasing ownership and control by local disabled people's organisations (Carrington 2006). It has become an approach that recognises the complexity of disability and seeks to address it (Hartley et al 2009). Developing from the rights based approach to rehabilitation (articulated in the UN Article 26 Convention) a system has emerged where CBR mid-level workers are seen as a pivotal part of primary healthcare services, and they undergo short training programmes that are bespoke to the local need (MacLachlan et al 2011). The WCPT advocate that the education of physiotherapists should be to a professional level (they suggest a minimum of four years at university) in order to ensure the attainment of high standards of therapeutic interventions, they also suggest that physiotherapists can have a significant role in CBR (WCPT 2011). Bury (2003) identifies that this creates a dilemma for the profession in striving to balance the need for enhanced professional status and recognition, while achieving a more client or community-orientated focus, and this results in challenges for practice and education.

There are different conceptualisations of disability. The WHO 1980, 1999 and 2001 international classifications (WHO 2002), that incorporated disability, were based upon the individual or medicalised model, where the disability resides within the body of the individual and is directly associated with an impairment which may require medical management (Oliver 1990). It is perceived that this model creates a power imbalance in favour of the medical professional and at the expense of the individual with the disability. The

Convention of Rights of persons with Disabilities (UN 2006) is based upon the social model of disability. This model relocates the problem of disability from the individual to the society, the disability resulting from the society's exclusion of individuals due to the way it is structured and functions. Impairment exists and may benefit from medical interventions but it is not the result of disability; the two are dichotomous. Disability is seen as a political issue that is associated with social oppression (Barnes and Mercer 2003). To reduce disability, society must change and create an inclusive environment to enable people with impairments to perform their role as citizens (Ahmad 2000). The removal of social barriers (architectural, attitudinal, educational, occupational etc) that restrict the activities of people with impairments would effectively remove disability (Thomas 2004). Whilst there are critics of the social disability model and its partition of impairment and disability (Shakespeare and Watson 2002) the separation has conceptual value for rehabilitation professionals, whose expertise is focused upon reducing impairment and the associated physical effects of reduced mobility or pain at an individual level. They should not assume that their impairment based intervention will influence the individual's disability and equally should not attempt to medicalise the disability (Oliver 1990). Disability should be considered in the social and environmental context and not be owned by the individual. Oliver (1990) suggests that both the rehabilitation professionals and the disabled people must recognise each other's experiences; the rehabilitation professional attempting to understand how and why the individual experiences disability. They should support the empowerment of the disabled person.

By definition a profession is accorded an elevated position in the social strata in return for the service that the society, in which it operates, demands (Larson 1977; Evetts 2003). The physiotherapy profession has its origins in the medical model and the associated professional prestige (Parry 1995). Hence it's education heritage has been based upon the individual, medicalised model

of disability and it has been suggested that it has been slow to acknowledge more social models of disability (Nicholls 2005; Gibson et al 2009). The WCPT (2011) state that physiotherapy curricula should be relevant to the health and social needs of the particular nation and the legislative demands of the disabled are now based within the social model of disability. It is also suggested that in order to meet the responsibilities incumbent with profession status, physiotherapy curriculums should incorporate the social model of disability and equip graduates to work in community settings. This would equip graduating practitioners to engage with the management of impairments and disability within the disability rights model and alongside the other CBR workers. Futter (2003) describes that this has been successfully achieved in South Africa. However Bury (2003) suggests that the challenges may go beyond the curriculum preparedness due to perceived lower status conferred on those working in community or rural settings. However it is incumbent upon all rehabilitation professionals, in whatever context they work, to challenge the societal barriers that that create disability and to empower the individual with a disability. The way that disability is learnt about and understood affects the way people respond to the disabled people in society (Morris 2011).

1.1.5. India and Health Care

The 2011 Indian census revealed that 26.8 million people, 2.21% of the population (Government of India 2011) were described as disabled. India has a population that exceeds 1.2 billion, which is a sixth of the world's population and a third of the world's poor (WHO 2013). A third of the population live in urban areas, the mean life expectancy is 65.8 years and more than 50% of its population are below the age of 25 and more than 65% below the age of 35 (WHO 2013). The Indian 'middle class' is rapidly growing but over a third of the population live on less than US$1 a day, and around a third of the adult population, including over 190 million Indian women remain illiterate (UNDP

2010). India spends 4.2 per cent of its GDP on health, which is lower than comparable middle income countries such as South Africa, Brazil and China who spend up to 9% (OECD 2012), and between 70% and 80% of total healthcare spending in India is in the private sector (Pricewaterhouse Coopers 2007; OECD 2012).

In terms of revenue and formal employment, healthcare is one of India's largest sectors and it has expanded rapidly with an annual growth rate of 16% during the 1990s. In 2007 the total value of the sector was worth more than US$34 billion, with the private sector accounting for more than 80% of total healthcare spending (Pricewaterhouse Coopers 2007). There are 6.5 doctors and 10 nurses per 10,000 of the Indian population (WHO 2013) and an estimate of 2.5 physiotherapists. A Public Health Foundation of India (2012) study suggested a supply-demand gap of 6.5 million allied health professionals and indicated that the human resources shortfalls have resulted in the uneven distribution of all genres of health workers and training institutions across the Indian states, has resulted in a severe health system imbalance across the country, with major variations in health outcomes and the quality of health care services. This reflects both differences in levels of economic development and major disparities in public health spending (OECD 2012). In addition to the inconsistency in geographical provision, there is disparity of provision between social groups, different income levels and between the sexes. When it comes to healthcare, there are two Indias: the country with good quality medical care available to middle-class Indians and medical tourists, and the India whose residents have limited or no access to quality care (Pricewaterhouse Coopers 2007).

1.1.5.1. Physiotherapy in India

Physiotherapy has been practised in India for over half a century, with its professional body the Indian Association of Physiotherapists (IAP) being a

member of the World Confederation for Physical Therapy since 1967 (WCPT 2013b). Today physiotherapy in India is still dominated by medical doctors who continue to prescribe physiotherapy treatments. It is not a regulated profession and there is no protection of title. Over the last ten years there has been a lot of Indian government legislature drawn up but none of it enacted, as India struggles to develop a health care infrastructure to meet India's huge healthcare needs and the priorities and perspectives of all the healthcare professions vying for their places in the hierarchy. See table three for a summary and appendix one for more detail of the failed legislature.

Table 3: Summary of the Proposed Indian Legislature Affecting the Regulation of Physiotherapy

Year	Act and Key Implications
1992	Rehabilitation Council of India Act - Physiotherapists not included
1998	Notification to include physiotherapists in 1992 act - subsequently withdrawn
2007	Paramedical and Physiotherapy Central Councils Bill 2007 - no inferred autonomy
2008	Parliamentary Standing Committee report on the 2007 bill suggests amendments that infer physiotherapy autonomy
2009	National Council for Human Resources in Health 2009 Bill - disputes over the professional groupings and continuing medical dominance.
2011	National Commission for Human Resources in Health (NCHRH) 2011 - physiotherapists grouped with 'paramedical', no autonomy suggested
October 2012	A Parliamentary Standing Committee Report rejects the 2011 bill due to medical dominance
December 2012	Union Minister of Health and Family Welfare report - recommends enhancing Allied Health Professions roles and effectively autonomy.

The recent history of Physiotherapy in India appears to be one of conflict with the doctors, positioning against the other allied health professions and lobbying the government for recognition (Ahuja et al 2011; Kumar 2011; Sinha 2012). However, in recent years the physiotherapy entry level education requirements have moved from a two year diploma to a four year degree with six month internship (IAP 2013a); but it is acknowledged that significant challenges remain to contextualise it to India's needs and to ensure quality across educational institutions (Ravindra and Debur 2011; Swaminathan and Vincent D'Souza 2011). In addition there are calls for more evidence based practice (Ahuja 2010a; Naik and Pandey 2010), more research (Stepindia 2010) and more engagement with continuing professional education (Ahuja 2011; Sinha 2011c).

1.1.5.2. Indian Association of Physiotherapy (IAP) split

The IAP is the professional body that represents circa 30,000 physiotherapists' interests in India; it maintains a register of members; approves educational institutions for the delivery of physiotherapy courses; sets and ensures ethical professional practice and standards of independent practice by members; advises government and organisations on policy affecting the development and practice of physiotherapy; organises continuing medical education programs and promotes scientific research and technology to enhance the status of the profession. It is governed by an administrative council comprising of ten members, and is led by a president. All members are elected by the membership which occurs every three years. Branches are formed regionally where there are sufficient numbers, to implement the objectives of the IAP (2013a).

During the course of this study there was some significant upset within the IAP, a knowledge of which will inform an understanding of the study findings. In 2011 the election resulted in the long standing President Dr Ali Irani apparently losing

the election to Dr Umasankar Mohanty; however Dr Irani contested the vote and it was the subject of tribunals and High Court judgments none of which appear to be enforceable. The end result is a split within the IAP, with each 'elected' president leading a different version of the IAP. Each IAP has its own website (http://www.physiotherapyindia.org.in/ and http://www.physiotherapyindia.org/) which closely resemble each other; they each appear to claim the full membership complement and to be operating on the same membership list. Each, reportedly, are inspecting and approving education institutions for the provision of physiotherapy courses and are collecting membership and inspection fees. Two annual conferences were run in 2012 (both in Delhi) and two were planned for 2013 in Goa (although the Dr Irani organised conference was stopped by a court order from the Goan physiotherapy branch). Reportedly both IAP 'factions' were represented at ministerial lobbying discussions regarding the formation of the Council. Anecdotally, allegiances are aligned loosely along branch lines according to who the branch convenor sides with; many of the younger members side with Dr Mohanty, and there are others who support neither. What all in Indian physiotherapy appear to agree on, is that the split is harmful to Indian physiotherapy development at a time when they are seeking a regulatory council and professional practice autonomy. Further elections are scheduled for February 2014 which may resolve the dispute.

1.2. Conclusion

The issues associated with the impact of globalisation upon education, health care and health professions are diverse and complex. Migration statistics show that health care professionals have been increasingly mobile in the last decade and that Indian physiotherapists are seeking to work or study in the UK and other English speaking countries. The issues associated with the migration of doctors and nurses from developing countries have been documented but mainly from a workforce planning perspective. One of the articulated benefits of

global mobility relates to the effect upon knowledge transfer back to the home country. The published research has identified that there are differences between the motivations of doctors and nurses and also the country of origin. There is no research that explores the issues associated with the mobility of physiotherapists from developing countries or to suggest how the evidence from the nursing and medical literature should be extrapolated to physiotherapy.

1.3. Research Question

Why are Indian physiotherapists choosing to be globally mobile?

This research provides an understanding of the migration of Indian physiotherapists. Knowledge and understanding of the discourse is of value to inform our thinking and practice in relation to the phenomenon of global mobility of healthcare professionals. Those interacting with Indian physiotherapists in the host countries may use the understanding to support access to higher education, and to inform the content of masters and professional development programmes. In multicultural workplaces an understanding of colleagues backgrounds and perspectives should support workplace integration and enhance collaborative working and therefore may lead to better health care provision. Indian physiotherapy, healthcare providers and the government could utilise the knowledge and understanding to ensure that the professional practice, knowledge and skills acquired by the migrant Indian physiotherapists are capitalised upon when they return to India.

2. Chapter Two: Methodology

A qualitative methodology is required to gather an in-depth understanding of the reasons that govern the decisions behind Indian physiotherapists' global mobility. This chapter explores the grounded theory methodology, its philosophical evolution and its pertinence to this research. The conceptual and methodological underpinnings to be used in this research are considered and the resultant method described.

2.1. Competing Species and the Evolution of Grounded Theory Methodology

Grounded theory is a systematic approach that is utilised to generate ideas and theories that are embedded within the data collected. It is a flexible yet rigorous approach to data collection and analysis (Bryant and Charmaz 2007). Grounded theory methodology was articulated in the mid 1960s by Glaser, who came from a Columbia University positivist background, and Strauss from a pragmatic symbolic interactionist Chicago school background. They aimed to move qualitative enquiry beyond descriptive analysis into explanatory theoretical frameworks to provide abstract, conceptual understandings of studied phenomena (Charmaz 2006). Over the years grounded theory has evolved, there has been remodeling that has resulted in the creation of competing genre underpinned by different philosophical perspectives. The resultant competing grounded theory species have engaged in significant debate, particularly regarding emergence versus forcing of data (Boychuck-Duchscher and Morgan 2004; Heath and Cowley 2004; Kelle 2005; Walker and Myrick 2006), with each of the originators often vehemently defending their genus. This methodological evolution does not detract from grounded theory as a valid methodology; it has resulted in a flexible framework within which research may be sited.

Each grounded theory variant reflects a multiplicity of ontological and epistemological underpinnings. Glaser and Strauss's 'traditional' or 'classic' version of grounded theory married objectivist positivism and pragmatism informed symbolic interactionism (Charmaz 2006). Different authors have attributed different philosophical and ontological labels to the evolving editions and divergent proponents, many are overlapping and some contradictory. The Glaserian approach has been variably described as positivist, post-positivist, critical realist and modified objectivist, and Glaser remains resolutely true in his adherence to the traditional grounded theory approach and the positivist paradigm in which it was developed (Glaser and Strauss 1967; Glaser 2007). Glaser permeated his grounded theory genus with detached empiricism, rigorous codified methods and emphasis on emergent discoveries (Noerager Stern 2009). The Straussarian version has been more fluid and evolved to emphasise the interactionist hereditary elements, the importance of the respondent's voice, discovering the respondent's views on reality and of verification. It has been variously described by others as social constructivist, relativist, subjectivist, pragmatist, poststructuralist, postmodernist and post-positivist (Lomborg and Kirkevold 2003; McCann and Clark 2003a; Dick 2007).

Charmaz (2006) who studied with both Glaser and Strauss describes both of their positions as endorsing a realist ontology and post-positivist epistemology and contends that the basic grounded theory guidelines can be used with modern methodological assumptions and approaches. Mills et al (2007) consider that the Straussarian version vacillates between postpositivism and constructivism as, although Strauss and Corbin recognise bias and wish to maintain objectivity, they acknowledge that it is not possible to be free from bias, acknowledge the importance of multiple perspectives and truths and contend that interpretations must include the perspectives of the participants studied. This range of descriptions and interpretations perhaps reflects the evolutionary journey that Strauss and Corbins' work has taken, with Corbin

more recently classifying it as pragmatist and interactionist (Corbin and Strauss 2008).

The constructivist mutation of grounded theory has perhaps evolved the furthest from the original objectivist epistemological species in that it is clearly cited as ontologically relativist, transactional, and epistemologically subjectivist (Mills et al 2006a). This genus of grounded theory and its interpretive understanding and co-construction of data is valued by many contemporary social scientists, as rather than data providing a window upon reality, the discovered reality arises from the interactive process and its temporal, cultural and structural contexts (Charmaz 2003).

This research utilises a constructivist approach to grounded theory methodology and methods, the underpinning philosophical constructions of which will now be explored.

2.2. Philosophical Framework

Crotty's (1998) knowledge framework identifies that there are distinct hierarchical levels of decision making within the research design process. The epistemological perspective of how knowledge is developed underpins the entire research process; the theoretical perspective will be implicit in the research question and will in turn inform the choice of methodological approach which in turn will inform the choice of research methods. The framework omits ontology but Crotty argues that ontology and epistemology are mutually dependent and difficult to distinguish conceptually. This research takes a constructivist approach and is embedded within subjectivist epistemology and utilises an interpretive theoretical perspective to inform a grounded theory methodology.

2.2.1. Epistemology - Subjectivism

Epistemology provides a philosophical underpinning regarding what kind of knowledge is possible and how to ensure that it is adequate and legitimate, and ontology is 'the study of being' (Crotty 1998). An ontological position implies a particular epistemological position and vice versa.

Constructivism denies the existence of an objective reality in the social world, it asserts that realities are social constructions of the mind and that there are as many constructions as there are individuals (Guba and Lincoln 1994). An ontologically relativist position is taken, which reflects the perspective that the multiple individual realities are influenced by context - life, society, culture etc and that there is no objective truth to be known (Guba and Lincoln 1994). Epistemologically it is subjectivist, the world is unknowable and the researcher's role is to construct an impression of the world as he or she sees it; constructivist research emphasises the subjective inter-relationship between the participant and the researcher and the co-construction of meaning. Constructivist research is transactional, as knowledge arises from the interactions occurring in a rhetorical situation (Lincoln and Guba 2003). The researcher is a part of the research rather than an objective observer, their values should be self acknowledged and form a part of the outcome (Mills et al 2006a). Corbin and Strauss (2008 p10) describe the constructivist grounded theory process as "*theories are constructed by the researcher out of stories that are constructed by participants who are trying to explain and make sense out of their experiences and lives, both to the researcher and themselves*".

2.2.2. Theoretical Perspective - Interpretivism

In Crotty's (1998) knowledge framework the theoretical perspective is defined as the philosophical stance informing the methodology and identifies that there

may be many theoretical perspectives that result from particular epistemological and ontological stances. Charmaz (2008a) considers that constructivist grounded theory is interpretive in that if offers a portrayal and not an exact picture of the studied world. Participants' implicit meanings, experiential views and researchers' finished grounded theories are constructions of reality (Charmaz 2006).

The interpretative approach is often linked with the concept of 'verstehen' meaning 'understanding something in its context' and that knowledge of social life must be based upon the meanings and knowledge of the studied participants (Weber 1978). The natural world of science is meaningless until a scientist imposes meaning or constructs upon it; the social world of people is full of meaning that is built upon subjective and shared meaning (Silverman 1970). Interpretivism utilises these subjective meanings to reconstruct them, understand them, to avoid distorting them, to use them as building blocks in theorising. Contextualisation, the position of believing all knowledge is local, provisional and situation dependent, and the understanding of knowledge through interpretation are both key to interpretivisim (Goldkuhl 2012).

The aim of interpretive research is to understand how members of a social group, through their participation in social processes, enact their particular realities and endow them with meaning, and also to show how these meanings, beliefs and intentions of the members help to constitute their actions (Orlikowski and Baroudi 1991). The interaction between the researcher and the participant during data generation is key to ensure that the participants are interpreters and co-producers of meaningful data (Goldkuhl 2012). The data generation is a process of socially constructed meanings by the researcher and participants; the resultant theory is a 'sensitizing device' to view the world in a certain way (Klein and Myers 1999). Due to the researcher's centrality in the data gathering

and analysis, it is essential that the researcher is reflexive and understands how their views have impacted on the research process. This consciousness serves as a basis for developing new understandings (Charmaz 2009).

For this study exploring the global mobility of Indian physiotherapists from the perspective of Indian participants, the constructivist approach is considered apposite. It is suggested that for research of this nature that there is not one truth; there will be multiple realities and perspectives underpinning the social construct of migration. The context in which that global movement of Indian physiotherapists is occurring will be key to portraying and understanding the impression of the phenomenon. It is acknowledged that the researcher will bring western values and conceptions to research that is exploring an occurrence embedded in Indian society and culture. It is proposed that by working together and dialectic relations that the researcher and participants can construct meaning out of the participants' experiences.

Grounded theory is an appropriate methodology for this research as its openness to empirical leads facilitates the researcher to pursue emergent questions and thus shifts the direction of enquiry (Charmaz 2008a). Such a progressive framework is invaluable in undertaking research exploring global mobility of physiotherapists as the dearth of literature means that there is little established direction to guide the research. The emergent and co-construction characteristics of grounded theory allow the research to respond to the evolving discourse and hence progress much further than a more structured initial exploration might allow.

In addition, the population will be empowered within their context and will have the ability to reflect upon the social, political and contextual underpinnings of the construct being discussed; a grounded theory methodology would utilise their

ability to articulate links between issues. Such a collaborative approach where the views and knowledge of the researched are valued, is important, especially when Britain's colonial past is considered. It is also vital that the research is not perceived as being exploitative. A collaborative approach to theory generation is needed, where generalisation and utility of the resultant theory are important and of value to both the researched and the researcher.

2.2.3. Methodology - Constructivist Grounded Theory

The methodology is the strategy, plan of action, and design underpinning the selected research methods. Different methodologies will have the same underlying theoretical perspective, similarly each methodology may be implemented utilising different combinations or research methods (Crotty 1998). Constructivist grounded theory methodology is the selected methodology for this research and strategies underpinning the constructivist approach will be considered here. Strategies underpinning the alternative forms of grounded theory will not be discussed.

Constructivist grounded theory facilitates the development of theories that describe or explain particular situations and accurately perceive and present another's world; they will address the "why" questions from an interpretive stance (Charmaz 2012). The methodology has an emergent structure with an open and flexible approach. The principle and distinctive strategies are a) synchronous collection and analysis of data, b) two-step data coding process c) constant comparative methods d) memo writing to aid the construction of conceptual analyses e) sampling to refine the researchers emerging theoretical ideas and f) integration of the theoretical framework (Charmaz 2003).

Iterative data collection and analysis cycles, resulting in simultaneous data collection and analysis are a key feature of grounded theory (McCann and Clark 2003b). Data is generated (in this case by interviews) and may initially focus on sensitising concepts that have been directed by prior research in the area or specific areas of interest; these are a point of departure for open-ended ideas and questions (Charmaz 2012). Analysis of the data occurs early in the data collection cycle, such synchronous activity allows the researcher to respond to the empirical evidence and evolving discourse and hence progress understanding much further than a more prearranged initial exploration might allow (Charmaz 2008b). Therefore sampling, data collection and data analysis are not separate procedural steps, they must be considered as a continuous cycle (Elliott and Lazenbatt 2005).

Constructivist grounded theory coding is inductive, comparative, interactive and iterative, and during the later stages it is deductive (Charmaz 2012). Coding consists of two phases initial and focused coding. Initial coding involves the close coding of fragments of data (lines, segments or incidents) to break the data into their component parts and to define actions and processes that shape or support the data. Focused coding selects the most useful initial codes and tests them against extensive data, they require decisions about which will make the most analytic sense to categorise data (Charmaz 2006). Charmaz (2012) contends that coding requires the researcher to interact with the data and supports coding in gerunds to build action into the codes. Coding is the pivotal link between collecting data and developing an emergent theory to explain the data and it may take the researcher into unforeseen areas and research questions. Focused codes are then raised into conceptual categories according to the emerging themes and analysis, thus the codes go beyond being a descriptive tool to one that can be used to view and synthesise data (Charmaz 2008a).

The constant comparative method facilitates analysis that generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with category, category with category and category with concept. The comparisons constitute each stage of analytical development and explore similarities and differences (Kelle 2007).

Memos are informed analytic notes that chart and record major analytic phases of the research journey. Memo writing starts early in the research and is considered to aid the construction of conceptual analyses. They are a key feature of grounded theory and provide a medium to consider, question and clarify observations from the data, and to interact with the data and embryonic analysis. Asking analytic questions in memos support the move from description to conceptualising data and allows data to be bought into the narrative (Charmaz 2006).

Theoretical sampling results directly from memo making; it is emergent and enables the researcher to gather pertinent data to develop and refine tentative theoretical categories. It facilitates the posing of increasingly focused questions and the seeking of answers as the enquiry progresses and it allows the elaboration and refinement of categories that will constitute the theory. The researcher continues to gather data until no new properties of the categories emerge and the properties of the categories are saturated. This is theoretical saturation (Corbin and Strauss 2008).

Grounded theory's analytical and conceptual focus makes relationships explicit, with verbatim material supporting the theoretical construction on which it is grounded. Charmaz (2008b) advocates the use of writing as a strategy for honing and clarifying the analysis to define essential properties, assumptions

and relationships. The final stage is to compare how and where the generated theory compares with the published literature in the area.

Constructivist grounded theory results in the generation of a theory that is of value, is meaningful and relevant to those from whom the data was derived and to those, whose actions and behaviour are involved (Charmaz 2006). The pragmatic underpinnings of the grounded theory approach places an emphasis on the practical and therefore any theory generated will be gauged by how well it addresses real practical issues and works in practice. It should clarify and articulate links between complex issues (Charmaz 2008c). The data is a product of the research process, co-constructed by the researcher and the participants (Charmaz 2008c). The resulting theory will be a construction of reality, embedded within the realities of the participants (Charmaz 2006).

2.3. Methods

Methods are defined by Crotty (1998) as the techniques or procedures used to gather and analyse data related to the research question. The following section describes the methods that were adopted for this research.

2.3.1. Sampling and the Participants

Participants were selected using purposive sampling which enabled identification of individuals who were most likely to contribute detailed and relevant data (Jupp 2006). Data generation was by focus group and individual interviews. The aim of the first focus group (FG1) interviews was to discover the key motivational factors and aspirations for overseas travel. This enabled the identification of factors that offered theoretical promise to be explored further in later interviews. The characteristics of interest in this group were that the Indian physiotherapists had just arrived in the UK to study for a masters degree and so

they had not been in the UK long enough to have modified their expectations to meet the reality of the move. The second focus group (FG2) consisted of Indian physiotherapists who had chosen to study for a masters degree in India. This group could have come to the UK but had elected not to. The emphasis was on identifying and understanding differences and similarities between the two groups. The first of the individual interviews was also conducted in this first phase of open and exploratory interviews.

Pseudonyms were assigned to ensure anonymity. The transcribed interviews were coded and from these codes, category groupings started to form. Based upon this initial data analysis, theoretical sampling determined the future interview participants selection and the interview focus. In this way further collected data would enhance understanding and development of the tentative theoretical categories.

Tables four and five summarise the participants' characteristics and highlights the expertise that was sought to contribute to the emerging analytic interests, developing categories and theory and the changing interview emphasis (Dey 2007). The theoretical sampling was cumulative and depended upon the data derived from the previous participant (Morse 2007). For practical reasons the Minda, Lalit and Rani interviews all occurred during a week timeframe in India but in between each interview top level data analysis occurred that informed the next interview focus. The sampling was flexible according to opportunities that arose. This allowed the interview of Manish at an overseas conference (Denscombe 2007).

Table 4: Participants characteristics and emphasis of focus group interviews

Date and Location	Participant	Gender	Age	UG Education	Work Experience	Sampling Characteristics	Interview Focus
Focus Group 1 February 2010 UK University	Dinesh	Male	24	Karnataka	2 years Mumbai	New to UK to study an MSc. All arrived in UK less than 1 month before the interview.	Question aligned with the literature review. Motivations: push / pull, repel / retain. Aspirations: short and long term. Brain circulation. Country choice. Challenges
	Suhani	Female	23	Karnataka	1 year Ahmadabad		
	Joseph	Male	23	Tamil Nadu	6 months Kerala		
	George	Male	26	Tamil Nadu	6 months Kerala		
	JK	Male	28	Gujarat	4 years Gujarat		
Focus Group 2 February 2010 at home institution Delhi	Madhuri	Female	26	Uttarakhand	2 years Delhi	Studying for a Physiotherapy Masters degree in India. All at same institution, some year 1 and some year 2.	Reason for studying masters. Why in India and not O/S? Feelings to those who are O/S. What motivates peers to go O/S? Value of O/S masters Affect of O/S physiotherapy on the profession
	Anuja	Female	24	Haryana	none		
	Shrishri	Female	25	Delhi	none		
	Daisy	Female	23	Karnataka	6 months Delhi		
	Monica	Female	23	Karnataka	none		
Focus Group 3 December 2010 UK University	Sushmita	Female	26	Karnataka	1 year Maharashtra	Completed MSc in UK Looking for physiotherapy work in UK.	Motivations to study O/S and to leave India. Aspirations. Differences in physiotherapy and education UK v India, Gender and north / south geographical differences. Perspectives on returning to India.
	Bipasha	Female	26	Karnataka	1 year Delhi		
	Lara	Female	26	Karnataka	1 year Delhi		

O/S - overseas

Table 5: Participants Characteristics and Emphasis of the Individual Interviews - continued on next page

Date and Location	Participant	Gender	Age	Education History	Career Profile and Sampling Characteristics	Interview Aims
March 2010 in Indian PT Clinic	Ashna	Female	40+	- Diploma PT '92 - BA Open University '95 India - MSc Clinical Research '98 UK - P/T PhD '10 Australia	Head of a clinical department and principal of a small physiotherapy college. 15 years plus in clinical work in India and five plus year in education. Has studied overseas and returned to India and then studied for a PhD overseas part-time.	Establish motivations and aspirations for studying overseas and for return to India. Opinions on physiotherapy global mobility Physiotherapy in India - changes over years.
October 2010 at an overseas conference	Manish*	Male	40+	- Diploma PT '90 - BPT '97 - PhD '04 India	Professor and head of a high profile physiotherapy institution. Career academic, strong clinical research interest Connections with IAP. Has not studied or worked overseas.	An educators and IAP connected figure's perspective on Indian physiotherapists global mobility. To have a better understanding of educational and organisational aspects of Indian physiotherapy. Returning issues, value, perceptions.
February 2011 in Indian Hotel	Minda*	Female	29	- BPT '06 - MSc UK	Worked clinically in India prior to recent MSc study in UK. Successfully returned to Indian clinical practice with previous employer.	Ascertain motivations / aspirations for UK study. Drivers and challenges behind return to India. Perceptions of value of overseas experience. Respect and Indian physiotherapy and issues

Table 5 continued: Participants Characteristics and Emphasis of the Individual Interviews - continued from previous page

Date and Location	Participant	Gender	Age	Education History	Career Profile and Sampling Characteristics	Interview Aims
February 2011 in Indian Hotel	Lalit	Male	29	- BPT '06 - MSc UK	Worked clinically in India prior to recent MSc study in UK. Successfully returned to India in a non-traditional physiotherapy clinical role. Now a clinical director working in sport.	Ascertain motivations / aspirations for study in the UK. Drivers and challenges behind return to India. Integrating practice and value of overseas experience.
February 2011 in Indian Hotel	Rani*	Female	40+	- BPT '78 - MPT '80 India - P/T PhD ongoing India	Professor and head of a reputable physiotherapy college. High personal profile in Indian physiotherapy education. Influential in physiotherapy political circles, previous IAP role. An educationalist - PhD study has an educational not clinical emphasis. Has worked in education in the Gulf.	Ascertain a senior educators perspective on Indian physiotherapists global mobility. To better understand the governance aspects of Indian physiotherapy and its implications on Indian Physiotherapy practice and its development. Understand perceived value of an overseas masters and experience in India.
January 2013 in UK University	Adeeb*	Male	30+	- BPT '05 - MSc '09 UK - PhD ongoing UK	Clinical work India and UK. MSc. and PhD study in the UK. Good Indian physiotherapy networks. A writer and activist in the profession in India - not IAP.	Verification interview, checking the categories and core category and theoretical model for resonance. Occurred after IAP split, all other interviews occurred before IAP split.

*Participants known to researcher prior to interview. PT- Physiotherapy P/T - part-time IAP - Indian Association of Physiotherapy
Participants were based in Karnataka x2, West Bengal, Maharashtra x2 and Punjab

Each participant was interviewed only once. When queries that required further explanations arose from the data analysis, instead of returning to the previous participant for further clarification, a different participant was sought with similar expertise. This allowed a broader range of perspectives, and expertise with different experience, to be included in the construction of the theory. For example focus group 3 (FG3) was able to develop on FG1's perspectives, as members of both groups had come to study for a masters degree in the UK. Manish and Rani were both experienced educators with experience of engaging with the IAP and the political infrastructure. These sequential processes of theoretical sampling, data analysis and constant comparison of data and perspectives are essential characteristics of grounded theory studies (Glaser and Strauss 2004; Morse 2007).

Gender, age and geographical location were not utilised in the sampling strategy but it can be seen (figure one) that participants were drawn from across north and south India and both males and females were interviewed. The focus group participants were younger, ages ranged from 23 to 28, with a mean age of 24.8 and 24.2 years respectively for FG1 and FG2; FG3's mean age was 26. Those interviewed individually were older, the participants aged 40 plus were all selected for their knowledge and experience of physiotherapy in India; in addition Ashna had studied overseas and Rani had worked overseas when low numbers of Indian physiotherapists left India to work and study. In FG2, none had travelled overseas, except for Shrishri who had holidayed in Indonesia and also the UK with her family. Manish's overseas experience was at conferences and visiting universities in the UK and USA.

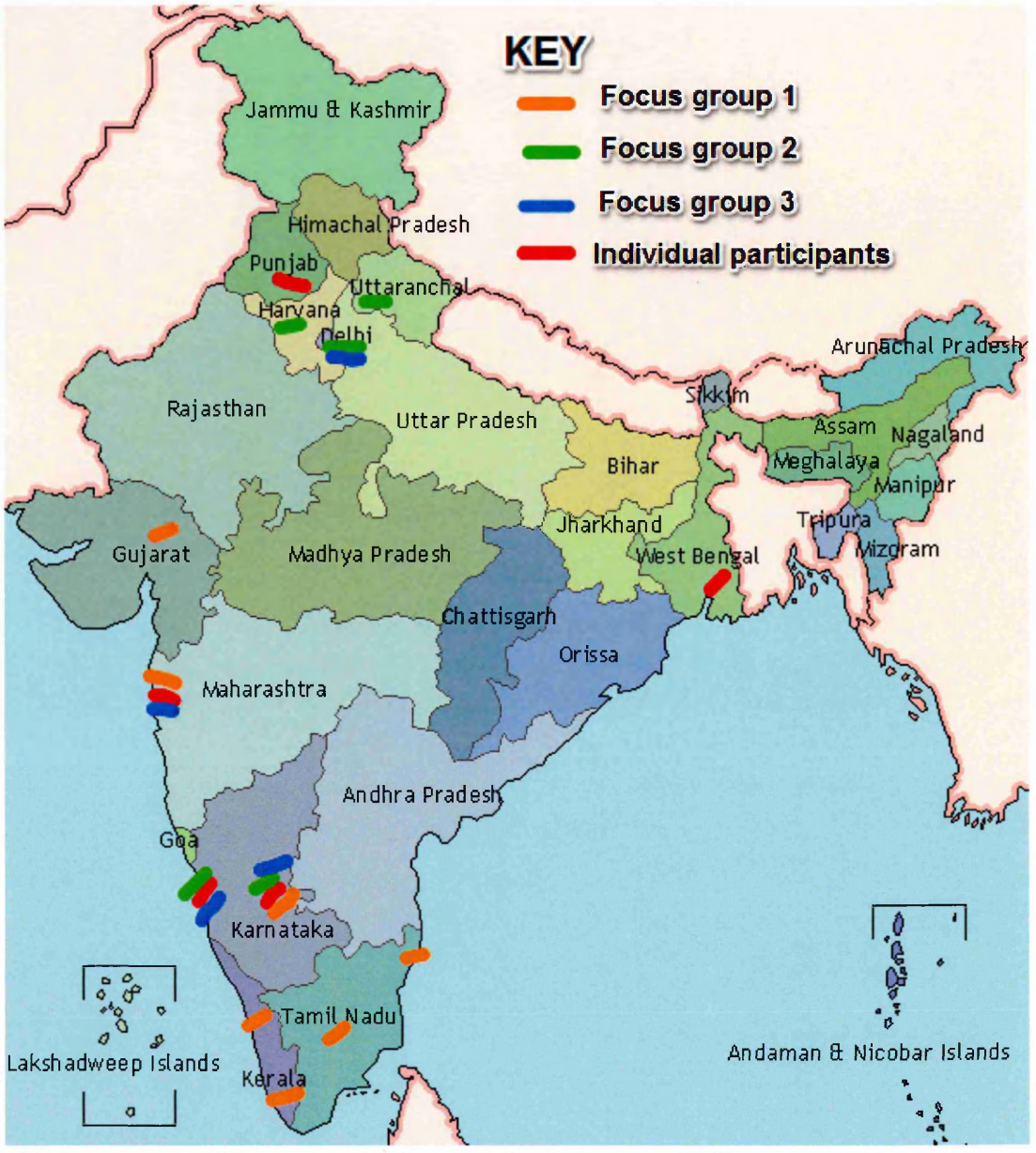


Figure 1: Geographic Distribution of Participants Education and Work Experience that Informed their Narrative

(adapted from Embassy of India map 2013)

N.B. Each colour mark may represent multiple inputs from the colour category

Informal Indian physiotherapy professional networks were used to identify appropriate participants. These were drawn from university alumni networks and Indian physiotherapy. FG1 participants volunteered for the study as the

result of an email, containing an information sheet outlining the study and consent form, which was sent to all physiotherapists that enrolled on the physiotherapy MSc in January 2010 (see appendix 2 for a sample participant information sheet). FG2 were recruited via the head of physiotherapy at a private university in Delhi. The interview took place at the university in a teaching room that was arranged by the university contact. He had also provided the participants with the information sheet and consent in advance of the interview. FG3 participants had graduated from a UK MSc the year previously and were identified by a colleague as being appropriately positioned to contribute to the areas of developing theoretical interest. Ashna and Lalit were introduced to the researcher by alumni physiotherapy contacts in India. FG3 and the individually interviewed participants were each contacted by email with a tailored information sheet based upon the sample in appendix two. The consent form (see appendix three) was signed at the start of the interview for all participants after the study aims had been discussed.

2.3.2. Data Generation

Interviews were selected as the most pertinent means of gathering data from the participants, as insights, opinions and feelings were sought, and these could not effectively be captured by questionnaires (Denscombe 2007). Constructivist grounded theory's epistemological underpinnings emphasised the interactive relationship between myself, as researcher, and the participants in the research process, and bring the centrality of the researcher to the methodological forefront (Mills et al 2006b). Therefore the establishment of relationships with participants that explicate power imbalances must be considered (Kvale and Brinkmann 2009), and strategies utilised to modify these imbalances (Mills et al 2006b). Where possible the interviews took place in a location that was convenient and comfortable to the participant and where they would feel safe. Some interviews occurred in India, some in the UK and one at an overseas

conference, according to where the participant was based at the time of the interview and where was mutually convenient. Pragmatically, the locations ranged from university teaching rooms, to rooms located in a convenient hotel where the researcher or the participant was staying, and one interview occurred in a clinical physiotherapy setting in India. In all cases the location was relatively quiet and free from significant interruptions.

Focus group interviews were used for the participants who were younger and more likely to perceive and feel constrained by a hierarchical imbalance, and also be less confident with the notion of an individual interview with a British academic. The social dynamics of the peer group were used to afford an atmosphere of support (Denscombe 2007) and to create a permissive environment where participants would feel comfortable discussing and reflecting upon their true opinions, rather than saying what they think the interviewer would want to hear or what those in authority would want them to say (Kvale and Brinkmann 2009). The focus group participants were not previously known to the researcher and each selected a Bollywood actor or actress's name to be identified by; this assured anonymity and also served to create an informal group cohesion to make the group feel at ease. There was no attempt to try and reach a consensus regarding the issues discussed. The emphasis was on hearing all the participants' perspectives and feelings around their and other Indian physiotherapists' global mobility. The group discussions became more lively and interactive as the sessions progressed, moving from an interview to group conversation as the participants became more relaxed. At all times the participants were sensitive and responsive to others viewpoints.

Individual interviews were used for the other participants who were more experienced and it was perceived would be more confident and less likely to be constrained by the inevitable power dynamics. It was considered that these

participants would feel more comfortable with the assured confidentiality that an individual interview would convey.

The format of the initial interviews was loosely structured to allow the participants to develop their ideas and thoughts and to draw out their experiences. Subsequent interviews gradually became more structured, seeking data to develop the theoretical conceptions and saturate the emerging categories (Wimpenny and Gass 2000). The first two interviews conducted were focus group interviews, which were used to capture the breadth of ideas and issues that were important to the group participants. These focus group interviews were then followed by individual interviews to gather further data with which to explore the emerging categories and further direct the analysis. The interview format gradually evolved utilising prompts, probes and checks to facilitate and subsequently direct the data collection process exploring and refining the theories being constructed (Charmaz 2006). The focus of the questions also changed between interviews as specific issues were probed and lines of investigation pursued, directed by the concurrent analysis and the construction of the theory (Kvale and Brinkmann 2009). The fluid interview structure and careful selection of participants helped to facilitate the required theoretical sampling (the gathering of specific data required to explore the developing categories and theory) identified in the preceding data analysis.

As this study was constructivist, it was essential to create a sense of reciprocity between the researcher and the participants in the creation of meaning, and ultimately the theory, that is grounded in the participants' and the researcher's experiences (Mills et al 2006b). The emphasis during the interviews was on informality and listening to the participants' stories, their perspectives and opinions. Where relevant, gently probing questions were used to clarify meaning or context. On some occasions a sharing of experience and empathy

was used to gain confidence and trust. In all the interviews, the participants were given the opportunity to ask questions and to identify issues they felt to be important to the conversation.

All the interviews were conducted in English. Although this was not always the participant's first language, all were able to communicate effectively as all physiotherapy education in India occurs in English. Each participant understood the written information sheet and was able to provide informed consent.

The interviews were digitally recorded and memos written immediately post-interview. These memos captured the interview context, perceptions and reflections upon the interview. They also contained immediate thoughts relating to the theory generation and further requirements for theoretical sampling. A mind-map of the key points articulated by each of the participants was drawn to provide a quick summary of the interview content and areas covered (see appendix four). The interviews were transcribed in India; whilst the transcribers clearly struggled with the interviewer's English accent, greater accuracy was obtained with the participants' narrative than if a non-Indian had transcribed the interview. Each transcript was subsequently checked for accuracy prior to analysis.

2.3.3. Data Analysis

Whilst adhering to the signature characteristics that underpin grounded theory, each of the different epistemological gurus advocates different approaches to the iterative process of coding, analysis and subsequent theory generation. Glaser (1978) in his classic structured approach refers to substantive coding, theoretical coding supported by coding families and emerging theory development through constant comparison of the codes and categories. The

resultant explanatory theory aims for 'achievement of parsimony and scope in explanatory power' (Kelle 2007). Strauss (Corbin and Strauss 2008) advocates the use of open coding, followed by axial coding to reassemble the fractured data; selective coding is utilised supported by an array of techniques to assist the theory development. The approach is often criticised for over complicating the analysis (Eaves 2001; Charmaz 2006) and Glaser (1992) considers that the approach results in data being forced into theoretical categories. The coding approach used in this study follows that advocated by Charmaz (2006) who views grounded theory methods as a set of principles and practices, and emphasises flexible guidelines resulting in a fluid analytical approach. Figure two summarises the coding and analytical stages for the participant interviews, it shows how some of the lines of thoughts were developed into the theoretical categories and ultimately the core category around identity transformation was developed. Appendix five contains sample diagrams that were drawn at each the analytical stage and capture how the ideas developed. These categories are explored further in the following chapters.

There were three cycles of interviews and a final validation and refining stage. The first cycle consisted of two focus groups and one face to face interview; purposive sampling was used. After each interview the transcripts were coded line by line to identify key ideas, issues, feelings and perceptions expressed by the participants. Some in-vivo code descriptors were used where they effectively captured the sentiment and feeling of the message; for example, the code 'same stories' describes the participants view of Indian masters education as being a repeat of their first degree just in a little more depth, this must be considered in the context of their perception of overseas masters degrees as containing the latest and specialised knowledge, and being delivered in a different style. The references and coverage statistics in figure two demonstrate that each of the participants was able to contribute to the discussion. As each

interview was coded, existing codes were used and new codes were added. Early comparisons identified key motivations, disjuncture's and underpinning issues that formed the emergent foci that required further exploration and informed the theoretical sampling for the second cycle of interviews.

As new interviews were undertaken in the second interview cycle the initial coding resulted in the generation of further new codes and was followed by focused coding that takes the most significant codes to develop into subcategories and ultimately conceptual categories (Charmaz 2006). At this stage the codes were grouped around the emergent foci and tentative categories were constructed. Utilising memos and free drawn diagrams (appendix five) the tentative categories were explored for relationships with other developing categories and ideas. For example the relationship the codes that linked with the motivations to leave India were explored. These consisted of codes around changing one's situation, career development, working, job opportunities, professional growth as a group. Another group of codes were those that related to aspiring to a better life and they included freedom, independence, job security, quality, respect. As a part of this analysis further questions were raised and gaps in the knowledge to support emerging ideas were identified. From these queries the characteristics of the next participants and the focus of the interviews were identified; these are shown in tables four and five. This theoretical sampling enabled identification of where to go with the study, to gather the data, to refine the developing theory, is characteristic of all grounded theory approaches (Charmaz 2003; Corbin and Strauss 2008). This iterative approach of coding, analysis, and theoretical sampling to develop and refine the categories, was continued throughout the three cycles of interviews; the categories were gradually constructed with each embedded in the interview data through the inter-relationship with the subcategories and codes.

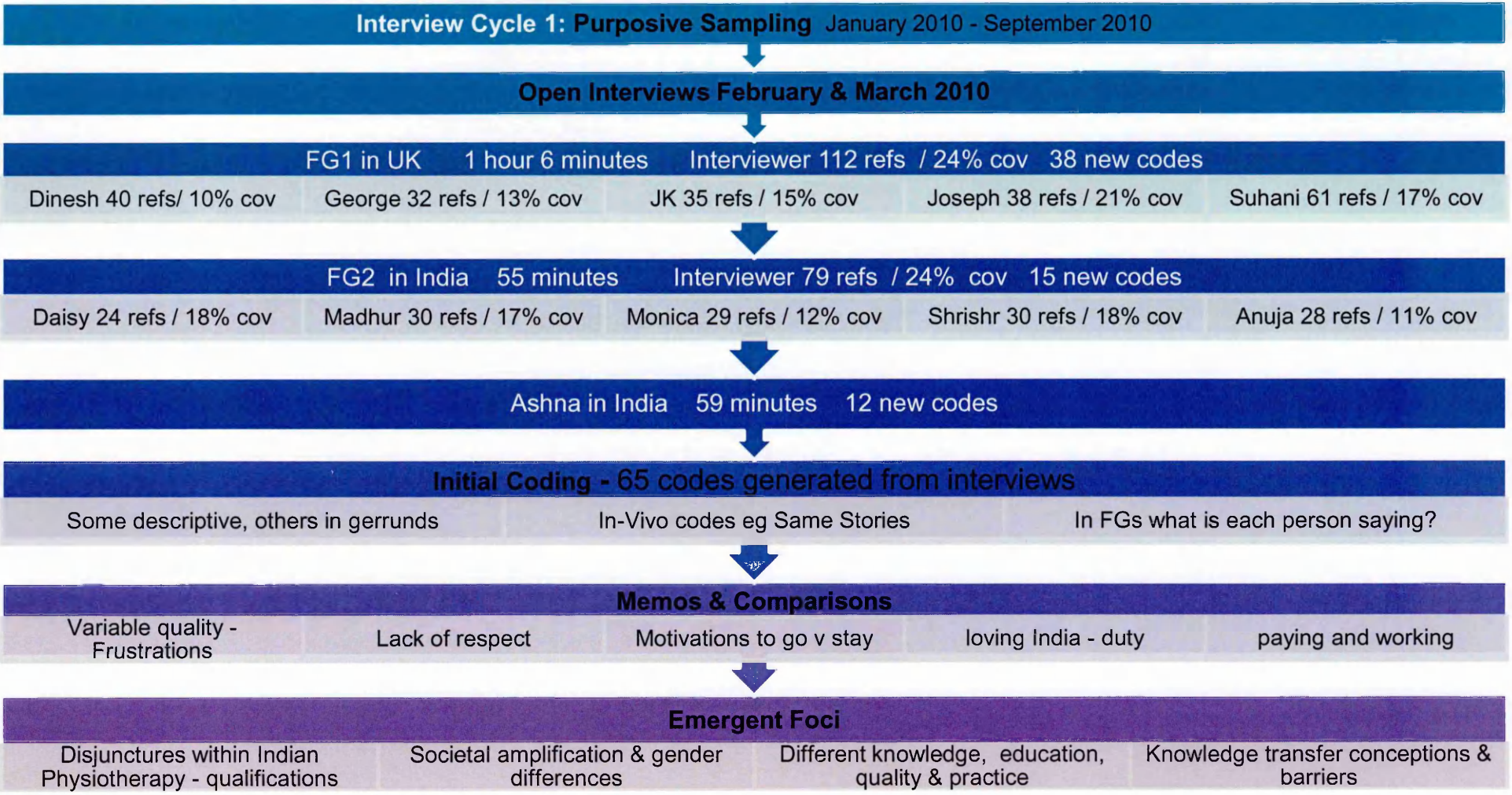
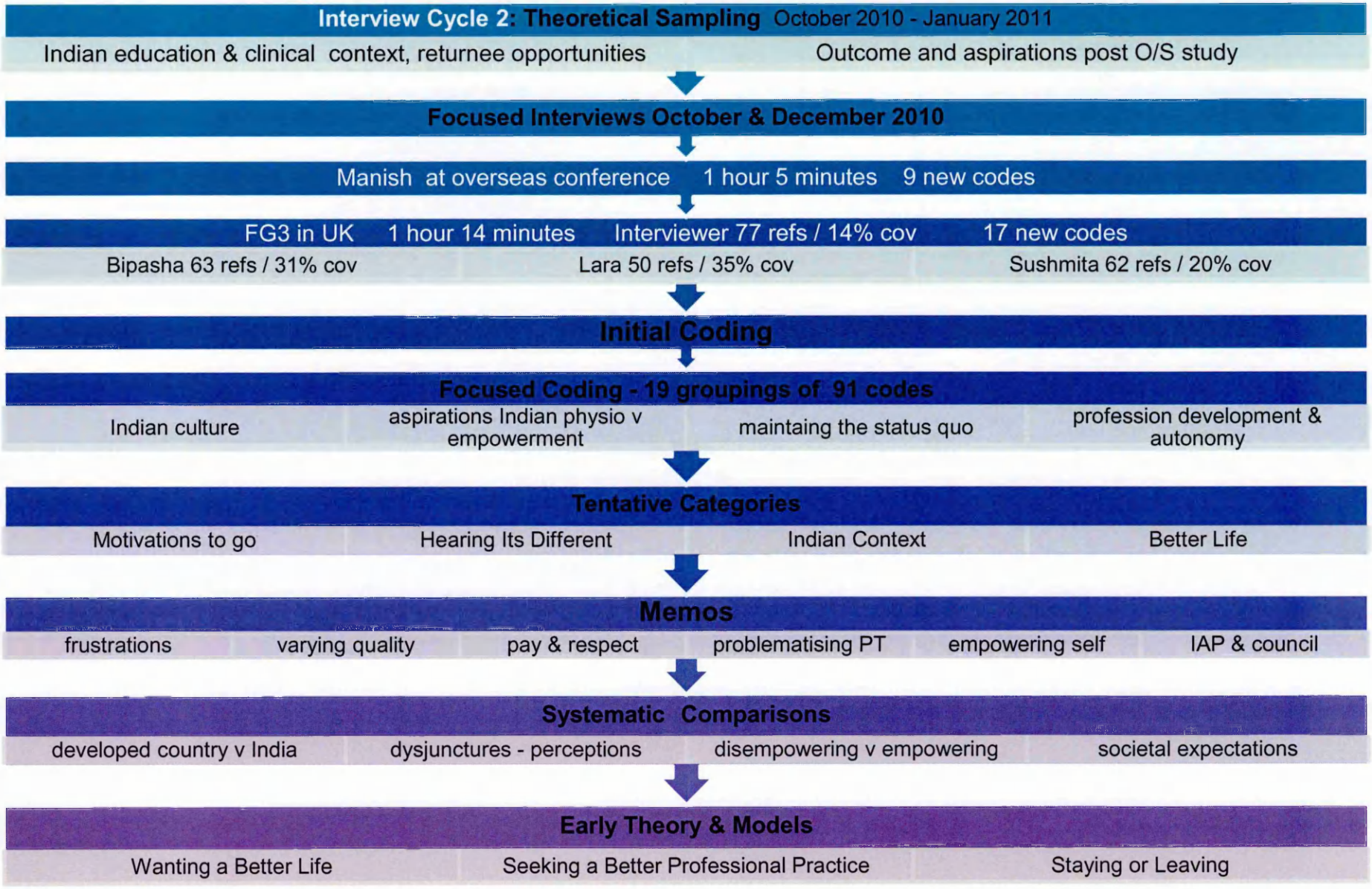
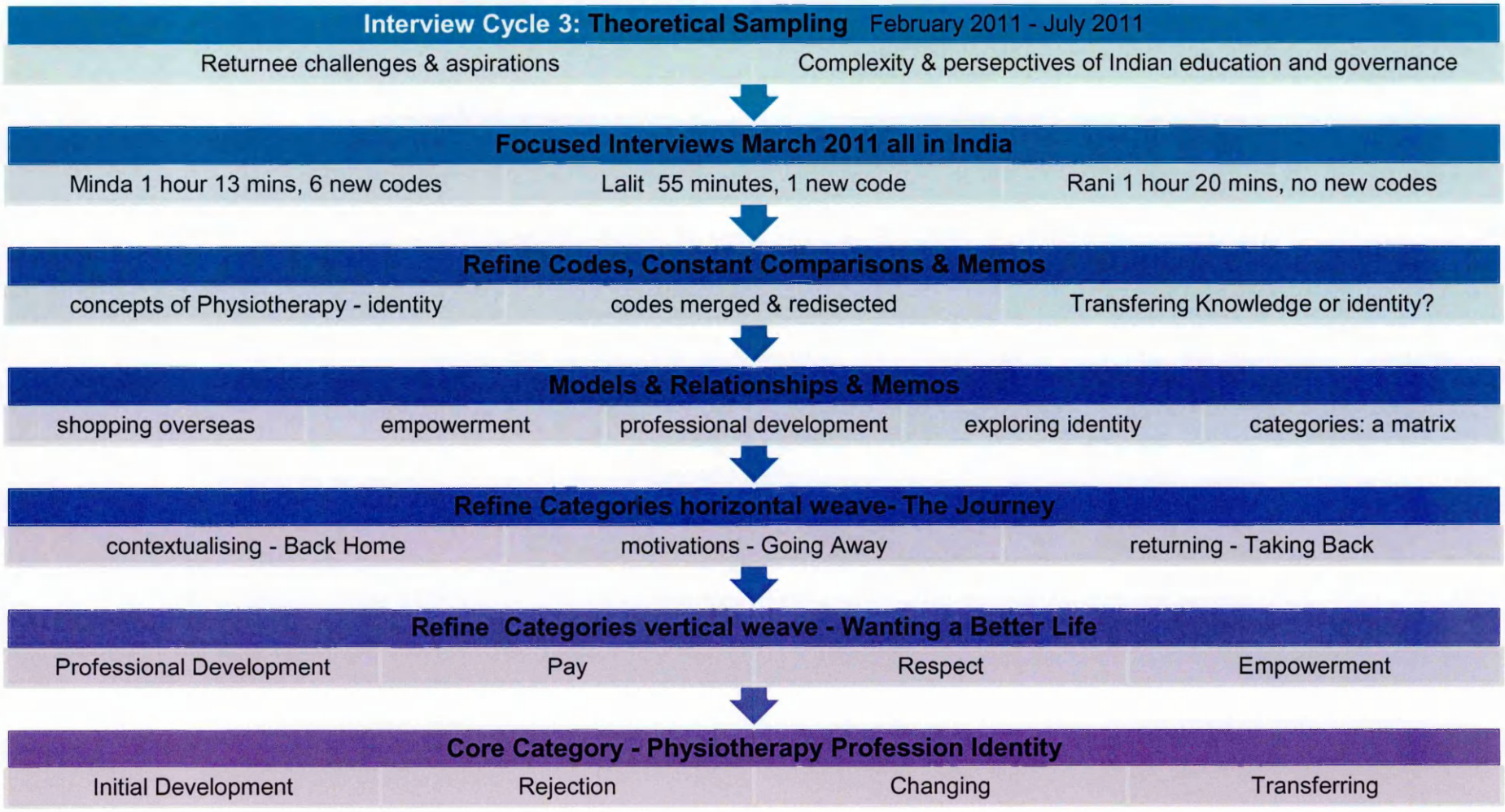
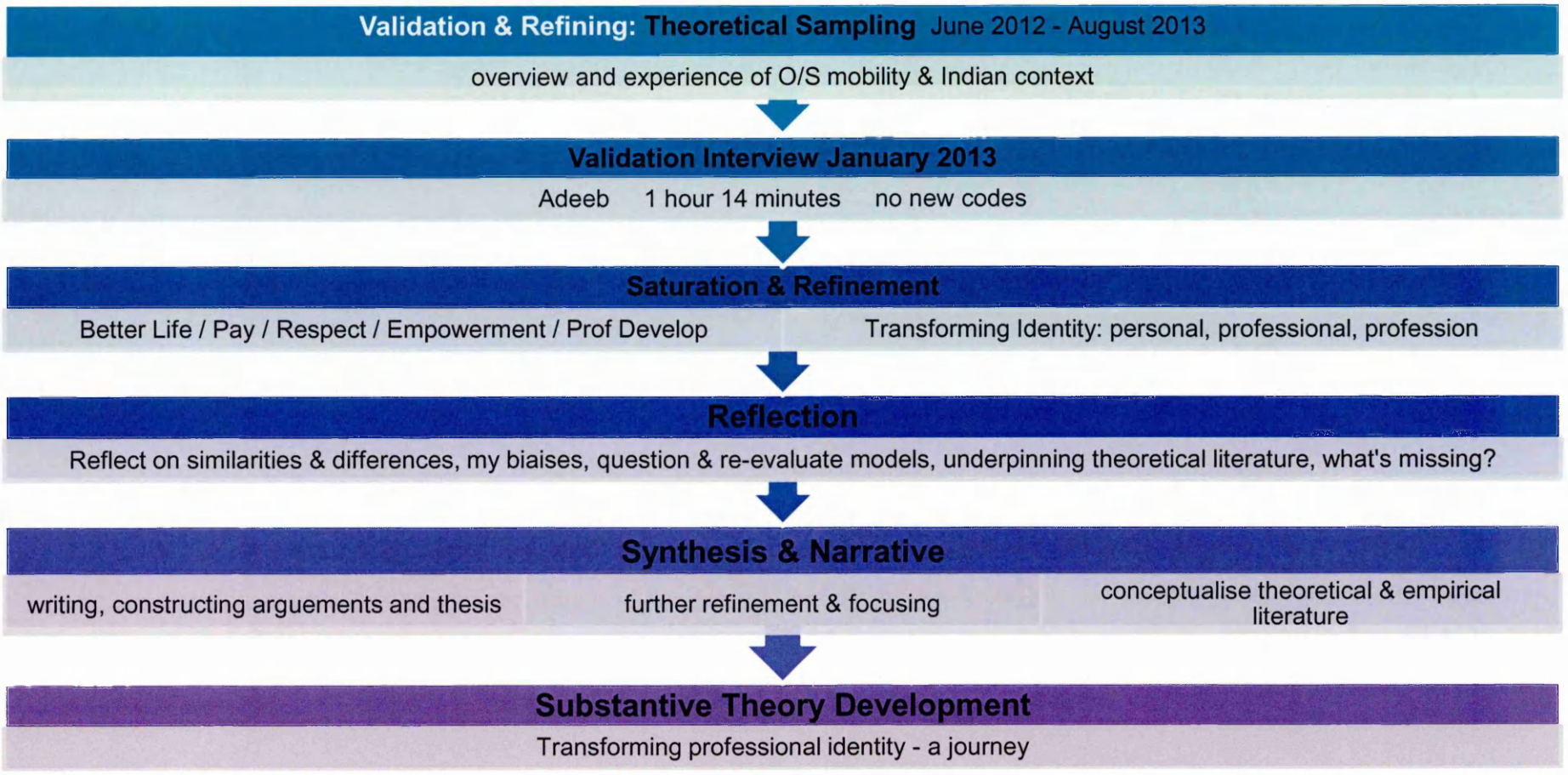


Figure 2: Study Audit Trail

KEY: refs = references, number of occasions individual spoke in interview
cov = percentage of participant interview coverage


Interview Cycle 2: Theoretical Sampling October 2010 - January 2011
Indian education & clinical context, returnee opportunities
Outcome and aspirations post O/S study
Focused Interviews October & December 2010
Manish at overseas conference 1 hour 5 minutes 9 new codes
FG3 in UK 1 hour 14 minutes Interviewer 77 refs / 14% cov 17 new codes
Bipasha 63 refs / 31% cov
Lara 50 refs / 35% cov
Sushmita 62 refs / 20% cov
Initial Coding
Focused Coding - 19 groupings of 91 codes
Indian culture
aspirations Indian physio v empowerment
maintaing the status quo
profession development & autonomy
Tentative Categories
Motivations to go
Hearing Its Different
Indian Context
Better Life
Memos
frustrations
varying quality
pay & respect
problematising PT
empowering self
IAP & council
Systematic Comparisons
developed country v India
dysjunctures - perceptions
disempowering v empowering
societal expectations
Early Theory & Models
Wanting a Better Life
Seeking a Better Professional Practice
Staying or Leaving


Interview Cycle 3: Theoretical Sampling February 2011 - July 2011
Returnee challenges & aspirations
Complexity & persepctives of Indian education and governance
Focused Interviews March 2011 all in India
Minda 1 hour 13 mins, 6 new codes
Lalit 55 minutes, 1 new code
Rani 1 hour 20 mins, no new codes
Refine Codes, Constant Comparisons & Memos
concepts of Physiotherapy - identity
codes merged & redisected
Transfering Knowledge or identity?
Models & Relationships & Memos
shopping overseas
empowerment
professional development
exploring identity
categories: a matrix
Refine Categories horizontal weave- The Journey
contextualising - Back Home
motivations - Going Away
returning - Taking Back
Refine Categories vertical weave - Wanting a Better Life
Professional Development
Pay
Respect
Empowerment
Core Category - Physiotherapy Profession Identity
Initial Development
Rejection
Changing
Transferring


Validation & Refining: Theoretical Sampling June 2012 - August 2013
overview and experience of O/S mobility & Indian context
Validation Interview January 2013
Adeeb 1 hour 14 minutes no new codes
Saturation & Refinement
Better Life / Pay / Respect / Empowerment / Prof Develop
Transforming Identity: personal, professional, profession
Reflection
Reflect on similarities & differences, my biaises, question & re-evaluate models, underpinning theoretical literature, what's missing?
Synthesis & Narrative
writing, constructing arguements and thesis
further refinement & focusing
conceptualise theoretical & empirical literature
Substantive Theory Development
Transforming professional identity - a journey

Interview cycle three explored the challenges and aspirations associated with return and further explored and established a clearer understanding of the complexity of the underpinning governance issues. Interviews with two returnees resulted in narrative around the different conceptions of physiotherapy in India and physiotherapy overseas. This was a trigger for exploration and theorisation around professional identity that subsequently formed the embryo of the core category. The codes, categories and memos were repeatedly revisited and the categories revised and refined as ideas and concepts were explored, as a result of frequently revisiting the interview narrative.

The core category was developed and the interpretive theory outlined prior to the final interview. This led to the validation and refining stage. In Adeeb's interview the categories and the constructed theory were discussed, and relationships explored and clarified. After the interview the final theory was reflected upon, and refined to enhance its clarity and focus. The conversation confirmed that the theory was resonant and the information, experiences and perspectives that Adeeb articulated established that saturation of the theoretical categories had been achieved, as when the data was compared with other data and the categories, no new characteristics were evident. The interview with Adeeb helped to focus and refine the articulation of the core category and the stages within it. Adeeb's interview confirmed that from his perspective the sub-categories of pay, respect, empowerment and wanting a better life were all inter-related and of equal importance. However, the empowerment sub-category was felt to be overlapping, resulting from and secondary to the Wanting a Better Life category, the associated sub-categories, and the core category; the category ideas were amended accordingly.

Saturation is another key tenet of all grounded theory approaches and is considered to be reached when gathering fresh data no longer leads to new theoretical insights or identification of new properties of the core theoretical categories (Charmaz 2008a).

Memos were written throughout the interview cycles, validation and refining stages, they were written for each of the codes, tentative categories and comparisons that were made between interviews and between codes, the similarities and differences were identified and analysed. Memos were also used to record and detail the process and analytic stages of the research, to support the progression from description to theoretical interpretations as advocated by Charmaz (2006) and others (Walker and Myrick 2006; Bex Lemphert 2007). Therefore the content and structure of the memos differed according to purpose. For example a memo reflecting upon each of the interviews captured what went well; what less so; the interview context; how successfully the theoretical sampling had been addressed; general impressions; reflections and feelings and initial thoughts upon how the interview linked with the other interviews and the codes and categories. Whereas a memo written to explore a developing conceptual category or a theoretical idea would include a narrative supporting the thinking behind the ideas; links to any literature that came to mind; they identified similarities and differences in the data and included sections of interview text to support the ideas. Free form diagramming was an important component of the conceptual memos, they were used to develop abstract and abductive thinking (Reichertz 2007), to explore the links between developing categories and ideas and to support the theoretical sorting. The conceptual memos also highlighted disjunctures and the identification of gaps in the analysis and further data requirements and therefore, led to the already discussed theoretical sampling. The memo writing was then taken a

stage further into the final synthesis of the theoretical structure, leading to the start of narrative writing.

The published literature was consulted around the category and core category areas to consider how the findings related to the work of others and to inter-weave the literature into the analysis presentation. The place of the literature review in grounded theory is disputed, with classic grounded theorists advocating that it should be undertaken at the end of the research to encourage the articulation of original ideas based upon the data (Glaser 1978). Contemporary research governance means that researchers should have a comprehensive knowledge of their proposed research area prior to commencing their study. In this study a thorough exploration of the background literature was undertaken prior to the study and informed the development of the research proposal. Several category areas and the core category in this research study, had not been included in the literature review as they had not been predicted at the start of the study. As it became clear that these areas were significant to the research and the theoretical model, the relevant literature was explored to inform thinking and enhance a understanding of the constructs. As advocated by Charmaz (2008b) the writing and rewriting of this thesis, was used to sharpen and clarify ideas and the analysis development, to formulate the theory and underpinning concepts in an abstract style, and also to ensure that the theory's grounding is substantial.

QSR-NVIVO version 9 software was used as a project management tool to store and organise all elements relating to the study, including audio files, transcripts, participant information, memos, coding and diagramming of draft theoretical memos. A research log was used to organise and navigate to all data components held within the software through the use of active links to connect the inter-related components. The log, with linked memos, also formed the basis of a reflective research diary to help track the development of the

analysis, to capture thinking underpinning the coding decisions and the evolving category structure. As advocated by Bringer at al. (2004) the NVIVO research log was used as an extensive audit trail of how the research was undertaken and the theory developed. The memo structure adopted reflected that used by Hutchison et al (2010). The ability to link pieces of related data together was invaluable to help manage ideas, integrate the underpinning data and capture the emergent thinking. In addition to the organisation functions, several researchers advocate the use of such software to assist with advanced analytical and coding procedures (Bringer et al 2006; Johnston 2006; Hutchison et al 2010). In this study a selection of the available NVIVO analytical tools were used, primarily to offer a different visual perspective and representation of the data. The tree maps were helpful in the early stages of category development for a quick analysis of the codes and the frequency in which the code had text assigned. Where the text was allocated to several different codes, coding stripes and coding queries exemplified intersecting codes, this was helpful in the refinement of overlapping codes. 'Sets' were useful to cluster the codes into broader groupings based upon potentially meaningful relationships prior to committing to a category. The models were invaluable in assisting the visualisation of the relationships between the codes and categories. Examples of the output of the analytical tools that were used can be seen in appendix six. The freeform diagramming models were constructed outside of NVIVO using 'Skitch - Evernote' software, which allow much more creative and fluid expression and manipulation of forming ideas, but the resultant diagrams were imported into NVIVO and linked or embedded in the relevant memo.

The theory presented as a result of this study is grounded within the data from which it was derived and is considered to be a substantive theory, as it is closely linked with the empirical situation and will link to practise and interaction (Charmaz 2006). The theory is not a formal theory as proposed by Glaser (2007) as application and generalisation beyond Indian physiotherapy is not

proposed. The constructed theory may however be able to explain similar situations.

2.4. Rigour, Trustworthiness and Credibility

Grounded theory methodology is considered to be embedded with its own rigor resultant from its positivist and pragmatist heritage, achieved through the constant comparative analytical approach, where the developing theory is constantly checked against the data as it is constructed, thereby refining or verifying it at the stage of production (Kelle 2007; Corbin and Strauss 2008). This study has followed a clear theoretical and epistemological approach to grounded theory, and the methods and approaches utilised align consistently with the constructivist approach selected. In this study the researcher undertook all the data collection and analysis; it is suggested that such an integrated approach optimal for grounded theory studies due to the iterative data collection and analysis approach (Charmaz 2008a).

Glaser (1999) considers that 'fit', 'work', 'relevance' and 'modifiability' are useful criteria to consider judging the quality of grounded theory studies. Whereas Charmaz (2006) identifies 'credibility', 'originality', 'resonance' and 'usefulness' as key criteria for evaluating the quality of grounded theory studies. As this study was constructivist and in the spirit of consistency of alignment to Charmaz's criteria, it is used to reflect upon the trustworthiness and credibility of the study.

'Credibility' is associated with the familiarity of the setting, the adequacy of data to support the claims and evidence of systematic comparisons between observations and categories. This study engaged 19 participants in different stages of their careers, residing in different geographical locations and with different employment histories, drawn from across India. The sampling did not

set out to target such a spread but the theoretical sampling that followed the developing theories and professional networks resulted in the diversity achieved. The in-depth interviews were conducted in an informal manner and strategies adopted to try and ensure that the participants were comfortable with honestly articulating their experiences, perspective and feelings. The flow of the transcripts show how with FG1 and FG2 the conversation became more relaxed and fluid as the interviews progressed and the participants gained their confidence. In FG2, Monica expressed a critical opinion and qualified it with *"I hope that this is confidential"*, this supports that the participants did feel able to express perspectives that they would not normally articulate in public.

Throughout this thesis excerpts of the interviews are used to evidence and illuminate the categories and theory with the participant's voice. This serves to illustrate the richness and context of the data, to support the development of the theory derived from the interview data, and to demonstrate the logical links between the data and the analysis. Charmaz (2008b) considers that the audible voice of those who constructed the data to be an essential characteristic of constructivist grounded theory. The identification of disjunctures, conflicting perspectives and interrelationships demonstrate the importance of systematic comparisons between observations and categories in the analysis. The research log and the diagramming were important in capturing the development of the emerging constructs and categories.

'Originality' is defined as the freshness of categories and the ability to offer new insights and original conceptual rendering of the data. This study and its findings are original, no other published study explores the global mobility of Indian physiotherapists. The findings identified experiences and perspectives that are specific to Indian physiotherapists. The categories and theory identified in this study did not imitate those already articulated in the published literature

around global mobility of other healthcare professionals. This study generated a new conceptual explanation of globally mobile Indian physiotherapists.

'Resonance' is an indication that the categories and theory portray the fullness of the studied experience and make sense to the participants and those who share their circumstances. Respondent validation is an accepted way of ensuring that the interpretation of the meaning of the data is resonant with those from which it was derived (Gardner 2006; Richards 2009). Adeeb's interview was undertaken for member checking to ensure the resonance of the findings and proposed theoretical framework. Adeeb concurred that the analysis was a resonant to him, he supported the importance of the categories and clarified elements that were particularly significant to him. This allowed a refinement and enhancement of the theory presentation. Adeeb considered that he had not consciously identified his personal journey conceptually as presented in the theory but that he supported and agreed with the pertinence of the categories and was able to relate to and support the proposed theory.

Indian physiotherapy discussion forums, web based media sources, the bimonthly Physiotimes magazine and Indian Health Ministry publications (NIAHS 2012) were accessed, to further my understanding of the Indian physiotherapy context and to follow the unfolding events around the IAP election and the faltering narrative around the council legislation. The messages that were document in these sources supported the participant interview accounts and the derived interpretation; these sources added resonance to the research findings.

The theory developed from this study embraces different perspectives and circumstances, it relates and links individual experiences to the position of the profession nationally and to the structures within which the profession operated.

Charmaz (2006) considers that positioning individual lives against larger collectives and institutions enhances the resonance of a study.

'Usefulness' is associated with the studies ability to offer interpretations that people can use in their everyday worlds and to identify further research in other substantive areas. The analysis in this study offers an interpretation and an understanding of the phenomena studied. It is suggested that it will support the understanding and self-reflection by Indian physiotherapists who are considering migration; they will be able to use the resultant theory as framework to consider their motivations and aspirations. The IAP and potential regulatory authorities may also find the narrative and resultant analysis useful in understanding the experiences, actions and perspectives of some Indian physiotherapists. Within the narrative there were disjunctures identified but also common acceptance of Indian physiotherapy's strengths and weaknesses and agreement upon the challenges to the profession.

Charmaz (2006) considers that a strong combination of originality and credibility increases the resonance, usefulness and ensuing value of the study's contribution. The contribution is also dependent upon a clear positioning within the context of relevant literature. The following chapters in this thesis present the study findings in the context of pertinent literature.

2.5. Reflexivity

2.5.1. Researcher Positioning

Reflexivity is the process of monitoring and reflecting upon all aspects of the research study, especially the role and influence of myself as the researcher on the study (Jupp 2006). The constructivist approach to the study acknowledges the effect that I, as a researcher, have on the data collection and analysis process (Charmaz 2008a). As researcher, I must reflect upon my underlying

assumptions and heighten awareness to listening and analysing participants narratives as openly as possible (Mills et al 2006b). Memoing throughout the research ensured that my thoughts and interpretations were captured throughout this study, this also supports the study rigor. The clarification of the position that I take in the text and the relevance of my biography was articulated through a reflexive analysis (Mills et al 2006b; Mruck and Mey 2007).

I am a white, middle class British national, a physiotherapist who qualified 25 years ago with a Graduate Diploma and not a degree. I have more than 12 years of experience of clinical work in the UK and Australia. For the last 13 years I have worked as an academic in one of the largest UK universities. I am currently employed as a senior academic with responsibility for international development in the health, sport and bioscience subject areas. Over the past ten years I have worked with Indian physiotherapists who have come to the UK to study masters degrees. This work has involved revisiting the design of the masters degree to ensure that international students' learning needs are supported and their study aspirations met; I have travelled extensively in India (and east Asia) promoting the university, counselling students regarding study in the UK and seeking to develop collaborative partnerships. I have visited private and public sector hospitals and physiotherapy departments, universities and colleges that train healthcare professionals and also those that award the degrees. Prior to undertaking this study, I had some knowledge of Indian physiotherapy and had met many physiotherapists who had studied in the UK, often making great sacrifices, socially and financially, to do so. This study was undertaken to try and understand Indian physiotherapy, and the decision making of Indian physiotherapists who elected to study overseas.

It was important throughout this research to ensure that my presence was not perceived to be equated to old colonial heritage but was recognised for what it was, a genuine interest in understanding the phenomenon from a distant

stakeholder associated with Indian physiotherapists' global mobility. This aligns with a fundamental tenet of constructivist grounded theory data collection and analysis, that is respect and trying to look at the world through the participants' eyes (Charmaz 2006).

2.5.2. Researcher Participant Relationship

Active reflexivity prior to and during the interviews was essential to manage the researcher participant power asymmetry that is an identified risk in any interview situation (Kvale and Brinkman 2009). In this research study the potential for perceived power relationships and misconceptions to influence the interviews was amplified due to the cross-cultural and cross-national context of the study.

For all the interview participants the risk of perceptions of colonial imperialism had to be minimised and ideally avoided. The establishment of a mutual relationship was sought, where my position as a researcher held sufficient expertise and credibility, so that I was felt to be worth engaging with. To counter this I clearly framed myself as not being an authority on the subject of Indian physiotherapy. The participant was the expert in this area and I valued their perspectives and opinions. This was a fine balance to achieve where the pivotal point was different for each individual. Although my side of the scale remained unchanged, the participants' prior experience, conceptions and knowledge of me personally varied. I therefore needed to respond according to their behaviour and responses. This required that I was alert, reflexive and adaptable.

Prior to each of the interviews I discussed with the participants what expertise and knowledge they held that I sought to capture and understand through the interview (this aligned with the theoretical sampling). Each of the interviews

started in a similar manner, with an explanation of the purpose of the research and the reason for my interest. It was important that I responded to any questions that participants raised in an open and transparent manner. I shared with the participants a brief personal and professional history of my career and how I started my career with a graduate diploma qualification, had travelled overseas to work and had returned to the UK, subsequently moving into education. This sharing of my early career history was important as it illustrated to the participants that UK physiotherapy had, in the recent past, not been at degree level and that I too had travelled to work overseas. My academic career history illustrated how, as an educator, I had developed my interest and knowledge of Indian physiotherapy. I also established Indian contextual credibility as I had fairly extensive experience and knowledge of India and Indian physiotherapy obtained through frequent visits to hospitals and educational institutions across north and south India, seeing and learning about Indian physiotherapy's educational and working practices. I was able to demonstrate some knowledge and understanding of their professional context that would help ensure that the conversation would not be considered judgemental. The biography that I shared was open, honest and transparent. I identified that I had experience of engaging with the international student recruitment network, with the British Council in India and of delivering the university's physiotherapy masters programme and that this experience had led to my current interest and research. Taking time to establish authenticity and to share a part of me was important to ensure that I was not perceived as imperialist or having hidden agendas.

During my research a UK colleague (who did not have travel experience) enquired how I established adequate communications with the study participants She personally found 'connecting' with her Indian students very challenging, as the students appeared unclear as to what was being asked and conversely she could not understand the rationale behind the responses to her

questions. This prompted me to reflect upon my interactions with my Indian students over the years and during this study. I realised how much tacit and intuitive knowledge and understanding I had acquired over a decade of working with Indian physiotherapists in India and in the UK. My interaction with them feels as familiar as talking to my office colleagues; I feel that I understand an Indian physiotherapist more completely than I do a physiotherapist from China or Nigeria where I have much less experience. During the interviews my knowledge and experience of Indian physiotherapy was invaluable in framing the opening questions and the follow-up conversations; I was able to engage with their issues from an informed perspective. Empathy can often be perceived as being patronising, especially across cultural boundaries. I found that my previous experience of Indian culture, whilst nascent, was an important counter to this and that as the interviews progressed, the participants became more communicative suggesting that they were relaxed and comfortable with engaging in the conversation.

Perhaps the most useful asset I had in establishing a mutual relationship was that of my professional background as a physiotherapist and educator. Sharing a professional identity immediately engendered a common ground that was used to establish a mutual understanding and trust. This was particularly valuable when first meeting the participants who I had not met before (FG1, FG2, FG3, Asha and Lalit).

The challenges associated with establishing a relationship with the participants can be divided into three participant groups: the recently qualified physiotherapists who had just embarked upon their masters level study (FG1 and FG2) and none of whom I had met prior to the interview; the recent post UK masters study physiotherapists (FG3, Minda and Lalit); and the experienced educators (Ashna, Manish and Rani).

With the recently qualified physiotherapists I was concerned that I would be perceived as an authority figure and that participants would only articulate what they thought they should be saying and what I wanted to hear, rather than their true perspectives. To mitigate this I dressed more casually, used humour in my introductions, and emphasised my role as a doctoral student researcher. The importance of confidentiality and assurances of their anonymity were essential. A particular challenge and concern arose during this introductory stage with FG2 when it became clear that the participants had not volunteered but had been selected by the head of physiotherapy who I had contacted to set up the interview. As soon as I became aware of this I emphasised that participation in the focus group was voluntary, that if they were uncomfortable in any way they could leave and no one else would be told who had chosen to stay or leave. All the participants completed the consent forms and stayed, whilst slightly reticent and cautious at the start of the focus group, they gradually become more confident in articulating their opinions and perspectives. At the end of the focus group one participant stated that she was glad that she had stayed and had really enjoyed the conversation. The other participants echoed agreement. Whilst creating an ethical challenge during the focus group, this occurrence also reminded me of the different pedagogical approaches to student and participant engagement between the UK and India.

The participants who had recently completed their masters in the UK presented the fewest challenges in establishing a relationship. Their experiences in the UK were still fresh and there was a clear sense of empowerment in how they articulated their perspectives. FG3 presented the challenge of ensuring that each participant's perspectives were captured and that the conversation was kept on track, exploring the areas that were required for the stage of theoretical sampling. They were confident and knew each other well, the dialogue was much faster and occurred between themselves. My role as interviewer was to introduce the topic area, to manage the free flowing conversation, to query

some statements to enhance clarity and to ensure that no one dominated and each participant was heard. It was very much a facilitator role and I was glad that there were only three participants in the group, more would have been very challenging.

Interviewing the experienced educators presented the challenge of finding out more about Indian physiotherapy practice and education, and the governance challenges, without being seen as judgemental or intrusive. In these interviews I emphasised my interest in education and the importance of ensuring that any overseas education that Indian physiotherapists sought would effectively equip them for their return to India. The most challenging of the educators to interview was Manish who, whilst he had travelled overseas extensively to conferences and on short staff exchanges, had not been employed overseas. He struggled more than the other educators, to understand some of the questions and was also less fluent in English but I felt that the response difference was due to a narrower conceptualisation of the questions. He was less comfortable extrapolating on his answers, often responding with 'yes' or 'no' to open questions. I needed to rephrase and restructure questions to move beyond what, at times, felt like formulaic answers. The dialogue felt more like an interview, whereas with Rani and Ashna it was a more fluid conversation. However when Manish was talking specifically about research, clearly his area of interest and passion, he was much more eloquent and expansive. This was the most challenging of all the interviews, possibly due to the gender difference but also due my lesser ability to 'connect' with Manish effectively, even though I had met him on several occasions prior to the interview.

In summary, cross cultural qualitative research can present many challenges to establish effective relationships and communications between researcher and participants. My experience of travelling within India, many years of working with physiotherapists from India, and professional background as a

physiotherapist and educator, effectively equipped me with the tacit knowledge and experience to establish an effective relationship with the participants. Consequently I was able to adapt my approach and responses in a meaningful way so that the interviews were in depth, addressed the focus and produced rich data. Participants commented post interview what a positive experience it had been and said they were glad that someone from overseas was taking an interest in Indian physiotherapy.

2.6. Research Ethics & Governance

2.6.1. Ethics

This research complies with the Declaration of Helsinki (WMA 2008) and the UK Department of Health Guidelines (Department of Health 2005). Approval to undertake the research was gained from the university ethics and research governance panels (see appendix seven) and indemnity insurance cover for the research was provided by the university. A project site file was maintained throughout the study and will be retained for a further five years.

There is international debate regarding where ethical reviews should take place when research is to be undertaken across different countries or where the sponsor and host countries are different (Nuffield Council on Bioethics 2005). *The Indian Council for Medical Research (ICMR)* guidelines (2006) are closely aligned with UK guidelines, but are principally directed towards interventionist experimental and epidemiological research. They state that for research involving human subjects approval should be sought from an institutional ethics committee and they provide the internationally equivalent titles; however there is no statement identifying in which country the committee must be based in. This research complies with the ICMR guidelines. However, arguably, this research proposal is of a social science and not a medical underpinning, and therefore might be considered to fall under remit of *The Indian Council of Social*

Science Research, who do not provide guidance regarding ethics or governance issues (Shah 2006). Enquires through the British Council in India, the university's office in India and Indian professional networks (Sabapathy et al 2009) identified that there were no specific in country approvals required for interviews to take place in India.

2.6.2. Consent

Informed consent was gained prior to participant interviews (see appendix three), following a consultation process during which they received a participant Information sheet that was adapted for their specific interview from the standard template in appendix two. Participants were informed of their right to withdraw at any stage during the research and that any data gathered from them would not be used in the analysis. FG2 participants were masters students who were recruited through the head of the physiotherapy department at a private university in India, the interviews took place at the university, therefore his authorisation for the interviews was gained.

2.6.3. Confidentiality and Anonymity

Participants were assured anonymity from the data reporting and that any individual aspect of the interviews may be subject to confidentiality at their request. The interviews were anonymised using pseudonyms, the signed consent form was the only location at which the pseudonym and the personal identity could be matched. Transcribers were not able to identify the individual participants and were requested to destroy electronic copies of the recording and the transcript once it had been completed. The transcripts were made available to the transcribers on a time limited basis via a password protected website. An encrypted USB stick was used to store the transcript recordings when moving between secure data storage interfaces.

2.6.4. Cultural Sensitivity

The moral and ethical acceptability of the research was of key importance, for if this was compromised so too would be the validity of the research. It was vital that the research was not perceived as being exploitative. The collaborative approach to data generation that is implicit within grounded theory methodology; the validation interview to ensure the resonance and utility of the theory derived were all essential components of establishing ownership and validity of the substantive theory.

Whilst the research area did not evoke the 'traditional' ethical sensitivities of experimental methodologies or research involving vulnerable populations, there were sensitivities to be acknowledged. The 'truth' of the research findings must be carefully constructed and conveyed in order to ensure that they do not just reflect the western researcher perception of truth but also reflect eastern philosophical notions of truth. It would have been ethically unacceptable to develop a discourse where the truths were embedded within a colonial sub consciousness and indulge western hegemonic protectionist structures - for example professional bodies. The findings should be handled carefully and the most effective mechanism of disseminating the findings considered, for once knowledge is disseminated the researcher has no jurisdiction over its use. The ethical acceptability of the research was of key importance for if this was compromised so too would be the validity of the research.

2.6.5. Risk Assessment

The participant interviews were considered unlikely to evoke sensitive issues that might lead to psychological harm. Therefore it was considered that there was minimal emotional risk to participants in engaging with the research and no upset or distress was observed during the interviews. It was considered that

there was minimal physical risk to the participant other than travelling to the interview, which were arranged during daylight hours and at a mutually agreed location.

A full travel risk assessment was undertaken prior to my visits to India. Travel plans adhered to the guidelines identified in the university travel policy and included strategies to minimise the risks arising from a lone female working in a foreign country. Travel insurance was obtained.

3. Chapter Three: Introduction to the Findings

During the analysis the data was constructed into groups and themes, and then deconstructed and formed again into different organisational and thematic groupings, until a sense of coherence was achieved that reflected the narrative from the interviews and encapsulated the 'stories'. The resultant subcategories and categories were interpreted and conceptualised into a core category, that encapsulated the key elements into one frame to provide an explanation that illuminated the complexity that was evident in the dialogue with the participants.

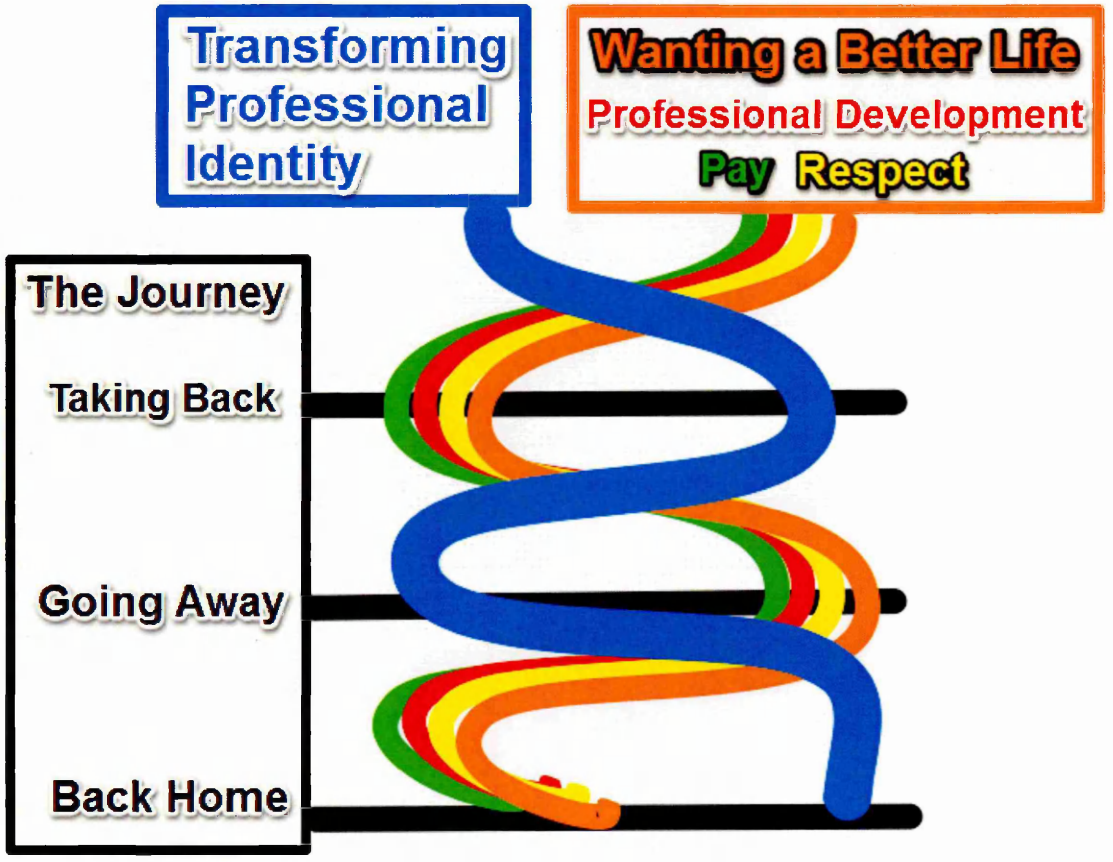


Figure 3: Why Indian Physiotherapists are Globally Mobile.

The categories capture different conceptual perspectives but they are interconnected and form a matrix (see figure three). 'The Journey' subcategories form the horizontal scaffold in which the codes were organised to capture stages in the participants' narratives. The 'Wanting A Better Life' subcategories weave through 'The Journey' scaffold and interweave with each other, they borrow narrative from within the subcategories and codes. The 'Transforming Professional Identity' core category proliferates throughout and provides a coherent link that elucidates the complexity and ultimately leads to the theory.

Table 6: The Categories

Core Category	**Transforming Professional Identity**		
Category	**Wanting a Better Life**		
Subcategories	Pay	Respect	Professional Development
Category	**The Journey**		
Subcategories	Back Home	Going Away	Taking Back
Subcategory groups	Being Indian Great Expectations Educating India's Physiotherapists Under Doctors Orders Challenging the Status Quo	Hearing It's Different Developing Self Working Overseas	Returning Knowledge Transfer

'The Journey' category sequentially captures the Indian physiotherapists' professional journey on many levels. The subcategories within the group are

compartmentalised into the journey stages 'Back Home', 'Going Away' and 'Taking Back', see table six. 'Back Home' is about becoming a physiotherapist in India. 'Going Away' explores the factors that draw the Indian physiotherapists overseas. The 'Taking Back' subcategory explores the physiotherapists return to India.

The 'Wanting a Better Life' category captures the aspirations of the Indian physiotherapist and the specific elements that underpin their motivations: 'Pay', 'Respect' and 'Professional Development'. This category is entwined throughout 'The Journey' stages. The 'Transforming Professional Identity' core category cuts across and is inter-related with the key components of both the categories. It consists of four stages that are resonant with the journey metaphor of 'forming', 'storming', 'transforming' and ultimately 'transferring' their personal physiotherapy identity and the identity of the Indian physiotherapy profession. This theory proposes that the journey of identity transformation is the crux to understanding and exploring the phenomenon of Indian physiotherapists global mobility.

The next three chapters will explore each of the category groups and the core category. It will be seen how they were constructed and demonstrate how they are derived and grounded in the discourse resulting from the interviews. The weaving and entwining of the categories and core category into a theory will be explicated. Literature will be considered that supports the underpinning analysis leading to the theory construction. The narrative, from the interviews, reports individual perceptions and their interpretations of the context in which they exist. There are differences and commonalities within the narrative, juxtapositions and disjunctures; there is no one truth, for each individual's perspectives and perceptions, based upon their ontological positions combine to form an epistemology that is explicated by the resultant theory.

4. Chapter Four: The Journey

The journey category is divided into three subcategories, each of which captures a stage within the journey. The 'Back Home' stage explores the context of physiotherapy in India and the affect upon individual physiotherapists. The 'Going Away' stage captures the aspirations and motivations that underpin Indian physiotherapists' global journeys. The 'Taking Back' stage highlights the issues associated with the physiotherapists' articulated desire to return to India.

> *"Yes, I met all the aspirations that I came with over there, basically learnt quite a lot and today I am applying quite lot what I have learnt in every which way and I think I am a better physiotherapist after I have come back from there; so yeah I think **it's been quite a journey**."*
>
> Minda (recently returned to Mumbai following Masters study in the UK).

Globally mobile Indian physiotherapists embark on a journey on many levels. They undertake not only a physical journey but also a journey of personal development and self-discovery; it is apposite therefore, that the journey is used as a metaphor to convey and explore the underpinning complexity of their mobility.

4.1. Back Home

To understand the Indian physiotherapists' journey and why they wish to travel overseas for education and work, it is important to consider their experiences as physiotherapists and the position of physiotherapy in India. Foucault considered that knowledge of such archaeology and culture is essential to understand the narrative and resultant discourse from such research (Foucault 1972). The 'Back Home' subcategory captures the experiences of physiotherapy in India as perceived by the participants. It explores the physiotherapists' undergraduate

education that forms the starting point of any professional journey, the clinical environment that they graduate into and the hierarchy that controls it. Developing frustrations with the clinical and professional context were reported by some Indian physiotherapists, and the rationale for leaving Indian physiotherapy and journeying overseas was identified. All of this was set within the social and cultural context of 'Being Indian' and being a physiotherapist in India. 'Back Home' is about the start of that journey, about becoming and being a physiotherapist in India.

4.1.1. Being Indian

During the course of the interviews, the importance of Indian contextually based social and cultural factors became evident, they appeared to amplify and enhance the significance of aspects of the narrative. Shashi Tharoor (2007) in his book 'The Elephant, the Tiger and the Cellphone', a reflection upon twenty-first century India, considers that the cultural context is of such importance, that he devotes the final chapter to 'The A to Z of Being Indian'.

'Being Indian' is to live in a hierarchical and caste based society that has clear gender role expectations. Parental influences are strong and arranged marriages common. There is a strong sense of duty and serving the country, although it is a competitive society driven by extremes of wealth and poverty. It values many attributes of developed countries and ironically some vestiges of its ex-colonial masters.

Indian commentators identify that hierarchical status is an archaeological fixture in the Indian social structure; it defines and classifies an individual's relative place in the world around them. It permeates all aspects of life in India and is pervasive and ingrained; individuals constantly judge others and mentally classify them as above, at the same level or below themselves. It happens

inside families, work places, and socially when individuals go out to meet someone; classification determines behaviours (Ashraf 2012). Some determinants of an individual's position are bestowed at birth: caste, colour and gender; others an individual can influence: position, money and language (Deepak 2012). Throughout the interviews there were constant references to hierarchy, its underpinning relevance and how it affected emotions and decisions. Jacobson (2004) considers that the acceptance of such cultural themes have allowed India to create social order from complexity, bringing together disparate ethnic, linguistic, economic, religious, class and caste groups in structured efforts to benefit the wider society.

"... and of course Indians are very class conscious people."

Ashna (overseas returnee, clinician and educator)

The narrative from the interviews repeatedly indicated that gender divides were prevalent in Indian society and that they impacted upon the issues raised. Expectations on males and females differed significantly with females expected to spend more time at home, follow their husband's wishes and look after the family. Whereas for males there was an expectation that they would be the 'breadwinner' and support their wife and children. This meant that the issue of low levels of physiotherapy pay in India was more acute for men. Education was important for both genders but for a female it was about societal expectations, marital value and social status, while for a male it was about financial drivers and career prospects.

"... in our society - if the girl, she basically they can get married and their husband can do all the earning and she can sit at home and that is not frowned upon or anything like that. That is the norm. So there is no compulsion, and I don't mean to sound derogatory in anyway, so there is no compulsion for the girls to actually work out a living."

Lalit (male, studied in UK, returned to India)

Clearly reflected in several of the participants' narrative was the importance of family and how parental wishes played a strong role in Indian society ranging from the choice of career to the selection of spouse, professional prospects and the expectation of care into old age. It was important to gain parental support prior to travel overseas and it also influenced the desire to return to India. The responsibility to their family was one of the main reasons cited by FG2 participants for not travelling overseas.

" When I was young, a child, my parents wanted me to be a doctor"

Adeeb (male, studying in UK for PhD)

"As per Indian culture, means parents are up to adult life parents are supporting us on all the aspects. Means if we don't have any difficulties, and then it is our duty to support them after."

Suhani, FG1 (female, just arrived in UK)

This clear sense of duty articulated by some participants, extended to serving India and its citizens. This was articulated not only those who had stayed in India to study their masters degrees but also by some of those who had travelled overseas, and was identified as a reason to return.

" I still love India and I want to be here, want to practise here, in my people to serve them, that's it."

Madhuri, FG2 (female, masters in India)

'Being Indian' is to live and work in an competitive environment where individuals must fend for themselves, where survival, having an edge and being the best are underlying drivers for many. The focus group participants used terms such as *"fighting for themselves" (Lara FG3), "survival of the fittest"*

(Joseph FG1), "you've got to fill your own pocket first" (Adeep), '"need to be the best" (Joseph FG1).

Several participants referred to India and Indians valuing things non-Indian but more specifically from the developed world. This included overseas education, work experience, knowledge and even marriage to a non-resident Indian; there was the perception that if something was from a developed country, it would be more up to date and better.

> *"In India we still have that charm about anything that comes back from England. We still haven't shed it off. I think there is some level of genetic coding there."*
>
> Ashna (clinician and educator).

It is interesting to consider the cultural and societal traits that emanated from the interviews, and were captured in the 'Being Indian' subcategory group, and how they align with the identified cultural classification first described by Hofstede (2001). Hofstede's landmark study was based upon data collected in the 1980's at national subsidiaries of IBM and have subsequently been updated through study replications and extensions. The model classified each country according to its characteristics; three of the dimensions are of interest here. Firstly, India rated high (77) in the power-distance dimension, an indication that all individuals in society are not equal and that there will be a top-down structural hierarchy where power holders are inaccessible to those with less power. This description aligns closely with some of the interview narratives, for example Minda stated *"there is lot of hierarchy and things like that. .... but going to the top most level is still quite difficult"*. Secondly, in the individualism-collectivism dimension India scored 48, which indicates a society with clear collectivist traits, where belonging to a larger social framework is important, as is the influence of family and neighbours. This was articulated across the

interviews, Adeeb stated *"I want to be with my family, that's very important for me, that's my priority that I want to spend time with my family and live with my family."* Thirdly, India scored 56 (mildly above mid-range) in the masculinity-feminity dimension but was categorised as masculine in Hofstede's classification. A masculine society is driven by competition, achievement and success; success is defined as being the best. A feminine society is where caring values and quality of life are measures of success. In this study participants articulated evidence of the masculine traits for example Joseph (FG1) *"Everyone's fighting for themselves for their own survival in Indi."* and Bipasha (FG3) *"to get an edge over others"*. Similarly, feminine traits were evident, for example Adeeb referred to the *"important role in the overall quality of life"* and Madhuri (FG2) stated *"I want to be here, want to practice here, with my people to serve them, that's it."*

4.1.2. Great Expectations - IAP and the Council

All the interviews, except the confirmatory interview with Adeeb, occurred during the lead up to the IAP elections. Minda's, Lalit's and Rani's interviews occurred two weeks before the IAP election result announcement. Adeeb's interview occurred after the latest 2011 regulatory bill had been rejected and as the Goa dual conference dispute was occurring.

Throughout the interviews participants identified that the IAP was only a professional advisory body that retained a register of members, and that it was not a regulatory or statutory body, therefore the IAP was powerless in many contexts and was often not listened to by the universities. The interviewees articulated different expectations of the effectiveness of the IAP role which were unanimously identified by participants as firstly, setting a common curriculum for bachelors and masters degrees for the universities to develop their courses upon; and secondly, monitoring the minimum requirements to run a

physiotherapy course (infrastructure, staff to student ratios etc) and to inspect the colleges. Manish considered that the IAP were effective in these duties. Mindha and FG3 perceived the IAP was ineffective and not responsive to change. Adeeb reported perceptions of corruption that ranged from vote rigging to lucrative incentives associated with the approval of colleges.

Perceptions of the IAP that subsequently lost the disputed election differed and ranged from "*the association has well meaning people who are kind of trying to have a stringent quality control so that things won't go* awry" (Ashna) to a body that "*has not achieved anything in the last 50 years*" (Adeeb) and *"for making some permanent change or for some making it brighter, even I think they are not doing much*" (Srishri, FG2).

> *"...they are still stuck in trying to become something themselves individually, that they don't think of the entire profession really and they are very conservative in their views and are still stuck on the old concept of what physiotherapy was around 20 years back and they don't really want to move on."*
>
> Minda (studied in UK, returned to India)

Rani and Minda both identified that there were a lot of things that the IAP could be doing to change things, for example it should be the body that physiotherapists would look to for policies, guidelines, career pathways etc. It could bring together groups to discuss the issues and identify ways forward, but these things were not happening. Only Adeeb was interviewed after the IAP split and he was broadly supportive of the new IAP cast, as opposed to those who had lost the vote, but also stated that he had resigned his IAP membership several years previously.

There was an optimism expressed by all participants, except for Adeeb, that things were slowly changing despite frequent government reversals in

establishing a regulatory council. All participants referred to the proposed regulatory council and suggested that everything would improve when it was in place. Throughout the interviews, participants referred to beliefs, hopes and expectations that once physiotherapy had a government recognised council in place the problems within Indian physiotherapy would be resolved. They believed that there would be increased respect, that pay would improve and that the practice scenario would improve, because as physiotherapists they would have clinical autonomy.

The understanding of the role and the scope of the proposed council was mixed and differed between participants but it was not timeframe dependent and so did not reflect the changing proposals. Expectations of the council were identified:

- To improve physiotherapy practice and help to retain physiotherapists.
- To regulate physiotherapy practice and to "*protect it*" from *"quacks"*.
- To lead to increased pay.
- To increase the profile and awareness of physiotherapy, especially with other professions.
- To set the curriculum (the IAP would set the standards of practice and have a strong influence with the council, as IAP members would be on the council). Curriculum changes submissions would be expected to be time consuming and cumbersome due to the associated bureaucracy.
- To tell state governments how many physiotherapists should be employed in the public sector and the positions required to create a coherent career pathway.
- To establish mandatory, continuing professional development (CPD) to remain registered.
- To sponsor physiotherapists to study overseas and ensure they return to India post-study.

However in the aftermath of the latest failed government bill, Adeeb was more sceptical, *"a Council won't sort out anything really"*, he considered that if physiotherapists are grouped with technician level professions then it would not achieve autonomous status and in a regulated system he felt that it would mean that physiotherapists would not be able to set up independent practices, take self-referrals and that they would be *"working under the thumb of a doctor"* only able to give the modality that the doctor prescribed. All the clinical decision making and everything that he had studied for in the UK would be "*gone*". In the absence of a government level bill, Adeeb reported that the states appeared to be establishing councils of their own, with some inferring physiotherapists' autonomy (Maharashtra and Tamil Nadhu), and some not (Punjab).

An article in the Physiotimes by Sinha (2012) identified that the 2011 Health Bill would bring much needed reform to the Indian health sector and would be good for physiotherapy in the long term, as new regulatory councils (even though they are not specifically mentioned in the 2011 Health Bill) could be easily established. He suggested that the Health Bill's rejection reflected the doctors concerns that power would move away from doctors to bureaucrats. Issues associated with medical dominance and authority have featured extensively in the literature over the last two decades; specifically in the context of reorganised workforce requirements, changing health economics and systems of delivery, increased autonomy of the allied health professions and blurring of professional boundaries (Friedson 1985; Ovretveit 1985; Kenny and Adamson 1992; Nettleton 1995; Colyer 2004; Watts 2009).

4.1.3. Educating India's Physiotherapists

4.1.3.1. Developing knowledge, developing physiotherapists

Based upon the interview discourse it is suggested that the aspiring Indian physiotherapist's journey starts with his/her undergraduate education, where a student develops a sense of understanding of who he/she is professionally and

what they can offer as an individual within a professional construct and context. Lalit and Manish reported that increasingly people were entering the profession as a first choice profession (as opposed to a medicine fall-back) and therefore the student's academic ability and approach to the profession had changed.

Most of the interviewees (educators and clinicians) suggested that undergraduate physiotherapy education in India had changed and was continuing to evolve to meet India's developing health needs. Educators described a four year degree course with integrated clinical postings. There were reports of an increased range of clinical skills being taught to cover new subject areas and to equip graduates to work in expanding clinical areas, such as women's health, illness prevention and social aspects. Educators reported an increased emphasis on theory as well as clinical expertise. One educator (Rani, returning overseas educator) articulated concern that there was too much content, that the undergraduate curriculum was overloaded, and also that there was disagreement amongst educators about bringing in new content without "*throwing something out*". She questioned how it was possible to teach all the required content in sufficient quality and depth in the time available.

The educators described how they valued exploring different education programmes globally and how ideas and practice from overseas education had enhanced Indian physiotherapy education. They aimed to merge the best of different systems to meet India's physiotherapy educational needs within the constraints of its educational structures.

> *"So if you can merge the two methods of thinking, and the two methods of, I mean the way of having been taught from there and the way the Indian system teaches, and if you can merge it and deliver it to the next generation of physios, I think it will be a more comprehensive method of education delivery."*
>
> Ashna (overseas educated, principal of a small physiotherapy college)

Manish (principal at a large private university) estimated that 30% of his institution's change was due to the influence of physiotherapists returning from overseas. Rani stated that when she returned to India after teaching overseas that she was *"no way"* she was returning completely to the way that she had done before and talked about the challenge of changing practice upon return. Indeed all the educators identified that this fusion of educational ideas took time and was challenging.

"It wasn't easy, it took me almost 4 or 5 years to get started to have change in the way they would do things, "

Rani (worked overseas as an educator, now returned to India)

The educators all talked about what they saw as limitations in the education and said that further developments in the Indian physiotherapy education were required. There was a general consensus regarding what changes they perceived were needed and their observations were supported by the comments from the recent graduates. These included better clinical reasoning skills, critiquing skills, evidence based practice and research. An increased emphasis was on students being more independent and in developing how the students think, so that they would be better able to debate and be critical.

"...overall the reason is research or evidence-based practice are not well incorporated in all the universities of India."

Manish (educator)

"The average Indian degree probably equips you with developing the basic skills (...) there is not much of clinical reasoning that happens in an undergraduate program."

Rani (returned overseas educator)

However, despite the unanimous testimonies of change amongst educators, there were clinicians (FG1 and FG2 participants and Minda) who reported that they perceived that that the curriculum had not changed over the last 10 years, or that even though many curriculum revisions had been reported, that there had been little change in curriculum delivery. The observations regarding curriculum delivery were supported by Rani who expressed particular concern that teaching staff needed to develop a knowledge and understanding of pedagogical principles. She identified that in Indian education there was too much rote learning and lecture delivery, and students needed to develop more analysis and other higher taxonomy levels of learning.

> *" ...we haven't changed the style in which we deliver our programs for a long time now (...) it's a lot of rote learning (...) standing in a class and delivering a lecture."*
>
> Rani (returned overseas educator)

The educators reported that there were mandatory staff education development programmes in some institutions. They considered that their institutions and some other named institutions (there was commonality in those named) were innovative in their practice and at introducing curriculum and delivery changes. The educators all identified that the changes in curriculum, educational delivery and staff development that they referred to were not occurring everywhere. Rani made the observation that the private universities appeared to be able to move faster in terms of updating their delivery than the public universities. All of the participants interviewed referred to a substantial variation in the quality of undergraduate physiotherapy education, due to a rapid expansion in the number of physiotherapy colleges, with associated poor regulation and a lack of quality control. It was reported that these colleges produced poor quality graduates. All the educators agreed that on paper there is minimal variation in

the curriculum but that the difference was in the standard and method of delivery.

> *"...so there are so many number of universities in India. These universities give affiliation to so many number of colleges. It is very difficult to control. (...) Here the curriculum is I would say would vary between 80 to 100%, but structurally it will still be the same. However, the way it's delivered is anybody's guess game. The delivery system is very varied, very varied."*
>
> Ashna (overseas educated, principal of a small physiotherapy college)

The challenges associated with entry level physiotherapy education has been considered in the Indian physiotherapy literature, ranging from didactic narratives regarding multiple aspects educational practice (Mokashi 2011), to dialogue around purpose and content of the entry level curriculum (Swaminathan and D'Souza 2011), and the importance of clinical education (Shroff 2011). Ravindra and Debur (2011) observe that *"health professionals of tomorrow are taught by teachers of today using curricula of yesterday"* and that this reflects a need for better training for educators in teaching methodologies, to develop pedagogic expertise.

4.1.3.2. Same Stories

Masters level study forms a part of a graduate Indian physiotherapist professional development journey. There were mixed perspectives on the Indian masters degrees, most participants commented on the variable quality of programmes across India. Other areas identified for consideration in decision making were the clinical component and the apparent repetition from undergraduate study. There was a consensus amongst participants that the ability to work and contextualise learning throughout the course (two or three years in length) was a key strength of the Indian physiotherapy masters and something to be valued. However, Minda perceived that the balance between

work and academic study was often skewed, with all hospital work and no lectures or teaching, the education becoming secondary. Conversely, FG3 perceived the Indian masters to be very theoretical, even though they acknowledged its practical elements. This apparent disjuncture may reflect Ahuja's (2010b) observations regarding the use of examinations as the prime assessment method, which he argued would emphasise memorising theoretical aspects of practice.

The main and almost unanimous reported criticism from the interviewees was that a masters degree in India was a repeat of their bachelors' degrees and that very little was new but it was just in more depth. Suhani in FG1 referred to this as the "*same stories*", a term that clearly resonated with the rest of the group and the essence of which was repeated in subsequent interviews. There were reports (Minda, FG1, FG3) of peers and teachers saying to aspiring masters students that if you want to learn new skills and knowledge then you need to study overseas.

"In India we are getting bored of learning same thing, and same thing, always same stories."

Suhani, FG1 (studying UK masters)

The issue of repetition between the academic levels was also acknowledged as a problem by all the educators (Rani, Ashna and Manish) who identified that the starting point for masters study was going back to where the undergraduate course left off.

" So most of the students actually spend their first year repeating what they did at the undergraduate level."

Ashna (studied overseas, educator)

Masters study was identified by the educators as being about more depth, more literature analysis, evidence based practice and clinical skills, and an opportunity to specialise (usually in the second year). Rani (overseas experienced educator) identified that the programmes needed more clinical reasoning. The degrees typically culminated in a set of written and practical exams.

> *" ... so it's scratching the surface a bit more but not in the direction of clinical reasoning as I would expect it to see."*
>
> Rani (returned overseas educator)

The educators all identified a need for institutions to adopt less didactic delivery styles, with Rani calling for more teacher training programmes. Manish was passionate about developing a better research evidence base for Indian physiotherapy, the importance of which was articulated by the other educators and those returning following overseas study.

Recent Indian publications support this call for the development of pedagogic expertise and also emphasise the importance of institutional accreditation (Ravindra and Debur 2011). Ramachandran (2010) also emphasised the importance of curriculum standardisation alongside closer regulation of post-graduate education. However there is an absence in the Indian literature with respect to clinical reasoning, although evidence based practice is discussed (Ahuhja 2010; Naik and Pandey 2010).

In summary the Indian physiotherapist has been trained and educated by enrolling on a developing, content rich and content driven undergraduate curriculum. His/her degree is a blend of clinical practice and theory. In some institutions what they learnt was influenced by a diffusion of knowledge and

practice from overseas. They have learnt through attending lectures and largely didactic delivery styles. They have been proficient at exams and rote learning and may have experienced other forms of delivery and assessment, and the quality of their educational experience has been largely dependent upon the quality of the college that they attended. They are knowledge rich and have experience of clinical work; they graduated with some understanding of clinical reasoning, evidence based practice, critical evaluation and research, but these will not have been well developed areas. During this period of study they would have developed an understanding and notion of what it means to be a physiotherapist in India and the context in which they would practice. However, the masters level education whilst integrated with clinical exposure, was not able to meet the expectations of many physiotherapists. Repetition, didactic delivery and rote learning examinations were acknowledged by the educators as challenges to be addressed.

4.1.4. Under Doctors Orders

Upon graduation the next step in the physiotherapists journey has been either to directly study for a masters course or to seek employment. Participants reported that there were issues about the availability of employment in some areas, attributed to the increased number of physiotherapy colleges turning out large numbers of graduates, many of whom could not find physiotherapy work. The educators asserted that the public sector had not increased the number of physiotherapists that it employed in the last twenty years, but that potential employers now included Non-Governmental Organisations and an increasing number of private hospitals in the cities.

> *"The scenario over there [India] was very much saturated. The physiotherapists all around, everywhere physiotherapists. There are more physiotherapists than the patients."*
>
> JK, FG1 (new to the UK)

The participants reported that physiotherapy practice in India was unregulated and there was no physiotherapy autonomy. Like the educational institutions there was purportedly a lot of variability in the clinical settings and the way in which physiotherapists practised within a department. The scenario commonly described by the clinicians and focus groups was that physiotherapists could only treat patients by following protocols, defined sets of exercises or an electrical modality would be *"given"* dependent upon the patient diagnosis. The doctor determined the diagnosis. They also identified that they saw 20 to 25 patients a day and so rarely had the time to take the history, evaluate in detail, think about treatment and then actually 'give' the treatment. Some clinicians (FG3 and Minda) described it as mechanical work without thinking; Lalit (an overseas returnee now working in elite sport) was more philosophical in his perspective

> *" ... the facilities have to be for the masses and not for the classes, and it has to be more about quantity than quality (...) so most of the institutes in India are here to treat the masses."*
>
> Lalit (overseas returnee)

The participants described two distinct work place scenes where the ways of working, scope of practice and levels of authorised decision making were different. The hierarchical culture within the department and the relationship with the medical fraternity determined which work culture was prevalent in any one department. These contrasting clinical environments are explored further.

Most of the clinician participants described a scenario where they found it difficult to implement practice that they had learnt in their training. The practice was based upon doctors referrals that were prescriptive and frequently demonstrated a lack of understanding of physiotherapists' skills. FG2 participants attributed this to diploma qualified senior staff who, due to a lack of knowledge, adhered to conventional treatments. Some FG3 participants

described departments where hierarchical structures meant that the head of department did not encourage dialogue, and there was an expectation that the more junior physiotherapists would not question or offer their own opinion; they should follow the protocol in the same way as the more senior staff would.

" ...there is a very major senior - junior thing in India (...) what your head of department is doing, so you just continue with that."

Bipasha, FG3 (masters in UK)

Participants in FG3 and Minda (overseas returnee) also talked about more progressive cultures where the heads were more proactive and advised on the use of McKenzie and other modalities, and encouraged staff to attend workshops. The physiotherapists described that they had been able to build a reputation by demonstrating their knowledge through dialogue with the doctors, suggesting alternative forms of treatment that were more beneficial for the patient. However, these conversations would only occur if they had the support of the head of department. The educators identified that once the doctors had seen the results a couple of times, they considered you differently and when they refered the next case they just said *'pain management'* and left the physiotherapist free to decide the modality. These clinical environments had evolved to an informal semi-autonomous way of working. The considerable improvement in communications and interactions with medics, was identified by the educators as being due to an improved physiotherapy knowledge base and the expanding scope of physiotherapy.

"Because it is because of the knowledge of the physiotherapist is increasing now. (...) the interaction between the physio and the physician has improved a lot."

Manish (educator)

However, there were also reports (Adeeb, Rani) of significant "*conflict with the doctors*", as a result of Indian physiotherapists prefixing their name with the title doctor; this is explored further in the 'respect' subcategory in the next chapter.

From a philosophical perspective, Foucault asserts that medical dominance, bio-power, exists as a 'necessary evil' and might be the best for the health of society (Gastaldo 1997), therefore other health professionals should compromise their professional standing and relinquish authority to medical practitioners and the ideology of medicine. Whitehead and Davis (2001) consider that the medical profession has been guilty of maintaining its strong societal position at the expense of other individuals and groups, and that health care has, and continues to be, organised around medical dominance. In the west there has been a gradual shift of this power away from doctors to a more equal basis with the introduction of evidence based practice and the empowerment of patients (Watts 2009). In this study the participant interviews suggested that a change in agency had not occurred in India. Therefore, it may be suggested that the control by medical doctors is disabling the effectiveness of physiotherapy practice, hindering the development of the profession and consequently is impacting upon the effectiveness of rehabilitation in India.

One discourse that was not evident in the research interviews of this study, was that of the patient and the position of their empowerment; patients had been talked about but very much as recipients of treatment and not in an empowered context. This may have reflected that the interview focus was on the individual physiotherapist and their motivations and aspirations, and Indian physiotherapy. Alternatively, it may have reflected the ongoing nature of the dominant cultural practices based upon a biomedical model, where the subjugated power relationships within a healthcare encounter ensure compartmentalised roles

between the patient and the clinician (Pease 2002, Eisenberg 2012), as well as between the physiotherapist and the medical doctor.

On a more positive note, the returning clinicians (Minda and Lalit) reported that they felt the overall perception of physiotherapy in the major cities had changed, as other healthcare professionals realised the scope of the areas of practice and of what physiotherapy services could offer. The public awareness and perceptions of physiotherapy were considered to have increased and it had become recognised as a viable alternative to surgery and other medical modalities. Lalit articulated a virtuous cycle of development that accounted for the increased recognition and standards

"The standards of physiotherapy have increased because the students are better informed and they want to learn more, they do extra courses, they do workshops, they keep updating, attend CMEs [continuing medical education]. On the other hand the community as a whole, has started appreciating the value of physios; so it goes hand in, hand in hand because the community expects more, the students work harder and because students work harder, the community gets better treatment and the whole thing rises."

Lalit (overseas returnee)

4.1.5. Challenging the Status Quo

Challenging the Status Quo subcategory explores narrative that illustrates how systems and culture in the Indian healthcare system perpetuate a way of practicing that did not effectively enable innovation and change in the physiotherapy clinical environment. This led to frustration and challenge to understandings that physiotherapy practice could be more than the prescription on the 'doctors orders'.

4.1.5.1. Maintaining the Status Quo

It was reported that a master degree qualification was seen as essential to enter teaching but was less valuable for developing clinical skills. Indeed many physiotherapy departments would not employ masters graduates (from India or overseas) in the clinical area, they encouraged them to move into teaching, and considered that they were over-qualified for clinical practice and that they would be bored working in the hospitals. A masters degree was described as a qualification for teaching and not for clinical practice. This scenario was described by the participants in different geographical locations across India, the exception apparently being reports that the large five star private hospitals of Mumbai would only employ masters graduates. FG3 participants considered that if masters graduates were be integrated into more clinical departments, that practice standards would be improved.

> *" I'm sorry you are over qualified and you'll get bored working here [in the hospital]. So I would suggest that you go over to the academic side. Why don't you apply to a university and become a teacher?"*
>
> Lara, FG3 (masters in UK)

It is theorised that two tiers of physiotherapy departments have emerged as a result of the reported segregation of masters graduates to work primarily in academia and their linked departments. Figure four illustrates the theorised routes of knowledge diffusion between the tiers of clinical departments and the IAP recognised educational institutions.

In tier one are the non-autonomous, medically controlled departments that remain entrenched in historic practice; they prefer to employ conforming therapists, and are headed by those resistant to change and with no incentive to change. The participants identified that the style of practice in these

departments was very different from the way they were trained to practise using clinical reasoning.

> *"...we are also not able to implement, no able to incorporate whatever we have learnt. So that is the thing I think basically lagging, because they are very particular about giving a very conventional sort of treatment"*
>
> Srishri, FG2 (studying their masters in India)

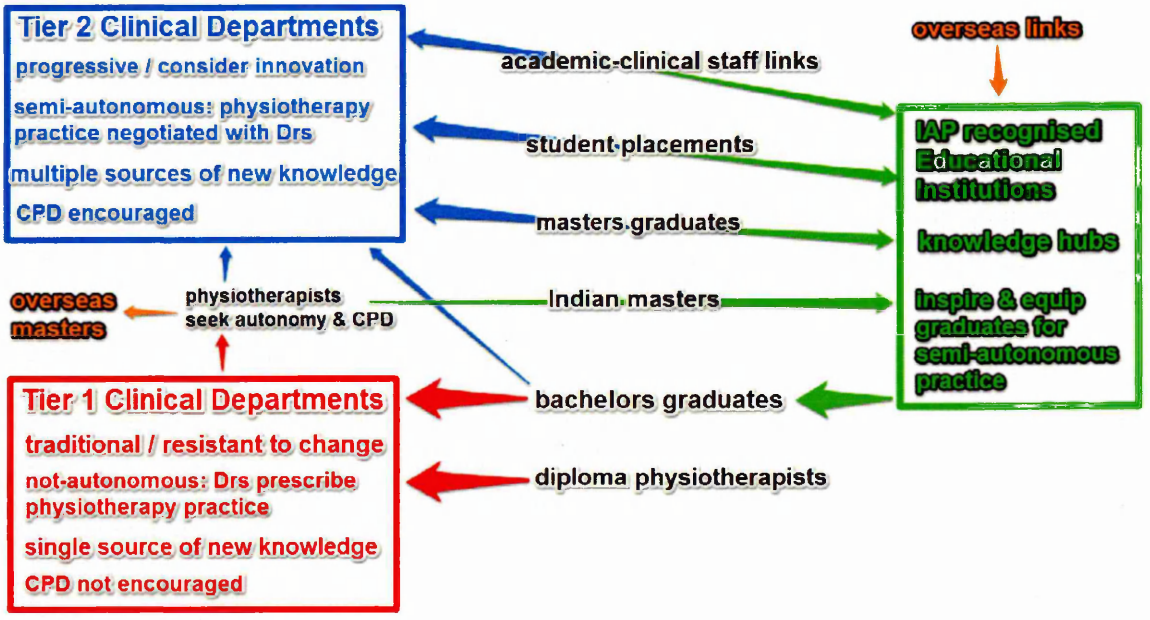


Figure 4: Sources of Knowledge Diffusion between Educational Institutions and the Theorised Two Tiers of Clinical Departments.

Treatment would be followed exactly as the doctors had prescribed; for example "*frozen shoulder - pendulum exercise and IFCT*" (Mindha). The department hierarchy was such that, as juniors, they could not change things and must do as they were told. They were critical of the very casual work culture that was clearly determined by the head of department, who due to historical, hierarchical structures were often diploma qualified physiotherapists and were

not seen as being knowledgeable, pro-active or open to any change. Lalit described them as "*parochial, and there is no incentive for them to change*" and suggested that "*good physios from good colleges won't work in these hospitals which pay less, so then the standard of physios in these big hospitals remains low*".

The tier two departments are semi-autonomous and progressive departments. Often linked to physiotherapy colleges or corporate hospitals, they would employ masters graduates who would have more knowledge, be more critical and more embracing of innovation.

> *"...they want people with knowledge and they respect that knowledge and they allow you to chop and change things, come up with your own rules, as long you know what you are doing and you can back it up with evidence."*
>
> Lalit (overseas returnee)

The interviews indicated that collaborative academic/clinical environments were semi-autonomous and strove to use the evidence base and clinical reasoning in their practice; this was the culture within which physiotherapy students were being educated. These academic institutions and their clinical partners would increasingly equip future generations of graduates to become "*more thinking persons*" (Rani), with the skills to work in these progressive 'semi-autonomous' contexts. This appears to have created a significant divide between what is taught and the reality of physiotherapy practice for many.

> *"...the work scene is very different from the studying scene. So after doing my bachelors in Manipal where the studying standard was very high, and we were completely exposed to a different scene."*
>
> Bipasha FG3 (masters in UK)

There would be some circulation of masters graduates being employed at other educational institutions and so some 'brain circulation' and sharing of practice

and ideas would occur between educational institutions and the associated practice settings. However, it appears that the sole carrier of the more contemporary physiotherapy ideas and practice to many clinical work places was by new graduates, who due to the hierarchical structure and culture of departments, were not encouraged or empowered to implement or share the practice. Each cohort of masters graduates taking their ideas and enthusiasm back into the educational institutions to develop the undergraduate education, would further remove educational physiotherapy practice from the reality of everyday physiotherapy in India.

> *"In India there is a big gap between academics and clinical. People they say that who's in academic cannot come into the clinical area. And they just teach. And people who are clinicians they you know they stick to that."*
>
> Bipasha FG3 (masters UK)

Such perpetual segmentation would only deepen the divide between education practice and many clinical practice environments. Already it appeared to be creating a two tier physiotherapy provision underpinned by discordant identities - 'physiotherapy as it could be' and 'physiotherapy as it is'. Indeed, the gulf between the two clinical scenarios could potentially widen as the progressive colleges and the academic linked clinical departments with their masters graduates would continue to advance practice, fertilised by engagement with innovative ideas and overseas developments. At the same time the non-autonomous departments could remain entrenched in their comfort zone being resistant to change and the more contemporary perspective of physiotherapy. Wackerhausen (2009) considered that such cultural environments developed immune systems, with defences which stifle any innovation or change that threatens the practitioners habitual, everyday practice. Similarly, Ricoeur (1992) suggested that if an identity is too grounded and stable it is can be difficult to change. Arguably, the divide between the skills and expectations of the graduating physiotherapist and the reality of employment would increase and

lead to significant disillusionment and frustration as graduates' employment experience would not meet their conceptualisation of physiotherapy.

4.1.5.2. Developing Frustrations

All the participants reported that low pay was a significant issue for physiotherapists. There was an unambiguous sense that pay levels were not commensurate with a degree level qualification and comparisons were made with degree qualified peers and siblings who were earning substantially higher wages. Minda and Lalit (overseas returnees) identified that although pay was slightly better in the larger private hospitals it was still "*horrible*". Participants also linked low pay with a perception of a lack of respect (personally and professionally). It was repeatedly stated that the lack of respect for physiotherapy was a significant issue and individuals felt undervalued. Lara in FG3, considered that "*with such low pay nobody would really bother to put in a lot. You know like I'm just getting this much, why should I put in so much work you know*"

Several of the interviewees linked variable quality and poor clinical practice with a lack of respect from the medics, and this lack of respect as the cause of low pay. They identified that the challenge for the individual and the profession was to improve practice, to gain reputation and respect, and so increase the pay.

> *" If you improve the practice and probably they will respect you more and give you more pay."*
>
> Lara, FG3 (masters in UK)

Throughout the interviews all participants reported a similar picture regarding the link between pay and respect but the more recent graduates were more emotional in their narrative. It was clear that there were a significant number of recently graduated physiotherapists who had been frustrated by the clinical context in which they found themselves post-graduation. The younger

participants reported that they had developed their understanding and experience of physiotherapy practice through placements in the clinical environments associated with their college, where discussion and clinical reasoning were encouraged. They then found employment in clinical environments that were prescriptive and protocol driven and where more independent practice was not encouraged. They felt unable to implement and incorporate what they had learnt as students. FG3 considered that the whole work ethic in these environments was different to their prior experience. It was described as less intensive, less knowledge based and more casual. They perceived that as a result of the low pay, the attitude was to delegate work to the intern in order to save their energies for the private patients that they saw before or after work. The net result was frustration and disillusionment.

" Working in India can get a little frustrating (...) you get disillusioned, you get de-motivated, and then you feel that you need to do something about that situation."

Bipasha, FG3 (masters in UK)

This experience of a disjuncture between training and the reality of many work clinical contexts appeared to be reflected beyond the participants interviewed, as Rani reported a similar message from her graduates.

" ...so what they understood about clinical practice was what they saw on our campus; and then when they go back to home town, that's not how it is and that they are very disillusioned with the, with what they are into and a lot of them say they want to move."

Rani (educator)

The graduates in these scenarios also reported not being encouraged to undertake CPD, and of there being no compulsion to develop clinically and professionally. FG3 participants considered that the culture of a lack of personal professional development in the workplace was perpetuated by the

predominance of female physiotherapists in India, who recognised that they were only in jobs until they got married and after that it would be the man who would earn the money.

> *"...if someone say's I've been on a course and I can do this and that, they're like, you're just wasting your money (...) I used to get that from my managers, 'why do you keep doing that, you don't need to do that.'"*
>
> Adeeb (UK PhD student)

It is interesting to consider the experiences evident in the interviews in the context of a critique of the professionalisation of some allied health occupations (but not physiotherapy) in America in the 1980's. Brutvan (1985) observed that many allied health 'occupations' that aspired to become a profession had focused upon acquiring the traditional attributes associated with a profession, and had neglected the professionalisation process, which resulted in intra-role conflict and a professional identity crisis. She considered that it was naive for allied health occupational associations to adopt a code of ethics and lengthy training programmes, without being able to guarantee their graduates professional status or occupational prestige. There were reported problems with job dissatisfaction, low morale and high attrition rates that resulted from a lack of occupational prestige, limited career opportunities and occupational burn-out. Graduates were frustrated that their expectations of being treated as professionals by physicians and patients were often not realised.

Brutvan (1985) emphasised that account must be taken of the implicit values embedded in the professional culture that have operated to concentrate power and prestige amongst physicians. Instead of focusing on the outwards signs and the professional image, more emphasis should be placed upon the process of gaining social control or professional autonomy, as this provides the key to an occupation's independence and ultimate professionalisation. There is resonance between the American allied health professions' experiences and the

Indian physiotherapy experience. Brutvan's assertion that there must be consideration for gaining professional independence perhaps provides assurance for Indian physiotherapy that the drive for autonomy is an essential component of the professionalisation process.

The more recently qualified participants reported that they compared themselves to their non-physiotherapist peers with similar qualifications, and perceived that as physiotherapists they worked as hard or harder, earned substantially less and as a result felt devalued. Some participants described feelings of turmoil in that they were not satisfied with their profession in India, but they still believed in physiotherapy, they enjoyed being with patients, and have proud relatives. They then looked at colleagues in hospital administration and saw that they were paid substantially more and drew greater respect. Studying an MBA to facilitate a change in profession (often to hospital administration) was one commonly cited career move for physiotherapists. The participants reported hearing from physiotherapy 'seniors' and peers that practice overseas was quite different but any move away from physiotherapy in India was not taken lightly by many. There were reports of having "*a duty to serve India" and "a duty to improve"* and not "*to simply criticise the system*" (Suhani, FG2). The focus group (FG1 and FG3) participants who had travelled overseas identified that for many it was not so much about leaving physiotherapy or indeed leaving India, but was about leaving Indian physiotherapy.

" My friends say 'If I am a physio in India, I will change my profession or I'll go abroad and work there as a physio. I don't want to work as a physiotherapist in India."

Lara, FG3 (masters in UK)

The narrative may be interpreted as a clear sense of rejection of the profession and the role or identity that they have had to adopt within that profession in

India. They are unable to practise and be the type of professional that they are trained to be. They appear to feel unsupported to engage in professional development within India and there is a lack of clarity regarding which direction the profession in India will take and how they identify their role within the profession. It is theorized that for some who embark on the journey overseas they are rejecting not India or the concept of physiotherapy but their identity as a physiotherapist in India; they seek to develop a different construction of what it means to be an Indian physiotherapist.

It may be postulated that whether an individual travels overseas or chooses to stay at home is partially dependent upon a complex interplay of influencing social and cultural factors, together with the drive for professional achievement. Members of FG2 did not travel overseas and had elected to study their masters in India, they reported that parental influence requiring them to stay home was a significant factor. Lack of finances was also key to the decision to stay in India and, to a lesser extent, a lack of confidence about their ability to adjust to the difference in study, living and generally coping overseas were also identified. Each of the FG2 participants identified a combination of parental, financial and personal factors that resulted in their decision to study in India. Monica and Madhuri both identified that they had no desire to travel and preferred the Indian masters degree as a preparation for working in India.

"I never wanted to go abroad because I love my, like, I never wanted to go away from my parents."

Monica FG2

"I was not that strong as of financially. That was one big reason for me to be, like doing my masters from India and there was some personal reasons also."

Madhuri FG2

4.1.6. India a Land of Extremes

India is a land of extremes and contrasts in multiple contexts, be it the wealth divide or the geographical and climatic extremes. The interviews suggest that physiotherapy in India reflects this culture of extremes. All the interviewees described and gave examples of excellence, innovation and development that they had experienced within Indian physiotherapy. This excellence ranged from educational institutions that were striving to develop and harness evolving knowledge, thinking and educational approaches, to departments where clinical practice was developing within a rapidly expanding private healthcare system, where physiotherapists could operate in an informal 'semi-autonomous' fashion. The more experienced described how the constructs of clinical reasoning and evidence based practice were being explored and interpreted. The interviews took place with enthusiastic physiotherapists who were self-motivated to undertake continuing professional development and fulltime masters courses, and also with experienced, 'worldly' physiotherapists paving the way for a developing profession. Throughout the interviews there was a narrative that highlighted a vibrant and emerging physiotherapy community that was striving to develop physiotherapy practice in India.

In contrast the same interviews also portrayed a darker image of physiotherapy in India; one where there were varying educational standards, minimal governance assuring quality, varying clinical standards and restrictive clinical contexts, where hierarchy and the doctor's prescription of rehabilitation dominated. Due to the political 'merry-go-round' that changed direction according to 'power plays' that were inherent within the Indian political system, the profession was struggling to position itself as an autonomous and regulated professional body. Physiotherapists were reported to be in constant conflict and negotiation with the medical hierarchy under which it serves. There were reports of individuals within the profession feeling underpaid, undervalued and

experiencing a lack of respect, who were striving for professional autonomy. There was an unbridled passion for a common objective of an autonomous and respected profession but a lack of consensus and coherent leadership for how it should be attained. This more sinister narrative has resulted in a generation of disempowered and disenchanted physiotherapists who seek a better life and a better profession.

4.2. Going Away

The 'Going Away' subcategory captures the aspects of the journey that takes the Indian physiotherapists overseas. It explores the narrative around what draws them overseas and why. From various sources they heard that physiotherapy and education was different overseas and this difference was alluring to them. A principle motivator to travel overseas was for personal and professional development, the context of which was explored. Working overseas was a key element of the journey, and its relationship to pay and personal development was explored.

4.2.1. Hearing it's Different

Throughout the interview narratives, there were reported perceptions of difference, experience of difference and a desire for difference. To understand the complexity of this difference, it needs to be considered in the context of 'Back Home', the education, clinical and social context that has underpinned the formative stages of the Indian physiotherapist's journey. 'Back Home' is the baseline from which the difference must be interpreted. It has been established that disjunctures and frustrations exist for many recent physiotherapy graduates, working within Indian contexts. Some have left Indian physiotherapy and seek something different.

Participants who travelled overseas reported hearing from families, seniors or peers who have travelled overseas and return to India, that education and physiotherapy practice outside India was very different.

"Developed countries like UK and USA, physiotherapy is more developed and techniques and skills what they are used is totally different from in India."

Suhani, FG1 (just arrived in UK for masters study)

Lara (FG3) considered that the Indian courses and workplaces were often isolated and it was only when an Australian visited for a conference that she realised that education was different outside India and that inspired her to seek experiences away from India. For others (Adeeb and FG1) the influence of role models was important. It was not just about conveying the message of difference and sharing knowledge and ideas, but also images of success, that were accessible and could be emulated.

"I see that someone (....) he's gone to England (...) got their MSc and they're settled there, and they are satisfied, that's the main thing, because that's what we projected, that I am professionally satisfied now. While there's a lot of professional dissatisfaction in India. So that I think role models who are satisfied with the profession in India, there are not many of those."

Adeeb (UK PhD student)

For the physiotherapists in India seeing the potential outcome of the journey was influential; the different ways of professional practice, perceptions of professional satisfaction and personal reward, which they felt that they too could achieve if they travelled. Figure five illustrates the suggested role model journey.

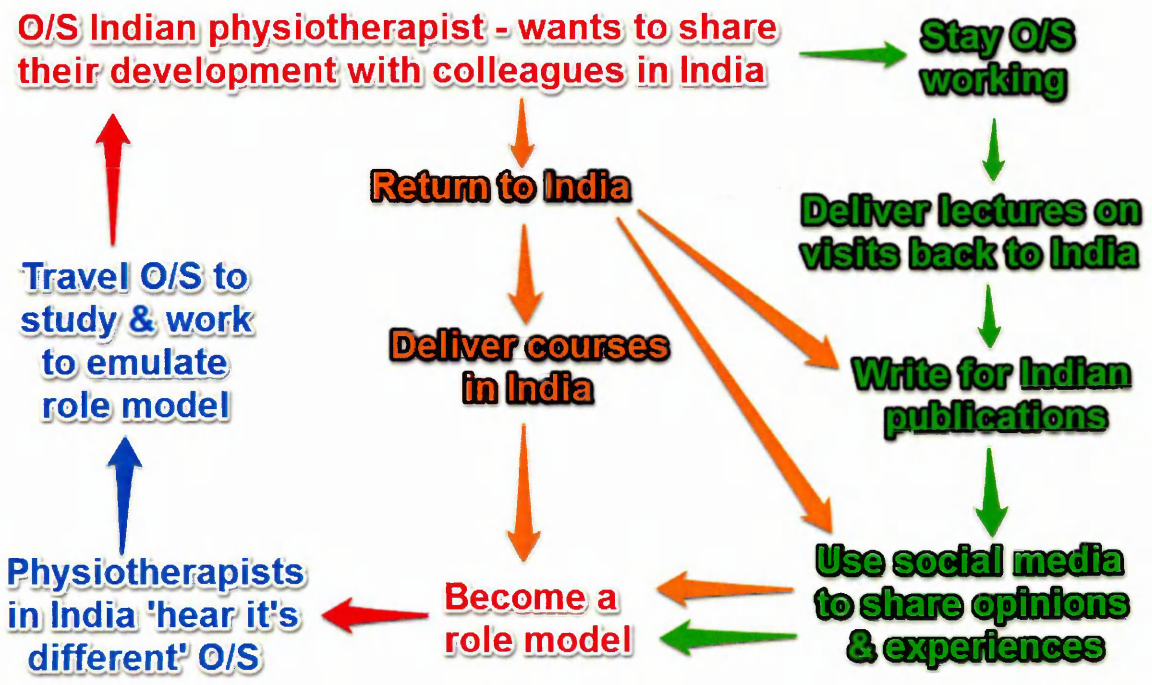


Figure 5: Overseas (O/S) Role Models Journey and Impact

Bauman's (2000) observations support the reported influence of overseas role models on the physiotherapists. Seen from a distance they possess a coherence and a unity, the distance blurs the detail, and individuals will view other peoples' lives as works of art at a single point in time, and will try to emulate them and achieve their own works of art. Sceptically Bauman considers that this is impossible as these works of art are identities that are fluid and constantly change.

The participants reported three key areas as being perceived as different overseas: knowledge, education and physiotherapy practice. Those who had travelled overseas (except Rani overseas educator) all identified that they were seeking knowledge that was not available, or of a high enough standard, in

India. The types of knowledge varied, specialist subjects such as sport science, ergonomics and research were sought, alongside the "*latest techniques*" and *"technologies"*, and skills that were the most "*updated*". Other participants described that it was about identifying differences in course content, differences in conceptual approaches or courses that had a very specialist focus. Closely related to the differences in knowledge and its application there were perceived differences in physiotherapy practice identified in terms of practical techniques, clinical reasoning, evidence based practice and autonomy.

"*...they provide the good knowledge and in terms of the updating of the latest technologies, latest knowledge, and everything.*"

JK, FG1 (just arrived in UK for masters study)

"*I wanted to get into a background which was a little different from what we did here.*"

Minda (overseas returnee)

The reports of differences extended to education, with quality, facilities, research, evidence base, syllabus and assessment all identified as distinct from India. The different overseas pedagogical approaches, variation in delivery, critical evaluation and assessment styles were all identified as challenging to participants, but were valued especially for their flexibility and ownership in what was learnt.

" ...they provide very good research facilities, course flexibilities which we don't have in our country."

JK FG1 (just arrived in UK)

"*...very different style of teaching compared to India (...)* there is a lot of flexibility."

Lalit (overseas returnee)

The only negative difference that was identified was the lack of exposure to the clinical environment during masters level study.

This narrative around seeking different attributes is resonant with elements of Lyotard's (1984) postmodern discourse on the commodification of knowledge. He contends that knowledge is a commodity that is produced in order to be sold; educational institutions through marketisation, have become providers of a commodity that is invested in. Students are rationally autonomous consumers, choosing and seeking out the best value for their investment; and the relationship between the two has moved from a pedagogical to contractual. The market is global and the Indian physiotherapists cannot find the commodity that they want in India, but through digital technologies they identify that the desired commodity is available overseas. The influence of role models supports Lyotard's assertion that knowledge is no longer an end in itself but is a commodity that must have "*use-value" (Lyotard 1984, p5);* they need to be able to see how the acquisition of different knowledge may be of value to them professionally.

"I wanted some knowledge which wasn't available here, it was available there and so I had to go and get it."

Lalit (overseas returnee)

The difference between Indian physiotherapy and the profession overseas was an area that all participants referred to. It was perceived that there was a greater respect for physiotherapy as a profession overseas, and that the physiotherapists' knowledge and skill set was valued by doctors and by the public. Participants linked this difference in respect with the autonomous position that physiotherapy holds in many countries overseas. Also noted was the difference in practice and salary; this combination of difference in respect

and working practice was something that the participants wished to be a part of and to learn from. There was also an emphasis on a seeking different experiences and seeing physiotherapy practised in a different way.

"I think it is really important to go and see how physiotherapist work elsewhere, because that work is entirely different from here (...) the concept of physiotherapy as a whole was quite different from what it was here."

Minda (overseas returnee)

" ...they've heard from, you know, their friend, their seniors, that's what we do for work and that's how we work our way out, they want that "

Rani (educator)

4.2.2. Developing Self

Self development was a key motivator for individuals travelling overseas and some reported that the sole motivator was to enable them to practise better and be a different physiotherapist. Others identified that this self development was just one step on a long and complex journey linked to pay, respect and wanting a better life. The interviews captured different strands that individuals identified they wanted to develop. These included intellectually based elements such as gaining knowledge, developing academically, and learning how to think. Rani (overseas educator now returned) identified that she sought a different experience to allow her to develop. The more complex constructs of personal professional development and the ability to work effectively in different clinical contexts were also sought.

In order to develop themselves the participants identified that they wanted to acquire the knowledge that they had identified to be different from what was available in India. The discussions focused very much on specialised knowledge, skills, techniques, research, different ways of learning and different ways of practicing. Daisy (FG2) referred to a search for the *"missing link"*, Ashna identified that she had not fully understood what the course would entail until she started it. FG1 (new arrivals for UK MSc study) talked about differences and what they wanted to achieve but appeared to not have a clear conception of what the difference was, other than it was something that was not available in India and it was what they perceived they wanted.

The participants who had completed their overseas study were able to articulate much more clearly the difference and the value. They talked about developing new academic skills such as clinical reasoning, critiquing and really understanding what evidence based practice was. Ashna described it as a "*mental training*" and "*learning to think*" rather than just learning skills. She considered that she had become *"more questioning", "more analytical", "more critical"* and *"more sceptical"*. Lara FG3 described it as *"you basically learn to learn"*. Rani had travelled overseas to work as an educator and it was not until she got there that she appreciated just how different overseas education was compared to Indian education. *"The delivery teaching style was also different (...) So I had to actually go and attend medical education courses."*

Professional development is another concept that was alluded to by the participants as a consequence of gaining knowledge. There were two faces of professional development presented. For some the term was used synonymously with an individual's personal practice development, from the perspective of developing new skills, knowledge, ways of thinking and practising clinically. The development here was internally focused and supported by a

desire to be a better physiotherapist and to treat patients as effectively as possible. Others referred to professional development in relation to how their new expertise would allow them to develop their careers, putting them ahead of others in challenging and competitive working environments. Development here was more externally focused and related to their career in terms of success - financial reward, recognition and respect.

There was a gender bias apparent between these two different focuses on professional development, with the participants identifying that females placed a greater emphasis on the development of both clinical expertise and personal self development, as ultimately they would be expected to marry and follow their husband's wishes and not be the main income earner. Whereas, for males the emphasis was on the longer term and more externally focused rewards associated with a successful career. Clinical skills and knowledge development were a stepping stone towards successful career development and ultimately increased earning potential. This reflects the influence of the 'Being Indian' social and cultural considerations.

"The male in India is the head of the family and he probably is the sole earning member here and he has to earn that kind of money (...) so his aspirations towards wanting to a learning, to moving ahead would be quite different to a female."

Minda (overseas returnee)

"But then the women who do come abroad are very motivated (...) They want to be independent. They want a better standard of practice. (...) They want to improve their situation and don't want to get complacent with the kind of work they are doing."

Bipahsa, FG3 (masters in UK)

Additionally some participants identified that the acquisition of an international postgraduate qualification in its own right was an important element of their journey. It was identified as an asset for the future and one that would symbolise their personal professional development, their journey, their international knowledge base.

"... to get a good MSc degree from a well qualified or equipped university from a developed country. That's what the main motivation for me and I think that will make an asset for my future."

Dinesh, FG1 (just arrived in UK)

This aspiration links again to Lyotard's (1984) commodification of knowledge but it also resonates with Bauman's (2000) ideas on the freedom of consumers to achieve self-identification through the acquisition of merchandisable commodities to stay ahead of others. The participants clearly viewed physiotherapy outside India as a global market and were looking for the location and institution that best met their bespoke and well considered needs analysis.

4.2.3. Working Overseas

For most of the respondents who travelled overseas gaining international clinical exposure was identified as an significant part of the journey. They had heard that physiotherapy practice was different outside India, that it was autonomous and by working they would be able to see and experience that difference. The participants interviewed aspired to gain the clinical practice experience prior to returning to India although most were finding it very difficult to find paid clinical work in the UK due to the shortage of jobs. Ashna (clinician/ educator) was the exception here but she had sabbatical leave from her job in India to study overseas and she identified that she did not want to work in the UK as she felt there were constraints within UK physiotherapy practice.

Whilst clinical work with pay was the preference, clinical work without pay was highly valued and failing that at a very minimum, clinical observation opportunities were sought. As a supplement to this some also considered doing some short CPD courses to gain further exposure to physiotherapy practice in the UK.

> *" I am still like really trying to get a job or an observership somewhere just to see how it is, how physiotherapy is practiced over here; just to get some kind of work experience (...) attend some workshops and courses, short courses."*
>
> Lara, FG3 (masters in UK)

As a way of covering their living costs, non-clinical work with pay was sought after but for an entirely different underpinning rationale. It was reported to be related to the notion of "*earn and learn" (George, FG1)*, and was about supporting themselves whilst they studied, to minimise the debt incurred and to pay back family or bank loans prior to returning home. Pay in India was reported to be so poor that it would never pay off the debt that overseas study incurs. Paid clinical work was aspired to by the participants as it allowed both the financial and professional development needs to be met simultaneously.

Several of those interviewed had decided that if there were no jobs in the UK or if they did not like the work context, they would seek out other countries in which to practise. Their selection criteria were based upon where physiotherapy was respected and where the clinical practice was perceived to be good. The US, Canada, Australia and New Zealand were specifically mentioned. This continued global mobility was identified as being about a better place to work for themselves, quality experience, respect and pay. They were seeking the complete package.

"New Zealand (...) the reputation that they give to the physiotherapists is really good (...) the pay scale is good and the practice (...) and mainly right now they are really focused on hands on technique."

George, FG1(just arrive in UK)

All the participants who were still overseas expressed a clear desire to return to India to work. Throughout the interviews the physiotherapists frequently referred to the time when they would go back to India, it was 'peppered' throughout the narrative and not just when they were directly asked about their plans. For some, also scattered throughout the narrative, was the intention to work overseas for "*some time*"; the timeframe for preferred return ranged from one year to ten to fifteen years. The availability of employment overseas was one factor determining the period of migration but it was also about when the right opportunity came up in India and when they identified that that they had met their travel objectives (financial or professional) and gained the clinical experience they required.

Whether a globally mobile physiotherapist would return to India or not was an issue that was debated yet unresolved. The educator participants all expressed an expectation that many physiotherapists would migrate permanently and would not return. Clearly several of those interviewed had already made the return journey and others were planning to do so but for those who had not there was an acknowledgement that the longer that they were away from India the harder it would be to return, as they become more integrated and settled overseas.

"I've been thinking of going back for 5 years now. It's the timing. I think once I have got my PhD."

Adeeb (studying PhD in UK)

Khadria (2004) documented that Indian nurses perceived their move overseas to be permanent but that doctors and IT professions planned to return as there were good career opportunities in India. Haour-Knipe and Davies (2008) considered that nurse migration flows were increasingly circular with people moving backwards and forwards, and migrating onwards. They identified that the patterns of movement were highly complex and shifting rapidly. The participants in this study demonstrated a desire to return but acknowledged the complexity of return.

4.3. Taking Back

The final stage on the globally mobile Indian physiotherapists journey is going home and taking back their learning, experiences, professional practice and ways of working. The 'Taking Back' subcategory captures the issues associated with returning, how India needs and values returning physiotherapists, but also the challenges associated with facilitating the return. It highlights anecdotal evidence of overseas knowledge influencing physiotherapy education and practice. The challenges and perspectives regarding the sharing and effective application of the 'different' overseas knowledge to practise in India were acknowledged.

"I'm very fine with people wanting to go out and you know look for other ways of doing things and learning. It would also be nice to see some of them coming back and trying to put that back into our systems. So, but for the percentages that go out, we see a lesser number coming back. So and since India needs physios, I think we have to try to analyze for ourselves why we are not coming back, there is a bit of introspection that has to be done and we are not making the environment conducive for them to want to come back."

Rani (educator)

4.3.1. Returning

The participants all identified a disjuncture within physiotherapy in India; there were some unemployed physiotherapists but there was also a need for physiotherapists to meet India's significant health requirements. It was reported that over the last decade that a considerable increase in numbers of variable quality physiotherapy colleges had resulted in an increased number of physiotherapists graduating. It was also identified that there had been a growth in the number of new private sector hospitals who employed physiotherapists. The government sector public hospitals were reported not to have increased its numbers of physiotherapists in the last 25 years, despite a need for more public sector healthcare provision to help address Indian's significant health challenges. It was evident that the private sector expansion had not been sufficient to absorb the numbers of physiotherapists recently trained and so there was an over-supply of physiotherapists. Whilst there was a need for more physiotherapists in the public sector, participants identified it was not a conducive working environment for returnees.

"...the more the number migrating to the other country, definitely it affects (...) providing the services to the communities, communities also getting affected. There is a lot of detrimental effect on."

Manish (educator)

Throughout the interviews the participants (those who had travelled and those who had not) referred to the perception that 'India' valued overseas returnees, their education and experience whatever their professional background. The general public and the medical hierarchy valued the label and the associated knowledge and skill set of someone who had undertaken overseas education. The participants who travelled overseas suggested that this subsequently led to increased professional recognition and respect. It was reported that the overseas masters qualification was valued and respected, and often considered

superior to the Indian masters degree, particularly by clinical employers. The educators all identified and valued the international perspective that returnees brought to the curriculum and there was a recognition that they return with different skill-sets, clinical reasoning, independent thinking, creative thinking, confidence in discussion and research expertise. This was combined with an enhanced professional maturity and confidence, all of which they felt could be valuable to enhance the physiotherapy profession in India.

> *"Yes it was valued. Everyone would turn around and I was probably one of the first few people who did a UK masters and came back to work (...) So it was kind of looked up at... [KG - by patients, colleagues and medics?] Yes, for all of them "*
>
> Ashna (overseas returnee, now clinician and educator)

There was consensus across the interviews about the challenge of facilitating physiotherapists return. The participants who had travelled overseas emphasised that timing the return was a key issue. They needed to return into the right job or have sufficient experience so that they could return at a higher level (pay and hierarchical) than they had left; this ensured that they felt that the investment of their overseas journey was being returned in some form of career development. Some participants report that this had been possible, and other subsequent opportunities had emerged as a result of their overseas education and experience. For example Lalit had returned to an acceptable job part sport physiotherapy and part pulmonary rehabilitation but had subsequently moved onto his ideal job which *"would never had got it if I had never done my degree".* Self-employment was a frequently reported aspiration but it appeared to be a much longer term objective due to the logistics of developing a reputation locally.

Minda identified that she had returned to a job with her previous employer, because it was an environment where she knew that she could implement in-

part the practice that she had learnt overseas and gain more experience whilst seeking to establish her own clinic. She reported that there was still protocol based practice and that she had to persuade the patients to accept a treatment other than what the consultant had prescribed. She identified that she had received a significant pay rise because of her a masters degree; despite this apparent success, she identified that she felt a "*little stuck because I am back to where I was really*". However she considered her return to be more successful than a friends which she described as

> *"...back to working the same mechanical way that they were working earlier, just to do a job; because they are again following protocols, again very focused on electrotherapy, as opposed to applying what they have learnt over there.*"
>
> Minda (overseas returnee describes a friends experience of return)

There were several reports of others who had returned and had found it difficult to get what they felt was the right kind of job. Some had reputedly given up working as physiotherapists as they were so frustrated with working in the hierarchical model with very poor pay. It was evident from the interview narratives that it is important to find an environment where returnees new skills could be used and that they could operate effectively in a semi-autonomous manner, with sufficient pay remuneration to have made their overseas journey worthwhile.

The participants' understanding regarding academic employment varied. The overseas masters was reported to be valued by employers, colleagues and the public generally. Manish (educator) identified that he liked to employ international returnees to help develop the curriculum to incorporate international standards; he considered that the overseas masters was recognised in India. Ashna (overseas returnee, now an educator) identified that

initially she had had problems with Indian recognition regarding the duration of her master's degree but stated that when she had presented her certificate and identified that that was the required duration in the UK, that it was acceptable for most people. The IAP was the significant exception and they had identified that she would not be absorbed into a university.

Rani's narrative clarified that the returning physiotherapist with a masters of less than two years duration, would be recruited but would be unable to progress beyond the position of an assistant professor. She identified that the federal body (Indian Universities Equivalency) that judges whether a qualification was equivalent used three criteria, the entry level must be the same, the content must be 75% similar and the duration of the programme should be the same. The Indian masters degree must be at least two years long and in some states it was three years (reportedly to match the medical masters study time and to raise the profile of physiotherapy). Therefore the overseas masters degrees that were studied in less than 24 months were rated as equivalent to a postgraduate diploma. Rani identified that the intensity of the study and the learning outcomes were not considered in equivalency assessments. She reported that the time spent studying was effectively a quality control system; therefore if an international masters of less than two years duration were to be recognised as equivalent, it would effectively devalue the Indian qualification.

> *..."they get bogged down by years of learning rather what went into that learning, the Indian system of education in that sense is obviously a bit rigid."*
>
> Rani (educator)

In summary, the key elements that support successful return were respect for their overseas qualification and experience and an ability to transfer the

overseas practice into the Indian work context and pay. The factors that deter the physiotherapists from returning were essentially the same factors that underpinned their initial migration. FG3 identified that it was not so much about not wanting to return to India but was about the state of the profession in India.

4.3.2. Knowledge Transfer

When the participants were asked about knowledge transfer back to India they struggled with the question; it appeared not to be something that they had really considered before and the returnees did not appear to perceive that they were contributing to transferring knowledge. Throughout the various interviews there was evidence that individuals had implemented learning gained from their overseas experiences into their current working practice. For some this was just about their own personal, professional clinical practice within their working context and within the system constraints. However, it often extended to sharing their knowledge and perspectives with other colleagues, thereby providing opportunities for others to take the learning on board and to change their practice.

"So, yeah that has happened and they are interested in knowing what new things or different things that I have learnt from there and come back, yeah."

Minda (overseas returnee)

"Yeah. I can say that 30% of our change in the Indian practice is basically because of the international students those who are trying abroad, come back they give their view and thereby there are changes."

Manish (educator)

The educationalists reported that they had implemented ways of thinking and ways of working and ideas that they had acquired whilst they travelled overseas. They identified that this sharing of practice had impacted upon other colleagues involved in education delivery who, in turn, changed their educational approach to comply.

> *" So there when we kind of complete the circle with my input and their input, I feel that we structure our teaching methodology better than other colleges."*
>
> Ashna (overseas returnee, educator)

They considered that these changes then influenced the educational development of the students, their expectations and the way they were equipped to function as newly qualified physiotherapy professionals. However, as has been identified, if the students then go out into *'parochial'* work environments, they often become frustrated with the employed clinical context not matching their training.

FG1 (just arrived in the UK) talked about changing practice across the profession and the health sector, but felt the challenge would be too much for individual returnees. The aspiration to improve practice in India seemed to be an important element for those who were more recently qualified and there was a clear sense that to effect this level of change, return was required. Also for this group there was minimal emphasis on sharing practice, possibly because there was a perception from many of the participants that those who returned to India did not share their expertise; they identified that this could be due to the competitive nature of Indian culture as, returnees needed to capitalise upon their investment and did not wish to share their knowledge with competitors. The interviews with those who had returned, identified that they felt they needed

more experience prior to setting up the continuing professional development courses that they perceived were a key route to sharing their knowledge.

It was identified that the overseas diasporas network was keen to share its knowledge either through lectures for academic staff or students when they returned to India on family visits, or through setting up online journals or discussion forums. Most participants considered that to influence effectively the profession and practice in India the physiotherapist should return. A need that was identified during some of the interviews was the establishment of a support network for those who had returned. The challenges of return for clinicians focused upon the ability to apply and utilise the international physiotherapy knowledge and ways of working but also to support the dissemination and sharing of practice.

King (2000) described different types of return, retirement, failure, conservatism and innovation. 'Return of failure' was where migrants had failed to adapt to their host country and this was identified as a concern; whilst UK visa changes had perhaps 'forced' an earlier return than some participants had planned, there was no sense that they had failed. 'Return of conservatism' was planned for, once goals had been met, often related to remittances and savings, they did not aim to change the social context they left. 'Return of innovation' was where migrants remain overseas for longer than planned, and return with ideas, values and ambitions. They considered themselves innovators and carriers of change. The participants interviewed in this study fell between King's conservatism and innovation categories; they aspired to innovation but felt constrained by the social context. The increasing return of physicians to India arguably falls in the innovation category and it is postulated that these entrepreneurs could help to change the character of medical practice in India and create a better

environment for nurses and other health professionals when they return (Haour-Knipe and Davies 2008).

The narrative captured within the journey category illustrates the complexity of the context from which the Indian physiotherapist originates, the significance of social, cultural, political and economic influences on the decision to travel overseas and also their influence upon the decision and ability to return. The challenges that the Indian physiotherapy profession faces, as it strives to establish its position in the Indian healthcare infrastructure, has clearly impacted upon individual physiotherapists as they have worked to develop their skills, thinking and role in order to deliver more effective physiotherapy practice. The importance of personal professional development, the desire to engage with different experiences, skills and knowledge and a global perspective on physiotherapy practice, all underpin the Indian physiotherapist's journey. Embedded within the desire to travel overseas and fuelling the journey was the ultimate aspiration to achieve a better life. The elements that underpin this ambition were identified by the participants and are discussed in the next chapter, 'Wanting a Better Life'.

5. Chapter Five: Wanting a Better Life

The 'Wanting a Better Life' category is drawn from an in-vivo phrase and was formed to capture the long term aspirations of Indian physiotherapists and many of the underpinning issues. This chapter explores what 'Wanting a Better Life' means to the participants and how it influenced their journey of exploration of difference. Within the category there are three subcategories: 'Pay', 'Respect' and 'Professional Development'.

The interviews indicated that they are all associated with each other and each held varying levels of importance to the different participants. All are significant influences throughout the journey and the narrative that supports each of the 'Wanting a Better Life' subcategories is the same narrative that supports 'The Journey' subcategories; figure six illustrates their suggested inter-dependence.

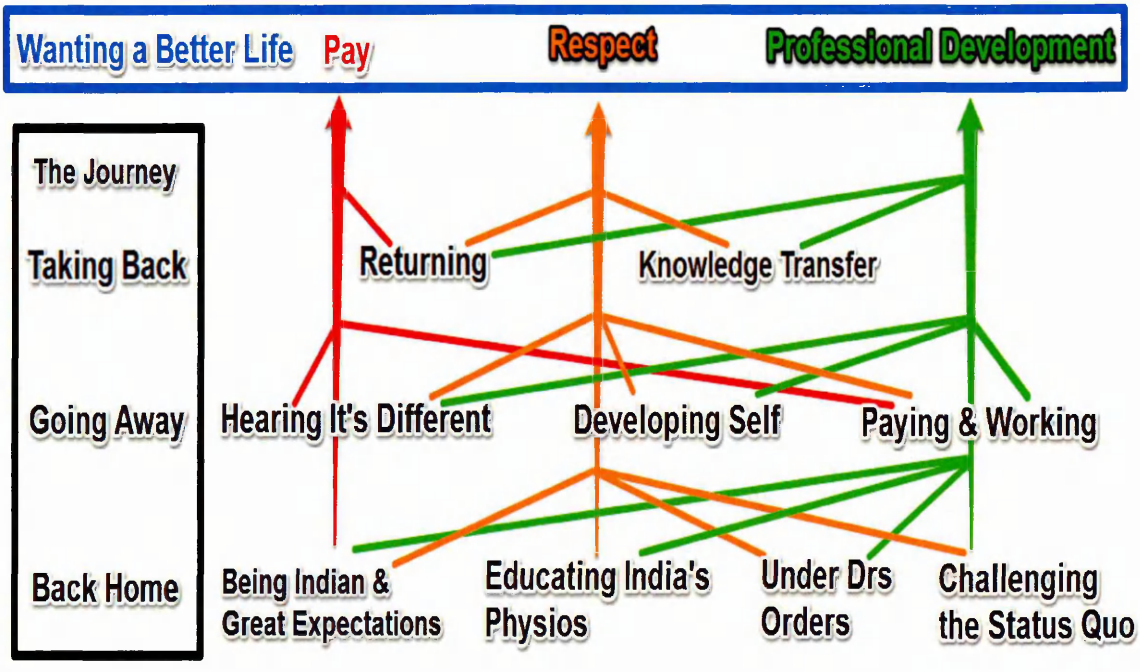


Figure 6: Wanting a Better Life and The Journey Interconnections

" A lot of people don't want to go back to India because I think they just don't want to go back to that practice. And being alone it is really difficult to change practice, you know. And they just ***want a better life****, because in physiotherapy especially for guys getting that sort of pay is not very good, because then they won't get married."*

Lara, FG3 (overseas MSc about to return to India)

The term 'Wanting a Better life' in the context in which Lara used it, illustrates the complexity of what a better life might incorporate; the importance of professional satisfaction and practice, the challenge of changing the cultural context in which practice occurs and the detrimental effect of low pay for males on their position within society and sense of self worth. Other participants also frequently used the term *"better"* associated with prospects, practice, earnings and quality of life across both professional and personal dimensions. So, not only was overseas perceived to be 'different', it was also perceived to be 'better'.

"...the main reason behind their moving from here to there is the better job prospect, the better living, better standards of living. According to me it's the main thing other than the respect."

Adeeb (studying for PhD in UK)

It was not just the more recently qualified participants who had travelled who articulated a dissatisfaction with their pay, perceived lack of respect and desire for more autonomous working; FG2 who were studying for their masters in India, vociferously echoed these concerns. The 'Back Home' subcategory captures the habitus that underpins the Indian physiotherapists frustrations and their aspirations. Aspiring to a better life is not unique to physiotherapists in India but it is well documented as a motivation for overseas migration generally and for nurses specifically (Khadria 2004; Vujicic et al 2004; Sparacio 2005; Kingma 2006; Vincent-Lancrin 2008). Indeed, aspiring to self improve and

better one's circumstances and hierarchical position was observed to be embedded in India's culture and amplified by its society. This was reflected in the bookshops and street stalls of India, which were crammed with self-help and development books, all offering the promise of greater success and personal fulfilment. Foucault's concept of 'bio-power' effectively captures such practical rationality as a way of governing, managing and controlling the behaviour of a population as vast and diverse as India's (Gastaldo 1997). This conceptualisation of control and influencing behaviour is illustrated in Bipasha's statement:

> *"...because I felt that I needed to do something else, because work was getting a little monotonous, frankly speaking. And I thought that may be if I come and do my masters internationally, I'll get an edge over others (...) I wanted to make my situation better. I was getting bored with my work in India and I had to do something about it basically."*
>
> Bipasha, FG3 *(overseas MSc about to return to India)*

Ashna and the FG3 participants all identified that they sought further academic challenge which they suggested was not available to them in India. FG3 participants all found their work places monotonous but Ashna emphasised a frustration with the physiotherapy establishment rather than her work place. She was a diploma qualified physiotherapist who had subsequently studied an Open University degree but was unable to progress to a physiotherapy masters programme in India as she did not possess a physiotherapy bachelors degree. Her words echoed a desperation that she could not achieve her potential in India and only by leaving India could she continue her professional growth.

> *" And I couldn't just stay like the way I did. I wanted to do more (...) It was pure personal zeal to improve on my current educational qualification."*
>
> *Ashna (now studying for a PhD)*

It is postulated that by travelling overseas the Indian physiotherapist feels empowered to achieve the better life to which they aspire. They would access opportunities for personal professional development through education, different work environments and experiencing different cultures. Participants perceived that their professional development and employment would lead to increased respect and better remuneration. However their attainment of a better life overseas had created a challenge for their return. Adeeb considered that he had a better life in the UK and felt settled but that he would return because of the importance that he placed on family. The return migration literature reflects this tension and suggests that the resolution relates to the importance of returning to an environment that is no less dynamic and to an increasingly globalised economy (King 2000; Haour-Knipe and Davies 2008).

"I think, I've got a better life here now, I am very well settled here. So I don't think I'll get a better life there."

Adeeb (PhD student settled in UK but planning to return to India)

5.1. Professional Development

Participants who travelled overseas to study or to seek new experiences through work, gave a clear identification that they were striving to fulfil their personal professional development needs. The 'Developing Self' section of the 'Going Away' subcategory captures the key elements that participants articulated as important; gaining new and different knowledge, and developing thinking and reasoning. It also documents the focus on professional development as an internal personalised activity that may have subsequently led to extrinsic career development opportunities.

"So to learn skill techniques and I want to gain more knowledge. That's why I am here."

Suhani, FG1 (just arrived in UK for masters study)

The participants identified that physiotherapy practice in the overseas destination countries was different from the way it was practised in India, and most wished to *"experience the work styles to see what is different"* (Rani). The narrative demonstrated how many Indian physiotherapists were frustrated with the Indian hierarchical prescribed practice and sought to engage with autonomous practice. The development of knowledge and skills to enable them to engage effectively and to understand the different ways of practising, were identified as an important elements of their overseas professional development.

"And the thing about the practice here is really good. The research from UK is really good. And then autonomous, again."

Bipasha, FG3 (studied UK, about to return to India)

"The aspiration was mainly was to learn as much as I could in terms of what physiotherapy was there [overseas]; the concept of physiotherapy as a whole, learn new techniques (...)and basically just getting as much as knowledge as I could so that I could come back here and practise better."

Minda (overseas returnee)

Professional development and professional knowledge are attributes that align with the characteristics associated with an individual's professionalisation (Richardson 1999). The participants wanted to increase the breadth and depth of their physiotherapy knowledge base; masters study would facilitate the development of reflective, critical evaluation and research skills, that would enable them to evaluate critically established modes of treatment and to develop new knowledge. FG1, FG3, Minda, Lalit and Adeeb had all aspired to

gain overseas practice experience in order to understand the contextual origin of the knowledge in different social and cultural environments; the more experienced, especially Ashna, were also cognisant of the different ethical ramifications that overseas practice brought. The participants journeyed overseas to meet professional development objectives, this illustrates their subservience to the central concepts of professionalisation, lifelong learning and the development of personal practice. All overseas participants aspired to return to influence practice in India, which supports their adherence to the last identified tenet of professionalisation, to work to professionalise the profession. Professionalisation of individuals is considered to be an essential element in establishing an autonomous profession that can command the rewards (pay and respect) that are associated with professional status (Bithell 1999).

The narrative was very much about Indian physiotherapists equipping themselves as practitioners, to be better physiotherapists and to treat patients more effectively, but in order to do that they needed a wider professional knowledge base, as identified by Minda, but she also identified the importance of the higher levels of learning.

"...things that I may have probably not studied here, wasn't as confident in doing over here and also applying all that - you know getting into that mode of lateral thinking, thinking broadly, into clinical reasoning and all of that."

Minda (overseas returnee)

The development of confidence referred to by Minda was highlighted several times by the interviewees and appeared to be particularly important for the female physiotherapists. The confidence was around improved knowledge of the research evidence underpinning their ideas and an ability to justify and reason through their practice; but also improved communication skills. There

was an expectation that the UK masters degree coupled with an increased confidence would help gain the 'respect' of doctors.

> *"But I think a masters from UK would help, because it will help in the doctors would* ***sit up and take a bit of notice****, because it is not just some bachelors young girl who is coming and trying to talk to me. And the thing is when* ***you know how to talk to them****, initially when we had done our bachelors, I was quite shy. And I didn't know how to approach and tell them that listen to me.* ***I know about this*** *and* ***I have better knowledge****. But now* ***I know how to do that*** *because* ***I have those clinical reasoning skills*** *and I have that, you know* ***I can search for articles. I know how to do that*** *and* ***I can show them articles*** *and* ***I can show them evidence*** *so* ***I know now how to communicate*** *and tell them and* ***make them take some notice.*** *And* ***that way they will respect you****, if you* ***show them written work*** *about it. And if* ***you show that I know what I am talking about."***
>
> Sushmita, FG3 (studied UK, about to return to India)

The increased confidence, the increased knowledge and an ability to articulate their ideas and to challenge the medical hierarchy to allow them to practise physiotherapy as the research evidence indicates, all support the notion of professional empowerment. The words in bold used by the Sushmita were all strong, positive and demonstrate a clear sense of someone confident in their profession.

5.2. Pay

Low pay in India was identified as a major source of dissatisfaction amongst Indian physiotherapists and consequently, a key motivation for going overseas was to seek increased pay. However, the importance of pay in isolation was not sufficient to instigate travel and participants identified that pay was a factor that inter-related with many other factors that influenced their migration: professional

and practice development, respect and seeking a better life. This frequency of the influence of pay and its connectivity with other influencing factors appeared to amplify the importance of pay as an issue. It was clear that different migrants placed variable emphases on the significance of pay in their decision to travel overseas. Some (Ashna, Mindha and Lalit) identified that increased pay had no influence on their desire to travel overseas; for them it was purely about gaining knowledge that was not accessible to them in India. For others (FG1, FG3 and Adeeb) the significance of low pay was more multidimensional and reflected a sense of self worth and respect, as much as a basic need to feed and provide for family and dependents.

It was suggested that the importance of pay levels was particularly pertinent in Indian culture and an individual's position in the hierarchy. Participants reported that their financial worth and potential worth would impact upon whom they were eligible to marry. They identified that Indian society expected males to be able to support their family and there was no expectation that females would continue to work once they have children. Hence the level of pay determined much more than an individual's spending power, it extended to his worth as a husband and so influenced his marriage opportunities. The importance of increasing pay as an aspiration was reported to be more pertinent to males than females. The females interviewed identified that the development of professional practice was more significant to them than the financial remuneration. This reasoning was articulated by many of those interviewed and refuted by none.

The interviews did display evidence of a gender difference beyond the value of their professional development. For males the empowerment to develop professionally and gain an overseas masters degree was clearly seen by many as a route to increased pay and hence financial and social empowerment. For female participants the emphasis was on personal professional development

and the intrinsic reward of managing a patient more effectively appeared to be a primary motivator. Their secondary gains, were associated with increased self-confidence in their skills, having a professional role and the ability to challenge.

" ...because the male in India is the head of the family and he probably is the sole earning member here and so his aspirations towards wanting to a learning, to moving ahead would be quite different to a female."

Minda (female, overseas returnee)

" The men go out there and mostly looking from a financial remuneration stand living in those countries but as the women would do it more because of the feel good factor of being professionally in a working environment which makes them in charge of their own work."

Rani (female, overseas returnee, educator)

"...that the female motivation might be more about knowledge study and things and the male motivations is more about money and pay."

Lalit (male, overseas returnee)

Sinha (2011b) published a historical discourse that illuminates the inverse relationship between qualifications and pay for Indian physiotherapists, he pointed to evidence that in the 1960's physiotherapists and doctors were on identical salaries. He charted the downward trajectory of physiotherapists pay relative to doctors and dentists, and the subsequent alignment with other 'paramedicals' who had a much lower entry qualification level. The article focused on comparisons with other health professionals and their perceived relative status and worth. It argued that since the 1980's the Indian pay commission had systematically set out to 'degrade and devalue' physiotherapists despite their increased academic status.

Participants frequently compared the financial remuneration that a physiotherapist received with the pay of other similarly qualified professionals. Several examples were given including comparisons with the hospital manager, a career path that was seen as an alternative to physiotherapy. These observations led to a feeling of not being valued as an individual and as a profession. Adeeb referred to a younger brother who post MBA was earning significantly more than he did as an experienced physiotherapist. The critical impact of this difference appeared to be very much the unspoken social perceptions, with the feeling that others were judging his low pay. There was also a conscious awareness of the effect that would have on his quality of life. He identified these social factors as being motivators for him to travel.

"He got a really nice job almost paying ten times what I am being paid (...) there was that comparison if you like, no one would obviously say it to your face, but that was always there, 'and he's only studied for 2 years and he's earning this much and you are only earning this much'. So that pay even though it is only just a small part of it, it does impact upon, it plays quite an important role in the overall quality of life if you like."

Adeeb (now studying for a PhD in UK)

When the potential return on investment of travelling overseas to study was evaluated, participants clearly took a long term perspective. They considered the costs of travel, living expenses, loans and study versus the expected increase in pay and long term prospects. Most felt that the prospects for an Indian physiotherapist were better overseas from a professional and a remuneration perspective. However, Lalit (who selected to study aboard because the specialist area of study was not available in India), argued that he considered that the prospects in India were better. He justified the statement by identifying that in order to achieve the increased pay level overseas, the physiotherapist must first take a loan for study and then work to repay that loan. If similar effort and time were invested in India a salary would be achieved that

would buy a car and a maid to cook and do the laundry, things than could not be afforded overseas. Therefore whilst the Indian salary was less, domestic services were affordable (by those at the top of Indian physiotherapy salary scale) and coupled with being with their extended family, he thought that the better quality of life was to be found in India. He conceded that items such as plasma televisions and other consumer possessions would not be affordable and that it was a question of what was important to an individual.

Vujicic et al (2004) published an analysis of health professions pay differentials (adjusted for purchasing power parity) between source and receiving countries and the supply of migrants. They concluded that there was little correlation between the size of the wage differential and the number of migrants, and identified that small increases in source country salary would not significantly affect the outflow of migrants. They suggested that there were other important factors affecting migration, which if addressed could be more effective in reducing migration.

Many Indian physiotherapists funded their overseas studies through loans from banks or relatives, and the participants were unanimous in identifying that, for those who have taken out loans to fund their overseas study, they must first repay the loan before they would consider return. FG3 participants identified that any kind of work in any overseas developed country would be a priority until the loan was repaid.

> "*They wouldn't necessarily come back to India to work because the pay here is just not good enough for a physio. The starting salary is pathetic.*"
>
> (Ashna returnee and educator)

The influence of an overseas masters degree upon a returnees pay in India was an issue that stimulated a lot of debate and uncertainty within the focus groups;

some participants perceived that a physiotherapist with an overseas masters degree would attract greater pay than if they had an Indian masters degree, others disagreed. Returning participants reported a more complex scenario, with the pay levels in some states being the same whether you are a bachelors or a masters physiotherapist, while in other states there were reports of masters graduates earning substantially more. It appeared that the differences could be attributed as much to types of employers and competition for highly qualified staff, as state differences. This variation of pay scales was confirmed by Sinha's (2011a) publication which stated that government sector pay was "*not up to the mark*" and that the private sector capitalised on the rising unemployment amongst physiotherapists who they exploited.

Overseas masters graduates did not appear to be paid more that Indian masters graduates but were perceived to be preferentially employed in some cases. What was clearly important from the interviews was that a returning physiotherapist would be able to earn more than they did prior to travel. For some the financial rewards were perceived to be a longer term investment. They would have the skills and reputation associated with the overseas exposure that would allow them to develop a private practice and reputation that would result in greater long term financial remuneration.

5.3. Respect

A significant factor in the decision to travel for several participants was a perceived lack of respect for physiotherapy in India. Respect was identified as being related to low pay and was talked about in the context of respect for the profession and also for the individual as a physiotherapist. Published literature considers that the social status and respect conferred upon an individual is a key feature of a profession (Witz 1992; Friedson 2001) and it is suggested that

in western society, a professional hierarchy has replaced class as a matrix of society (Perkin 1996).

"It is definitely the work you perform, it's in any profession, the work you perform you earn the respect. (...) When we say a doctor we have respect for the doctor and when we say a physiotherapist (...)[we] should have a respect."

Monica FG2 (masters study in India)

Whilst individual and professional respect are distinct entities, Monica's words capture their inter-dependency. Respect for the profession inferred automatic respect on an individual as a member of that profession; respect by association. Whereas each individual must also have earned respect based upon their work and behaviour. Both these aspects were identified by the participants as significant.

"Yeah there are plenty of people out there who think physios are on a lower plane than they are, especially among the medicos because that's the way it's been for all these years."

Lalit (overseas returnee)

The interview narratives acknowledged that many people in India, especially the doctors considered that the physiotherapy profession was inferior to medicine. They also identified that the physiotherapy profession in India aspired to achieve the same level of 'automatic' respect as doctors had acquired. Their failure to command this respect was a source of great frustration to individuals and the profession as a whole. One of the key elements upon which the claim for parity of respect was based, was the comparability with the doctors length of time spend studying. The entry level bachelors physiotherapy degree was 4.5

years and the postgraduate masters level study in some states was increasing from two to three years.

> *"But they try to make it 3 years because the medical masters became 3 years and this was inane, an inner sense of insecurity which made them feel we have to match with them, so that we get the same level of respect."*
>
> Ashna (overseas returnee, clinician and educator)

The statement from Ashna referred to a sense of "*insecurity*" which had resulted from not accepting that physiotherapy was lower down the 'pecking order' than medicine and the adoption of a tactic of matching the time the medical profession spent studying, in order to demonstrate that physiotherapy was on a par and therefore should be respected. This insecurity contextualised in the terms of Indian class consciousness is interesting as it appears to distort and amplify the importance of respect. This will be explored further in chapter six 'Transforming Professional Identity'.

Some of the participants referred to the use of the 'Dr.' prefix as a way of gaining respect from the patients and gaining status in society. Ashna identified that she found the title doctor was useful in gaining respect in the early days of her career but was less important now she was established.

> *" We've got this court order where we can prefix our name with Dr. and have a suffix of PT and that's because that's where you get the respect. It's now after so many years into practice I really don't give a damn. But initially to get that level of respect I had to, you know. "*
>
> Ashna (overseas returnee, clinician and educator)

Adeeb (UK PhD student) identified that the use of the Dr. title was contentious and had been a source of much emotional debate within the profession, but that for many the use of the title was an *"ingrained right"* that emanated from how the colleges recruited students with the promise that they would be a doctor upon graduation. Adeeb pragmatically considered this was a self made conflict that was not helpful to physiotherapy in the current professional climate in India, but he identified that others were insistent upon retaining the right. The IAP diplomatically promote that use of the 'Dr.' prefix should only occur when it is supported by the suffix 'PT' to differentiate themselves from medical doctors (Ahuja et al 2011). However, it was clear from Adeeb that the medical hierarchy were sensitive to the confusion that the use of the title created, and the impact upon their identity as medical doctors. The issue and legality of its use has been debated in the media and contested in the courts. There is no clear government regulation regarding usage of the 'Dr.' prefix and different state councils have taken opposing views, with Maharastra in support of its usage by physiotherapists, whereas Tamil Nadu have prohibited its use by physiotherapists (Mascarenhas 2010; Iyer 2012; Josephine 2013). The issue appeared to have been far from resolved.

Ahuja et al (2011) published a discursive article and identified the justifications for using the prefix; physiotherapists undergo comparable education; the title is used by allied health professionals elsewhere in the world and has academic origins, so physicians have no more right of ownership than other professions. Ahuja et al (2011) suggest that physiotherapy in India should take a longer term view, rather than the short term gain in respect. They propose that a better reputation would be gained by developing a stronger physiotherapy identity of their own and being confident in their own knowledge and skill, and not trying to utilise the medical doctors identity to achieve prestige. They consider that physiotherapists calling themselves doctor unnecessarily creates a conflict with their medical peers, when they should be working in partnership with them as a

part of a multidisciplinary team. Extrapolating these ideas a step further, it is suggested that attention could more productively focus on gaining regulation of the profession, standardising education and increasing the awareness of physiotherapy to the public and medical community.

If this 'Dr.' prefix discourse is considered in relation to Foucault's ideas it might be seen that the Indian physicians are taking an oppressive approach to disciplinary power by legislating to stop physiotherapists using the 'Dr.' prefix, in an attempt to protect their own position. The natural response to such authoritative power is to resist and that is what Indian physiotherapy is doing (Foucault 1991). Those who consider that the doctor title is not so important perhaps identify that real power lies within the more subtle forms of influence, and that concentrating on gaining professional regulation and standardising physiotherapy knowledge may be more effective in the long term. This recognises that achieving legitimacy may be delivered through a more 'governmental' approach (Nicholls 2012).

Despite the desire for automatic respect to be conferred upon them by nature of their profession, the participants were also extremely pragmatic and clear that respect could not be demanded and must be earned. These statements initially appeared to be contradictory with the demands for respect from and parity with doctors, but it became clear that participants were referring to respect as an individual professional. The FG2 participants, were particularly passionate about the issue of respect and how they must work to gain respect through good practice as an individual and as a profession. The variability in quality of physiotherapy practice was acknowledged, with poor practice perceived to be holding the profession back and impacting upon all. It was not only the doctors that the Indian physiotherapists compared themselves to in terms of respect, participants also perceived that physiotherapy was not respected as much as

other administrative professions, such as hospital administration and the IT industry, where the rewards of pay and respect from the public would be higher.

> *"Respect is never like, you always earn it. You have to be there and you have to prove themselves, that you are also important part of that rehabilitation. So I think it's a, basically upon the physiotherapist who has to take the lead."*
>
> Madhuri FG2 (masters study in India)

It could be suggested that if each Indian physiotherapist was able gain respect individually, that collectively they are the Indian physiotherapy profession and therefore, the respect for the profession would grow and move the profession forward. The interview narratives reflects a dichotomous picture and suggests there are contrasting 'micro-ecosystems' (Wackerhausen 2009) within the Indian physiotherapy. Some departments had evolved over the years to establish respect from their local medical hierarchy, which allowed them to operate in a semi-autonomous fashion (as described in chapter four 'Maintaining the Status Quo'). Conversely, others 'micro-ecosystems' had not evolved and an autocratic medical hierarchy persisted (the non-autonomous departments) where it was challenging for an individual to practise in a way that allowed them to gain respect from the medical hierarchy. This more lowly position in the medical 'pecking order' may result in physiotherapists feelings of not having their voice heard and may ultimately impact upon their personal sense of identity and position in the world. The medical hierarchy and physiotherapy's position within it, would provide a cultural frame that would define each individual physiotherapist's life and their position within India's stratified class conscious society.

In departments where mutual respect was perceived, it was identified by participants that this had been "*earned*" through good knowledge of

physiotherapy, good clinical practice and very importantly by effective communication between the doctors and the physiotherapists. The respect had to be built up over a period of time, was the clear message from participants who had worked in departments that allowed a semi-autonomous approach to practice. For those physiotherapists who worked in the non-autonomous departments, where they had felt that they were not respected, several participants from FG1 and FG3 identified that they did not feel confident to engage the doctors in debate. A part of their motivation for studying overseas was to develop the knowledge and skills needed to develop their individual reputation and thereby gain respect. The other reported attraction of going overseas was to work in an environment where physiotherapy enjoyed greater respect, practised autonomously and did not have such a physician dominated hierarchical healthcare system.

> *"...the health delivery system is hierarchal; you have a doctor on the top (...), and the physio (...) has to work under the guidance or suggestions of what the doctor would like to prescribe (...), and I think that when they go out or if they've heard from, you know, their friend, their seniors, that's what we do for work and that's how we work our way out, they want that, as one big reason for moving away from the system."*
>
> Rani (educator, worked overseas)

In Rani's narrative she identified the importance of Indian physiotherapists hearing how their peers were working in different ways and wanting to engage in autonomous practice. In addition to hearing that physiotherapy practice overseas was respected and autonomous, other participants have also highlighted the importance of overseas role models who reported that they felt respected and worked autonomously. So through migration overseas and a common physiotherapy identity, Indian physiotherapists perceived that they could experience the respect that was enjoyed by the host country

physiotherapists. Importantly there was also the perception that the *"whole tag of going abroad*" (Lalit) would confer increased respect upon their return.

5.4. Summary

The search for a better life through migration to another country where the '"*complete package*" of good professional practice, pay and respect is available, is a global quest (figure seven). Some participants articulated that if the environment in one country was not conducive to practise in a way with which they felt comfortable, they would move to a country where it did feel right; but they all indicated a clear intention to return to India.

Figure 7: Wanting a Better Life: The Attributes Sought

The interviews indicated that pay levels were not the sole driver for participants to study or work overseas, respect was also clearly articulated as a factor and the importance of both these elements varied between participants. The element that united all the participants who travelled was the journey for professional development and the search for different knowledge and experience from that available in India. The interviewees identified that pay and

respect were clearly linked and that until respect for physiotherapy in India increased the pay would remain low. They identified that increased knowledge and consistent quality of professional practice was key to achieving respect. Through journeying overseas the participants sought to develop themselves professionally, to earn respect and the remuneration often associated with increased respect together with the overall aspiration of achieving a life better than they left in India.

6. Chapter Six: Transforming Professional Identity

6.1. Introducing the core category

The core category 'Transforming Professional Identity' captures the discourse of Indian physiotherapy professional identity formation and subsequent transformation. The journey consists of four stages: forming, storming, transforming and transferring. The 'forming' stage occurs as an individual physiotherapist engages with a process of professional socialisation in educational and clinical environments. They develop their physiotherapy identity contextualised in these progressive and protected environments. However, when they move into the employment context, many find themselves working in non-autonomous environments, and 'storming' occurs as they become frustrated and disillusioned with the identity of the Indian physiotherapy profession. They feel unable to practise effectively and do not feel valued or respected. For these physiotherapists, the paraprofessional identity they must adopt as employed physiotherapists does not match the professional identity that they constructed as students, and they are reluctant to compromise their identity and aspirations.

The Indian physiotherapists hear that the physiotherapy identity is different overseas; practice is autonomous, and there is different knowledge (specialisms and research). 'Transforming' occurs as they travel overseas in search of professional development which would enable them to achieve better professional practice, thereby gaining respect and improved pay, to ultimately attain a better life personally and professionally. The journey is one of identity transformation from a paraprofessional physiotherapist to an autonomous physiotherapist with the associated skills. 'Transferring' occurs as the physiotherapist returns to India or continues his/her global journey. Successful reintegration in India is dependent upon the individual's ability to transfer his/her transformed professional identity to the local Indian context. The more Indian

physiotherapists who return with their autonomous professional identities, the more supported they should feel in transforming the Indian physiotherapy professional identity. This chapter explores these four stages which underpin the 'transforming professional identity' core category.

Throughout the interview narrative there was a common discourse concerning practice and professional development, and seeking difference. Minda (overseas returnee) identified that she felt encouraged to travel when she heard that overseas *"the concept of physiotherapy as a whole was different from what was here [in India]."* She talked about some Indian physiotherapists being "*very conservative in their views and are still stuck on the old concept of what physiotherapy was around 20 years back".* Srishri (FG2 studying in India) felt that the lack of a council and therefore lack of government recognition meant that Indian physiotherapy was devoid of an identity. The narrative indicated that there were ontological and epistemological differences between Indian and overseas physiotherapy, and a paradigm split within Indian physiotherapy, which had resulted in uncertainty underpinning the identity of physiotherapy itself and therefore physiotherapists in India.

> *"...we started off initially with a lot of electro-therapy, and that was* ***the concept which had changed****, when a lot of the colleagues and therapists, who came back, said* ***that's not physiotherapy****, so that kind of encouraged me to go outside and study. Well the aim or aspiration was mainly was to learn as much as I could in terms of* ***what physiotherapy was there****; the* ***concept of physiotherapy as a whole****, I felt that I could probably bring about a little change at least wherever I worked, if not on a larger scale* ***in terms of what physiotherapy is."***
>
> Minda (overseas returnee)

Minda's narrative elicited questions about the importance of understanding the social construction of physiotherapy and how it varied in different contexts. This in turn would influence the construction of physiotherapy identity, of what it

means to be a physiotherapist in different global contexts and the impact upon the global mobility of Indian physiotherapists. Even though the actual term 'identity' was only used once throughout the interviews (by Srishri, FG2), the concept was alluded to and echoed throughout the narrative (as illustrated in figure eight); it provided a coherence to a complex assortment of discourses articulated throughout the Indian physiotherapist's journey. This chapter will explore the concept of identity, the construction of personal professional identity and its transformation through overseas travel. It articulates a theory regarding the stages inherent in the transformation of professional identity that encapsulates, clarifies and unifies the melee of frustrations, motivations and aspirations that were expressed throughout the interviews.

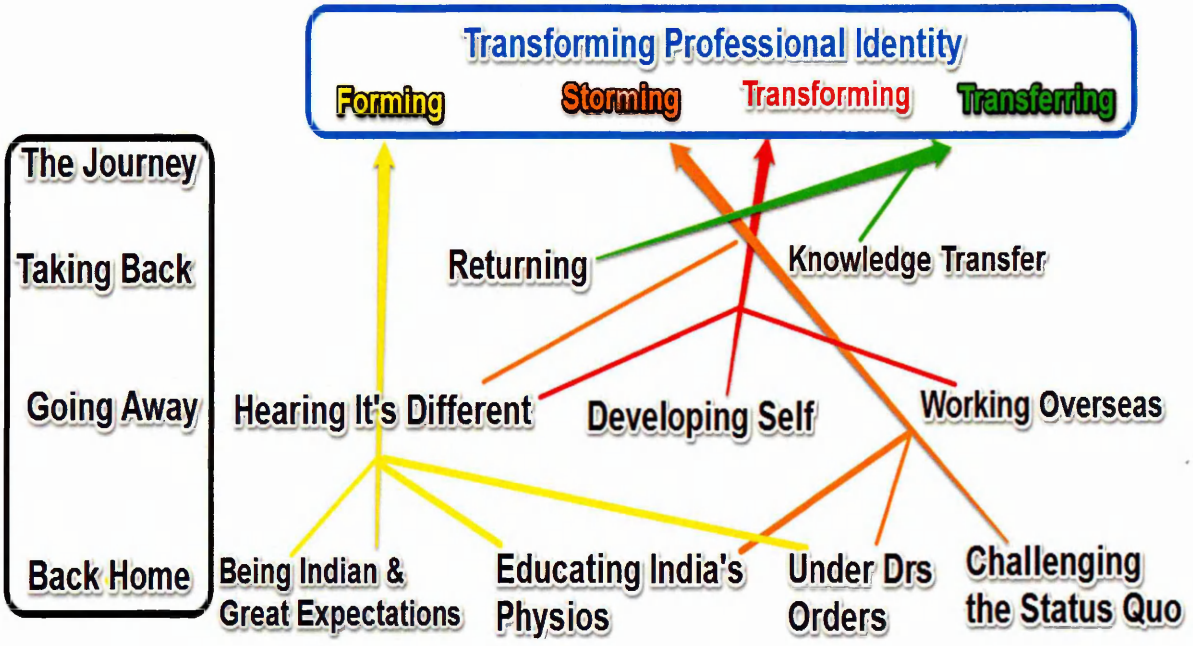


Figure 8: Transforming Professional Identity Core Category and Inter-relationship with The Journey Subcategories.

In order to explore sequentially the core category of transforming professional identity, it is helpful to establish the current status of the Indian physiotherapy

profession and the influence upon an individual's identity. The chapter will then briefly consider the conceptual complexity of identity and explore theories of personal identity development. Understanding these social constructions will allow the elucidation of the transforming professional identity theory, its constituent elements and their relationship with the globally mobile Indian physiotherapist's journey.

6.2. Identity, Profession and Indian Physiotherapy

The core category captures the discourse that suggests that, integral to an Indian physiotherapist's overseas journey, is an underlying quest to transform his/her professional identity. Transformation is a dynamic entity, moving from one identity formation to another, therefore to explore the Indian physiotherapists journey of identity transformation, it is pertinent to consider the starting point for the journey, the identity of Indian physiotherapy as a profession. The concept of a profession is a social construction, and so may be construed and perceived differently within different social and cultural contexts. Larson (1977) defines a profession as an occupation with special power and prestige; it has special competence and an esoteric body of knowledge and it is granted respect by society. There is a symbiotic relationship between a profession and society. Society demands a service, the profession provides it in return for an elevated position in the societal strata. Professions are often self-regulated, knowledge based occupations, the membership of which is attained following years of higher education or training (Evetts 1999; 2003).

The interview narratives identified variable perceptions regarding respect for Indian physiotherapy, and lack of common conceptualisation of physiotherapy in India. This suggests an absence of coherence regarding Indian physiotherapy's identity and questions its status as a profession. Bithell (1999) summarises the characteristics of a profession as an exclusive knowledge base, occupational

control of rewards, an ethos of service to the public, autonomy of practice and self-regulation of standards. If an occupational group only partially fulfil these criteria it may be categorised as a semi-profession or paraprofession, or undergoing a process of professionalisation (Friedson 1970). The professional status of Physiotherapy is integral to its identity and has not been taken for granted by the English speaking nations, as there has been scrutiny regarding how physiotherapy meets the characteristics of a profession. It is generally conceded that physiotherapy just meets the criteria of a profession, with areas for ongoing development acknowledged (Heap 1995; Bithell 1999; Richardson 1999; Turner 2001; Sparkes 2002; Scarpaci 2007). However, the participants in this study articulated perceptions of difference between physiotherapy in India and physiotherapy in the English speaking countries which became their destinations. It is therefore questioned whether Indian physiotherapy possesses the attributes of a full profession. A failure to demonstrate the attributes may elucidate the reported perception of lack of respect and the variable conception of physiotherapy identity, both of which underpin the Indian physiotherapists' identity at the start of their global journey. To explore this further, supported by the narrative from the interviews, Bithell's (1999) summary of the characteristics of a profession is used to evaluate how Indian physiotherapy performs against the criteria of a profession.

6.2.1.1. An exclusive knowledge base

Over the last few decades there has been a growth in research that directly evaluates physiotherapy practice; this has created a physiotherapy episteme embedded within a spectrum of ontological perspectives that underpin the nascent paradigm of physiotherapy. Practitioners have become more reflective and reflexive, facilitating learning from practice (Eraut 2011); contemporary literature refers to the extensive physiotherapy knowledge base (Shaw and DeForge 2012). However the physiotherapy knowledge base is considered to be embryonic and there are calls for further exploration of physiotherapy's

conceptual underpinnings through philosophical exploration (Nicholls and Gibson 2012) and for more interpretive based research (Petty et al 2012).

Professional knowledge contextualisation will vary between countries according to utilisation, application and local contextual application. The evidence from the interviews suggested that Indian physiotherapy did not effectively engage with the 'exclusive' physiotherapy knowledge that was available globally. The IAP recognised courses include a 4.5 year degree course, masters courses of two or three years and a few physiotherapist have progressed to PhD study (anecdotally these are mainly supervised by doctors). So, Indian physiotherapy does have an academic framework for the acquisition and development an 'exclusive' physiotherapy knowledge base. However, the interviews identified that there was a membership legacy from pre-1996 when only two years diploma study was required to enter physiotherapy, and that these therapists had a knowledge base that was "*lagging*" although they held key positions in departments (Daisey FG2). Minda identified that Indian physiotherapists' access to published research was usually limited to the freely available abstract summaries. Other participants (Manish, Adeeb, Ashna) indicated that research knowledge and expertise was "*lacking*" in India and there was very little funding to support research activity and that critical interpretation of what research is accessible would be minimal.

A significant contributing factor for travelling overseas was to access knowledge that was not available to them in India (FG1, FG2, FG3, Minda, Lalit, Adeeb, Ashna). Most participants reported that evidence based practice was often not widely followed in India and that many outdated treatment modalities, for which there was little supporting research evidence, was routinely used (FG3 Minda). This could suggest that many physiotherapists had not updated their knowledge and/or that the medical prescription of physiotherapy practice was constraining practice. Some participants (Minda FG3) indicated that reflection was a new

skill learnt overseas and that it was not an activity that Indian physiotherapists routinely engaged in, therefore limiting the opportunity to generate knowledge from every day practice (Eraut 2011). In summary, it is suggested the Indian physiotherapy professional knowledge is reliant firstly, upon the Indian doctors knowledge base and its interpretations in the biomedical paradigm and secondly, the physiotherapy knowledge base that has been developed in western cultures, some of which has questionable transferability to the Indian context.

6.2.1.2. The occupational control of rewards

Globally the control of occupational rewards varies depending upon different healthcare systems and the position on the continuum between government sponsorship and control, and private sector funding and control. The participants reported a mixed model in India, with huge needs but a significant lack of funding. Most physiotherapists were reported to be employed in a range of public and private sector hospitals or clinics. Throughout the narrative participants referred to the poor pay in India and for many this was a significant element in seeking further professional development overseas. Some interview participants referred to exploitation and low pay due to the apparent over supply of physiotherapists (Ashna, FG3). It would appear that self-employment was aspired to from a financial and practice perspective but that it was competitive. Therefore it is concluded that Indian physiotherapy does not have occupational control of rewards.

6.2.1.3. An ethos of service to the public

The ethos of public service highlights the behaviours that are associated with professionalism: accountability; altruism; compassion/caring; excellence; integrity/ethics and commitment to professional duty and social responsibility (Eraut 1994; Scarpaci 2007). These attributes are difficult to evaluate based

upon the interviews, however, most of the participants displayed a strong sense of duty and emotional commitment towards physiotherapy and India and a determination to improve health care provision. FG1 and FG2 were particularly driven by their sense of public service, "*serve the people of India*" (Monica FG2), "*it is our duty to improve the kind of a status of India because we are citizens and we are supposed to*" (Suhani FG1). The messages around engagement in lifelong learning were more mixed, those who travelled overseas were clearly engaged on a journey of lifelong learning but there were also reports of places where a culture of CPD was not encouraged. So there seems to be a strong sense of professionalism in terms of 'service' amongst many of India's physiotherapists but there also evidence that further development is required, which suggests only partial fulfilment of this criterion.

6.2.1.4. Autonomy of practice

The global picture on physiotherapy autonomy in practice is mixed (Higgs et al 2001). The countries that participants talked about (USA, Canada, Australia, New Zealand, UK) all have some form of statutory professional regulation with protection of title. It was evident throughout the interviews that in India the lack of physiotherapy regulation, protection of title and autonomy were significant factors that participants perceived undermined their practice and the identity of the profession. The long and tortuous journey through government legislature with a lack of tangible outcome, appears to have resulted in a sense of pessimism and a feeling that things would never change (Adeeb FG3).

6.2.1.5. Self-regulation of standards

The interview narrative described the IAP as a self-appointed and constructed association, that was recognised by the WCPT but did not have official recognition in India. It had identified standards of practice and levels of entry to the profession, which it monitored through educational institution inspections

(IAP 2013a). In the absence of any regulation of physiotherapy it was reported that employers would only employ physiotherapists who were IAP members or had graduated from an IAP approved educational institution. However, the interview participants frequently referred to variable quality in terms of education and clinical provision. The IAP had no requirement for ongoing CPD and as physiotherapy was not a protected profession in India, the effectiveness of the IAP's regulation would be limited.

> *"I basically want to myself, practice good practice, you know have good work ethics and incorporate good things, because that is the main thing which beats us in India."*
>
> Lara, FG3 (masters overseas)

Judged against the criteria of what constitutes a profession, Indian physiotherapy could not be considered to have met the criteria of a fully established profession. The evidence from the interviews suggested that Indian physiotherapy was a paraprofession that was undergoing a process of professionalisation (Friedson 1970). Thus, it would seem that the starting point for an Indian physiotherapist's journey of identity transformation was from an identity associated with a paraprofessional status; one that did not enjoy the same privileges and rewards that are associated with established professions and with many of the overseas physiotherapy professions.

6.3. Identity and Identity Role Theory

Identity is a virtual construct and has been conceptualised extensively from multiple ontological positions. What most ontological perspectives do agree upon is the complexity and multifaceted nature of identity and that we possess multiple identities (Cooper 1999; Gergen 2000). A synopsis is presented here to provide a contextual background for the concepts that have resonance with

understanding the Indian physiotherapists' journey of identity transformation. Self identity, personal identity and social identity and how they relate to professional and profession identity will be introduced. Identity role theory is explored in more depth as it provides a conceptual framework for explicating the transforming professional identity grounded theory.

6.3.1. Identity Synopsis

Simplistically, identity hinges on what makes something the same or different. It is about what makes an entity definable and recognisable in terms of possessing a set of characteristics that distinguish it from entities of a different type (Harré 2000). The social sciences use identity as an umbrella term to describe an individual's comprehension of him or herself as a discrete, separate being, and it is contrasted with the notion of self. Self is central to psychologists' thinking. Psychologists' conception of identity encapsulates self-image, self-esteem, self-reflection, self-actualisation whereas, sociologists consider the notion of role behaviours and identity negotiation that may arise from learning social roles through personal experience.

Locke's (1690) theory of mind is often quoted as the origin of contemporary conceptions of identity. It focused on self and defined self as a continuity of consciousness, it contends that man was born without innate ideas and that knowledge is determined by experience, derived from a sense of perception. Therefore, personal identity is based upon a consciousness, self awareness and self-reflection as perceived by oneself; it is not based upon substance, as perceived by others. This perspective of permanence is echoed today in some psychologists' interpretation of identity, whereby identity involves a subjective feeling of self-sameness and continuity over time. Hence in different places and situations the individual has a sense of being the same person and others recognise this continuity of character (Erikson 1971).

Giddens's ideas do not recognise the role of experience as Locke's ideas do, but they do emphasise an understanding of self in the context of an individual's biography. Giddens (1991) argues that self-identity is based upon reflexivity, knowing cognitively or subconsciously what one is doing and why. Ontological security is important, those who are self-assured and empowered, have the confidence and self-belief to engage and manage externally impinging events, and to effectively engage in an external environment full of changes. They are not preoccupied by apprehensiveness and risks to their own existence; they have developed a trust in their own self-integrity. Giddens (1991) contends that self-actualisation is a balance between opportunity and risk, and letting go of the past generates a multiplicity of opportunities for self-development.

Professional identity, is specifically concerned with groups in the workplace and relates to how people compare and differentiate themselves from other professional groups (Tajfel 1981). Wackerhausen (2009) subdivides professional identity into macro and micro levels. The macro-level is the identity of the profession, its public face, a combination of official recognition, public perception, and the profession's view of the profession. The micro-level professional identity is at an individual level and dependent on their being a fully acknowledged member of the profession in terms of knowledge base, qualifications and acculturation to the tacit expectations and behaviours of the profession. Therefore, the micro-level individual and macro-level professional identities are interrelated and interdependent but they are also distinct entities. An individual's personal professional identity will be informed by their personal identity of self.

Personal identity focuses on interpersonal relationships. Individuals define themselves according to how they perceive others responding to them. They become aware of their impact upon others and use that awareness to determine

future communications of the self. There will be different relationships with different people, resulting in multiple identities according to these social interactions (Mead 1934). Each person is a part of many social identities with regards to engagement with different social groups and associated behaviours.

Different strands of theory around personal identity have emerged. Identity theory focuses upon roles, self-verification and salience of the context (Stryker and Burke 2000), and social identity theory focuses upon groups and intergroup processes (Stets and Burke 2000). From the interviews the importance of both the role and the societal context upon individual Indian physiotherapists has been clear. Therefore in the deliberation of the discourse of an Indian physiotherapist's personal professional identity and in expounding the 'transforming professional identity' grounded theory, an integrative approach to the theories has been adopted.

6.3.2. Personal Identity Theories

Identity theory explains social behaviour in terms of reciprocal relationships between self and society (Hogg et al 1995). It is embedded within the symbolic interactionist theoretical perspective and is based upon Meade's ideas that *'society shape, self shapes behaviour'* (Meade 1934, p181). Underpinning the theory is the understanding that individuals have many identities that are based upon networks of relationships in which they occupy positions and play roles. These social roles such as friend, student, parent form the basis of a person's self-identity, and they are linked to positions within a social structure, and provide individuals with the meaning and guidance necessary for the development and maintenance of self-concept and wellbeing (Haines and Saba 2012). The individual identities are internalisations of these social roles, and the role labels convey meanings and expectations of behaviours for those who occupy the roles. Each role is externally defined by others expectations, the

expectations determine normative behaviours associated with the role and are the standard for group membership, the identity standards (Stets and Burke 2000; Stryker and Burke 2000).

Individuals will define their own identities internally as they accept or reject the role expectations as a part of who they are. The identity standard for a role, is the reference point against which an individual verifies their internalised identity (Stets and Burke 2000; Stryker and Burke 2000). As different roles are adopted each internalised identity will subscribe to a different set of identity standard rules. Once an individual has accepted and internalised expectations for the role as a part of his/her identity, that then becomes a part of the cognitive framework for interpreting new experiences (Colbeck 2008). In the context of Indian physiotherapy the identity standard could be considered to be the normative behaviours expected of a physiotherapist in the different stages of the professional development and career i.e. student, intern, new graduate, junior, senior. Different clinical departments would, therefore, have different identity standards according to the culture of the department and an individual's role within the department. This leads to the notion of different meanings and expected behaviour in different work environments that an Indian physiotherapist would seek to verify his/her identity against. The challenges for the Indian physiotherapy graduate would be moving between these environments and the associated differences in behaviour expectations and role meaning, and aligning their personal professional identity as a physiotherapist with the role expectations.

As an individual has multiple identities forming their personal self identity they are organised in a hierarchy of saliency (Deaux and Burke 2010). Identity salience is linked to the stability of the role and the associated identity and how it aligns with other identities that have similar meanings. Identities that entail

significant social and personal costs in no longer fulfilling them have higher salience, as do those to which an individual is committed and those that have common frames of reference and meaning (Haines and Saba 2012).

Interactions with others are an essential source of feedback to compare our self-perceptions of our internalised self identity and associated meanings to the identity standard (Stets and Burke 2000; Stryker and Burke 2000). Where there is congruence there is verification of the self-identity and this is usually associated with a positive emotion and increased self-esteem (Deaux and Burke 2010). Where there is a discrepancy between the internalised self identity and the role identity standard, then the individual must adopt a behaviour to repair the discrepancy; they either need to alter the situation, or to create a new situation, until they can verify the identities' alignment and achieve salience (Burke 2006; Haines and Saba 2012). A large or persistent lack of congruency will create distress until the situation can be resolved. Self-verification is constantly in motion, therefore regular feedback is needed, which is gained from social interactions. Individuals place different value on various forms of feedback, depending upon how much they respect who is providing the feedback. Individuals will gravitate towards those who provide feedback that affirms their self worth therefore their self identity (Deaux and Burke 2010). They will select roles and situations that are likely to be salient with their self identity, therefore they can enact that identity. All situations and roles will involve a social structure, which consists of other individuals, their associated roles, their internalised self identities and meanings and therefore the identity standard (Stryker and Burke 2000).

In summary, taking a bricolage approach to characterising identity, it may be considered that identity is a continuum between sameness and difference, and that we have multiple identities. Identity is influenced by social context and it is fluid; responding to the external context, social perceptions and self perception

(Bauman 2004). Self-identity is about knowing and understanding ones-self and maintaining a consistent dialogue. It is dependent upon experience, biography and reflective awareness, and it influences how we engage with the world (Giddens 1991). Personal identity relates to distinct traits by which a person is known, it incorporates relationships and will be determined according to perceptions of the response of others. It relates closely to social identity which concerns self-categorisation with groups or identification with roles. Professional identity links with both personal and social identity constructs, which in turn will inform an individual's self-identity (Stets and Burke 2000).

6.4. Transforming Professional Identity: The Indian Physiotherapists Journey

The theoretical complexity identified in the last section suggests that the development of an Indian physiotherapist's personal professional identity is complex and multifaceted (Craib 1998). Their identity will be embedded within the identity of the Indian physiotherapy 'paraprofession' that was considered earlier in the chapter (Wakerhausen 2009). It will be embedded within Indian cultural and societal norms, dependent upon changing socio-political and socio-economic influences, and will be influenced by the globalisation of education, knowledge and healthcare (Meade 1934; Haines and Saba 2012). Professional identity is not static, it will be continually reappraised and restructured according to the external social factors (Burke 2006) and also according to changing internal self-identity (Giddens 2001).

Based upon the notion of a fluid Indian physiotherapy professional identity, it is theorised that it undergoes a process of forming, storming and transforming in response to interactions and the feedback gained from interactions with physiotherapy peers, seniors, medical staff, patients, family, friends etc.

6.4.1. Forming

6.4.1.1. Antecedent Identities

Indian physiotherapy professional identity will consist of multiple identities, each overlapping and informing the others (Burke 2006). When an individual chooses to become a physiotherapist they bring with them social identities and self-identities that they have already formed through prior experiences at school and those that they were born into: gender; religion; caste etc. Each of these have a defined set of accepted behaviours and actions, which create defining characteristics. As the student engages with the activities associated with their degree, some of these previously formed identities have little salience with the new professional identity that is being formed, and will be forgotten e.g. school based identities (Deaux and Burke 2010). Some will not be forgotten, and will have high salience according to their social meaning; there will be continual feedback on these identities (possibly from family) (Haines and Saba 2012). The new physiotherapy identity formed will be adapted to ensure that it is congruent with these established identities.

Research in the UK suggests that physiotherapy students already have a strong sense of professional identity as they enter their course (Adams et al 2006). Therefore it would be expected that the student would start their course with a conception of what a physiotherapist in India did and so had already started to construct their own professional identity. Adeeb and Lalit suggested historically that for many, physiotherapy was a second choice career after medicine for those who did not achieve the required grades, and that becoming a doctor was often a deep-rooted familial expectation. They also identified that, as physiotherapy's profile improved in India, more people were entering it as a first choice occupation. Therefore students enter with a conception of physiotherapy and its position within the hierarchical medical structures.

6.4.1.2. Professional Socialisation

The Indian physiotherapy education institutions, under the authority and endorsement of the IAP, are arguably amongst the most powerful segments of the profession, as they not only control entry (Bucher and Strauss 1961) but are the key shapers of professional socialisation (Lindquist et al 2006). Through this process of professional socialisation, students gradually develop and internalise a range of beliefs and attitudes about Indian physiotherapy, developing an understanding of the boundaries and the ways in which they should interact with others as healthcare providers (Richardson 1999). Their beliefs, attitudes and understanding of their roles, are socially constructed and shaped into conformity within the context of work and will inform their 'professional identity' (Clouder 2003). The students are not passive recipients of a pre-determined identity, they gain a sense of control by constructing their own roles and understanding the culture of the profession; this is important in informing an individual's professional identity and how they ultimately practice (Forsythe 2005). The student constructs the cultural dimensions of their identity based upon their experiences and interactions with other professionals in the work place and the university. Role models are important in identity construction, as individuals place different value on feedback according to how much they respect who is providing the feedback (Deaux and Burke 2010).

Professional socialisation is about gaining pertinent knowledge, skills and theory to inform professional practice, but it is also a process through which values, attitudes and beliefs are internalised intellectually (Richardson et al 2002). Students assimilate a web of 'taken for granted' values and beliefs. This occurs through a network of exchanges in an array of situations. Therefore the cultural dimensions of physiotherapy practice in the work environment would influence the construction of an individual's professional identity, through tacit learning regarding behaviour, ways of seeing, questioning and ways of communicating with for example doctors, nurses, patients and other

physiotherapists (Wackerhausen 2009). This learning occurs at a sub-conscious level and becomes habitual to follow established practice. The structure of the socialising institution, the professional orientation of the staff and the individual set of experiences, are all key components underpinning how an individual constructs his/her professional identity (Stelling and Bucher 1973).

When a student undergoes a process of professional socialisation they construct an identity according to the role that they perceive and it is then adapted according to how others respond to that role (Stets and Burke 2000). They will be exposed to an assortment of experiential contexts and receive feedback from academic and clinical supervisory staff. Students compare the feedback, with their internalised self-identity and associated meanings, to the identity standard (Stets and Burke 2000; Stryker and Burke 2000). Where there is congruence and verification it will become an internalised and embodied part of their professional identity (Stets and Burke 2000). Where a divergence is perceived, they will modify their behaviour, until their internalised identity verifies with the identity standard of the student physiotherapist role at that point in time and in that context. The self-verification process is iterative, according to feedback and the different roles that are adopted and internalised at various stages of their training (Stryker and Burke 2000). From these interactions the student assimilates his/her interpretation and knowledge based upon feedback, according to a social consensus of professional behavior in which they are embedded. Their internalised professional identity will be personal to them, as their experiences and interpretation will be unique (Stets and Burke 2000). Professional socialisation is not a linear process and people move through the socialisation process at different rates (Dinmohammadi et al 2013).

Richardson (1999b) conceptualised a wheel of professional learning, that emphasised the role of experience in knowledge construction and illustrated how professional and experiential knowledge is interpreted by an individual

according to his/her personal paradigm (professional self-identity). It is then acted upon and, dependent upon the experiences resulting from that action, situated learning occurs that informs future professional knowledge (see figure nine).

Socialisation continues throughout the degree as the student moves between different specialisms, learning experiences and academic years. Each creates a different role, with different expectations, against which student physiotherapists verify their internalised identities and adapt their cognitive framework for interpreting new experiences (Stryker and Burke 2000; Colbeck 2008). According to the social interactions experienced and the responses and the resultant feedback associated with these roles, the student physiotherapist constructs a personal professional identity that is internalised and is a part of their self-identity.

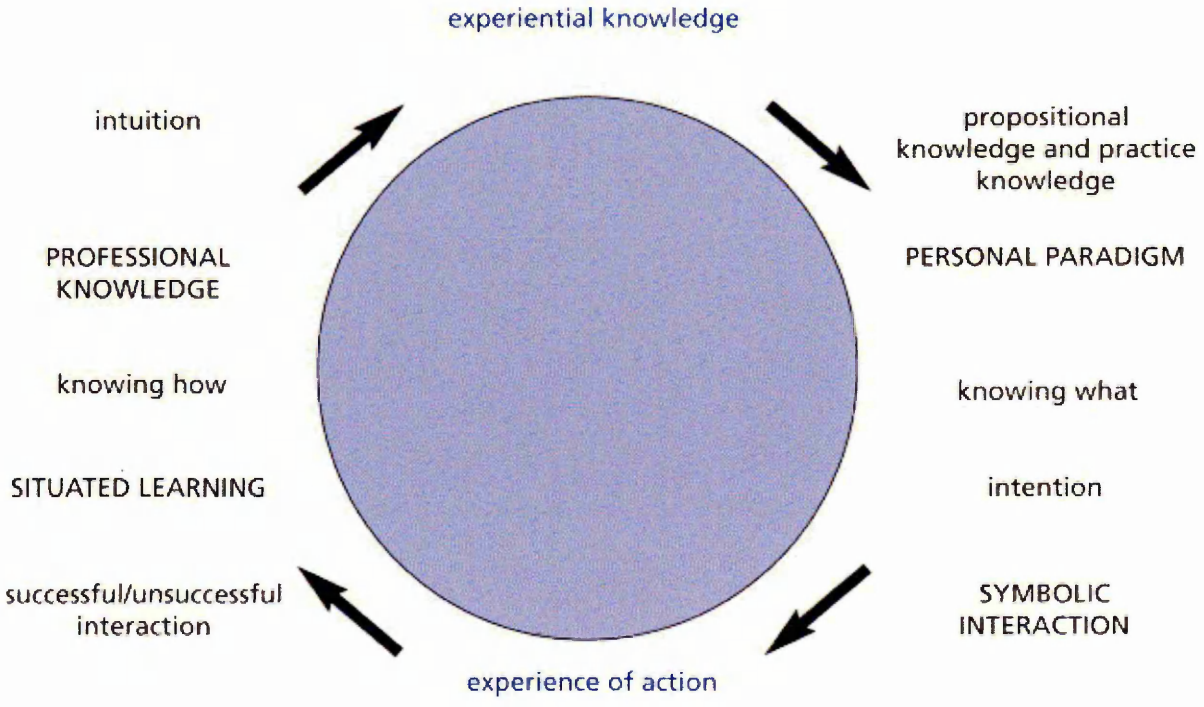


Figure 9: Wheel of Professional Learning (Richardson 1999b)

6.4.1.3. Shifting Identities

Much of the research underpinning professional socialisation was conducted in the 1950s and 1960s. Becker et al (1961) consider that professional socialisation was a molding process where students were little more than passive recipients of knowledge and skills passed to them through the use of didactic teaching methods and learning through example (Eraut 1994). Half a century later this perspective may still have relevance for some Indian physiotherapy educators, as on several occasions during the interviews a didactic delivery style of Indian education was referred to.

> *"... there's this little saying that says a lot of it is taken out from the minds of the teachers and been passed onto the minds of the student's without either of them really making sure that it has really retained in the mind; that is what is happening and then the way the exams are structured"*
>
> Rani (educator with overseas education experience)

However, it was reported in the interviews that undergraduate education had developed significantly over recent years and was continuing to evolve. The move to a four year degree plus six month internship resulted in an expanded curriculum covering more specialist areas, and leading institutions were gradually changing delivery style and incorporating ideas from overseas physiotherapy education; for example, it was reported by Manish that problem based learning was being considered for introduction into one of India's most reputable teaching institutions. Recent publications in the Indian physiotherapy media provided further insight into how the undergraduate education was evolving (Ravindra and Debur 2011; Swaminathan and D'Souza 2011). Therefore recent graduates should have a more contemporary knowledge base than those who qualified a decade ago, although curriculum content overload was an issue identified by Rani. As more creative delivery methods are introduced, the physiotherapists should develop more independence as

learners and be better equipped to direct their post-graduation learning. Such knowledge and independence may form a conscious and explicit element of their identity. Their ability to use the knowledge in changing contexts and their self-efficacy in that knowledge would inform their professional identity (Adams et al 2006).

"... the syllabus has changed to accommodate the changing trends and the expectations of people, so you no longer just stick to your musculoskeletal but you know a lot more, you know more about women's health, you know more about the preventive and social aspect of physiotherapy. So the course has become a bit broadened, more informative, more challenging, people are entering it as first choice, so automatically, the intellectual capacity of the students has gone up and their outlook has changed."

Lalit (overseas returnee)

Many Indian physiotherapy educational institutions are directly linked to a hospital that is under the same ownership, and this is where a significant portion of the clinical exposure occurs. Therefore the environments that a physiotherapy student is exposed to are contained and managed (Lata Shroff 2011), and a coherence of academic and clinical exposure can be created that supports the facilitation of individuals to develop a coherent professional identity that conforms to the requirements of a profession undergoing professionalisation. The professional identity would have been developed through repeated self-verification and therefore their personal professional identity at graduation should have congruence with the identity standard norm (and its associated meanings and expected behaviours) in the educational environment in which it was constructed. The interviews suggest that undergraduate physiotherapy education was structured at a level to prepare graduates for a role in an autonomous physiotherapy profession and that the

participants were extremely positive about their undergraduate educational and placement experiences.

The dialogues and narratives underpinning an individual's undergraduate education informs the individuals professional identity and also their sense of self-identity. It is argued that the professional identity of participants of the modernised and quality Indian physiotherapy education institutions would be distinct from those who have experienced a more traditional and variable quality physiotherapy education. Based upon this educational experience Indian physiotherapy graduates form a personal professional identity around an expectation of practicing in an 'autonomous style' and in a context similar to that in which they are trained. The interviews suggest that the reality is quite different.

> *"So while studying everyone is quite happy. But once they come to the work scene, that's when they start seeing like a large number of people changing their profession or just going overseas."*
>
> Lara, FG3 (overseas masters)

6.4.2. Storming

6.4.2.1. Transition

The interviewees suggested that post-graduation physiotherapists frequently moved away from the location of their training, often returning to their hometown. When they find employment, they move into a new role, in a new work environment and continue their journey of professional socialisation and development. Professional identity construction is a constantly mutating process, responding to the changing professional context and expectations, and results in changes in their self-identity (Sparkes 2002). As a graduate moves

into work they need self-affirmation and self-esteem, and to continue their learning (Evetts 1999).

The new role carries with it expectations and the associated normative behaviours. New graduates bring with them the personal professional identities which they developed whilst training. As they engage with the new role and associated expectations, they seek feedback in a process of self-verification of their perceived professional role against the identity standard for that context (Biddle 1986). Based upon the interviews, it is suggested that where students found employment in environments that were similar to where they trained, the feedback they received would demonstrate near congruence between the identity expectations and their personal identity. The physiotherapist would adopt behaviour resulting in minor adaptations to their personal professional identity in order to bring the two into alignment, achieve congruency and self-verification (Stets and Burke 2000). The positive feedback that they receive increases their self-esteem and results in positive emotions and feelings of security (Burke 2006).

Many of the workplaces offering employment to newly qualified physiotherapists were described as "*parochial*" and were traditional in their practice. It was identified that the "*work scene is very different from the studying scene*" (Bipasha FG3) and it was evident that many work environments offered a professional culture, work style and behaviours that were different from the 'autonomous style' of practice and cultures that the graduates were used to in their training. It is suggested that the identity standard in these environments would also be quite different, therefore role expectations, meanings and associated behaviours would be different.

CPD, reflection and reflexivity are all important components of continued professional socialisation, development and identity formation (Richardson 1999b). Whilst there was evidence of a growing interest in CPD (Ahuja 2011; Nayak and Mathew 2011; Sinha 2011c), the interviewees reported that in many departments it was actively discouraged, as was discussed in the 'Challenging the Status Quo' section. Those who did short courses were often told by peers and seniors that there was no need, that they were wasting their money and time, and that they would "*just end up applying the same things that I am doing, in the same way that I am doing it*" (Adeeb). Eraut (1994, p12) identified that "*for every work place setting that teaches and inspires the next generation of leaders of the profession, there are others that limit their development and perpetuate weaknesses of the previous generation*". Some participants reported working alongside graduates who trained at poor quality institutions and did not have the basic skills of physiotherapy. There was concern that it damaged the reputation of physiotherapy and the respect conferred by doctors. This too would impact upon an individual's perception of their own professions identity.

6.4.2.2. Adapting

The Indian physiotherapists who trained at institutions perceived as providing more progressive education, would have developed a professional identity that was based around a notion of professional autonomy and the associated practice and cultures. This would have reflected the identity standard norm, with which their identity was congruent. If he/she moved into work environments that reflected a different culture and ways of working then the new graduate would adapt their professional identity to conform with the new environment and expectations. This could mean compromising their developing 'semi-autonomous' role identity for one of a physiotherapist working in a more 'technician style', following routine and instructions. In this situation the new graduate would receive feedback according to their behaviours from the department head, senior and peer staff. The feedback may not confirm

alignment of their self-perception of their personal professional identity with the identity standard and the expected behaviours of that department. This lack of congruence could result in negative emotions and distress (Burke 2006). To resolve the divergence the student must either change their role (job) or adapt their behaviour in response to the feedback, to bring their perceived professional identity in line with the role expectations of that department. Over time their perceived personal professional identity would change and align with the feedback received (Stryker and Burke 2000) and their behaviours would conform to the expectations of the department. This adaptive cycle of behaviour modification and feedback allows individuals to fit into new situations and cultures where meanings are different.

"...because if the HOD is laid back and she just thinks yeah it is okay, just do it, the other people who are working in the department also get that attitude."

Bipasha FG3 (masters studied in UK)

The adapting new graduate, would have tacitly acquired the rules and habits, and have embodied the beliefs and habitual everyday practice expected of a practitioner in that department (Wackerhausen 2009).

6.4.2.3. Divergence

An individual's behaviour in response to the discordant identities could change the situation more quickly and such an adaptation would be adequate where only a small identity realignment was required. If the divergence between the role identity standard and the self perceived personal professional identity was too great and the individual either cannot, or chooses not to, compromise behaviours to bring them into alignment, this would lead to conflict (Burke 2006). The conflict may be resolved when the person subject to the conflict adopts some form of coping behaviour (Biddle 1986). This may involve a

renegotiation of the role but evidence from the interviews suggested that this was an improbable outcome for most new graduate physiotherapists in India. Instead the physiotherapist may adopt strategic behaviour that complied with the expected role behaviour as a holding position. They may engage with a longer term strategy where they identify the internal power structures (department head and doctors) and they learn 'to play the game' (Clouder 2003). Alternatively they may try to adopt a strategy of selective interactions, carefully selecting people and situations with whom to engage to ensure affirmative feedback that confirms their identities; conversely they would avoid people and situations who would disconfirm identity (Burke 2006). 'True-conformity' would require a change in personal professional identity and also a change in underpinning beliefs, and meaning of that identity. However for many the behaviour and meaning changes that would be required to bring their personal professional identity to align with the role expectations of the identity standard of a 'technician' physiotherapist would be substantial. The resultant personal professional identity would have little congruence with the coexisting social identities and expectations associated with gender, family status, caste. The coexisting identities would not be salient and compromises would need to be made by prioritising identities.

"So that was a little shocking for me, because I was used to a particular way of working"

Bipasha FG3 (masters studied in UK)

For many the compromise of moving to a professional identity associated with a technician level practice was incompatible with their personal and professional expectations. The reality of a professional identity associated with low pay and a lack of respect, that it was irreconcilable with the expectations that Indian society and culture has placed on an individual who has a 4.5 year degree qualification. The status associated with high respect and high income is

dominant and defining in Indian society, and it therefore amplified the identity disjuncture that emerged for many recently qualified physiotherapists. The result was frustration with the Indian professional identity that they must adopt in order to socialise and function within many Indian physiotherapy departments. Haines and Saba (2012) consider that staying in an environment where there is ongoing role and identity conflict will result in distress, depression, a loss of a sense of self, and confusion in professional identity.

Acute reality shock regarding the transition from education to work is documented in the UK literature, but the emphasis is about being prepared with good practical skills to make the transition into work and to provide holistic, individualised care, when short-staffed (Castledine 2002). The issues in India were not about staffing shortages limiting the provision of ideal care, it was about the hierarchical structures, lack of clinical autonomy and conservative attitudes, all limiting the ability to treat patients optimally. The reality of physiotherapy practice for many Indian physiotherapists was one of no autonomy. They were unable to utilise the defined body of knowledge that is owned by the 'profession' and they must follow doctors orders; there was no evidence of the respect or social standing that would be associated with a profession. Often, there was no opportunity for negotiation around their role to enable them to implement practice according to their set of professional values.

"Sometimes I feel that I shouldn't have been a physio, because maybe I would have done better in another profession, maybe, which gives you more satisfaction. But then I did like working, in India as well, like I really liked the profession as well. So it's got like both views kind of where like you are juggling between whether you want to really go into this line or you just want to leave it you know. It is kind of mixed, I feel."

Sushmita, FG3 (overseas masters)

6.4.2.4. Changing Direction

The physiotherapists' frustration was accentuated because they knew that physiotherapy practice could be different to the work context in which they found themselves. The interviews suggested that some physiotherapists do truly conform but that many do not. For many physiotherapists the behaviour and identity compromise was too much and they would reject employment in that role along with the associated expectations and identity standard. They may then seek out new roles in different environments that they perceive would more closely align with their personal professional identity and where they aspired it to be.

"... I just wasn't ready to take no for an answer. I just wanted to get on and so I pursued."

Ashna (educator, studied overseas)

Some studied for a masters degree in India and so returned to the education context in which their professional identity was constructed; they returned to an environment that had greater salience with their identity aspirations. Others looked beyond India and saw a vision of a physiotherapy identity that was well paid, respected and empowered to practise in an informed and self-directed manner. They were attracted by the notion that physiotherapy as a profession and construct was different overseas. For some, role models represented identities and goals that an individual could attain; they assisted them to develop their self-concept and to define aspects of their identity (Gibson 2004).

"I want to do what he's doing and be successful like him."

Adeeb (studying for PhD in UK)

The role model of the peer Indian physiotherapist who had already taken the risk of the journey overseas, demonstrated back to Indian colleagues that they

were practising a different concept of physiotherapy, and that they had found professional fulfilment where once they were dissatisfied. As Mathieson (1997) suggests, the overseas physiotherapists were part of a synopticon style society, with the many watching the few; their power was in illuminating the global physiotherapy identity that could be accessed by all who could afford it. Additionally, if the role models received positive feedback from those in India it would reaffirm their identity, increase their self esteem and validate their decision to travel (Gibson 2004). For others, role models did not appear to be influential, they travelled to seek experiences to draw upon for learning and feedback; they did not aspire to imitate the professional identity of others but they aspired to self-actualisation underpinned by an ontological security of self-belief and a trust in their own self-integrity (Giddens 1991).

For those who travelled overseas to seek out a role, it would also require a change to their personal professional identity. The change should align with their development aspirations, and have greater salience with their coexisting social identities that attached meaning and value to respect, overseas entities and a stratified society. For some the move reflected an explicit rejection of the Indian physiotherapy profession *"I don't want to work as a physiotherapist in India"*, for others it was a more subtle seeking to change and transform their personal professional identity through learning *"a different concept of physiotherapy*", or engaging in different experiences, in different contexts.

6.4.3. Transforming

6.4.3.1. Locating the Journey

All the participants who travelled overseas articulated that their objective was personal development to progress their physiotherapy careers. All sought something different, that they identified was not available back home, to support that development. Rani wanted a different teaching experience, Lalit sought

knowledge in sport science and Ashna wished to access research knowledge and a higher qualification that was denied her in India. These participants did not articulate a rejection of their Indian physiotherapy identities, just the need for different development. They all identified a transformation in their thinking, practice, and careers, which informed their professional identity. The other younger participants, who travelled, all indicated dissatisfaction with Indian physiotherapy, because the reality of the physiotherapy identity that they experienced did not reflect the identity that they knew a physiotherapy professional could have.

The participants identified that they were travelling overseas to seek different knowledge and autonomous ways of practising. Both were key professional attributes that had been demonstrated to be absent in the Indian physiotherapy paraprofession that set the identity standard. Ultimately the physiotherapists aspired to the identity rewards associated with an established autonomous profession: quality of practice; respect and pay. To achieve congruence of their internalised professional identity with the identity standard, migrant physiotherapists required a further period of professional socialisation (Richardson 2002). Their Indian physiotherapy identity and prior experiences formed a cognitive framework for interpreting the new experiences, ranging from university interactions to work place environments and day to day living; all would inform the identity transition. The physiotherapists would modify and develop their personal professional identities according to the interactions and feedback in the overseas environment (Stryker and Burke 2000).

"I think that if I have changed the way, this is how I perceive myself, that if I've changed the way I think that I want education to be delivered from a physiotherapy point of view. I think it is because I have been globally mobile."

Rani (educator with overseas experience)

The overseas masters' programme creates an opportunity for professional socialisation to the new country's culture and will also provide access to a specialised knowledge base. Those who study for masters degrees can target their professional development to specialist subject areas, hence supporting their identity transition from a general physiotherapist to a research, musculoskeletal, neurological or respiratory specialist physiotherapist. Gains from physiotherapy masters study have been described as the development of skills for lifelong learning, increased confidence and expertise (Stathopoulos and Harrison 2003). High level clinical reasoning skills, critical analysis in practice approach, critical use of evidence to inform clinical practice, advanced problem solving, analysis of concepts and arguments, and high level self evaluation and identification of learning needs are the six key behaviours developed through UK masters level study (Rushton and Lindsay 2008). The participants who had completed their masters degrees described the development of attributes and behaviours that aligned with the transformation described in these UK based studies, including an appreciation regarding the value of reflective practice and its role in professional learning and ongoing professional development. The post-study participants also described the development of cognitive capacity and reflected how their thinking had changed as a result of their overseas learning. They identified that they had engaged with *"different ways of learning", "a mental training*" and *"learning how to think"*. The outcome was that they *"no longer took things at face value*"', they thought "*more laterally" and "more broadly"* and as a result were *"more critical", "more questioning", "more analytical" and "more sceptical"*. These attributes are essential for the cognitive processes that underpin clinical reasoning and effective independent clinical practice; they all facilitate the critical use of research evidence and the application of that knowledge to the clinical context (Rushton and Lindsay 2008). Similar transformations have been documented in other studies on exploring the value of masters level study by healthcare

professionals (Stathopoulos and Harrison 2003; Spencer 2006; Green et al 2009; Petty et al 2011).

6.4.3.2. Acquisition

> "*So, I again did my shopping on the internet and I sent applications*"
> Ashna (studied UK masters and part-time Australian PhD, whilst in India)

It was evident from the interviews that the participants who travelled took a very rational, consumerist approach in their decision making in where they would go and how they would acquire the attributes to transform their practice and their professional identity. They rejected an Indian masters degree as a route to their transformation, as it consisted of the *'same stories'* from their undergraduate education. Therefore, it would not allow them to acquire the differences that they yearned for or to make the transition to a global physiotherapist. Participants identified where they could purchase the component parts of their new identity; the latest knowledge and skills, specialised knowledge and research knowledge were all available in Canada, Australia, New Zealand, USA and UK, but which offered the best package? Which would allow progression to employment after study? Which would offer autonomous practice and a better life overall? Their choice of where to study was based around external tangibles that would differentiate one course and experience from another, so they could identify which would best meet their needs and aspirations.

> *"If you want to pursue higher study, then you have to think for the social benefits, for the educational purpose, for the job security. You have to consider all things together and then only you can come to a conclusion of a single university. Where in UK I got a degree which I wanted to pursue. Where in US I couldn't get the things."*
> Dinesh, FG1 (just arrived in UK)

Bauman (2000) comments on such a "*shopping around*" (p83) approach to acquiring a new identity. He considers that identities are liquid and that we live in a society where an alternative identity can be bought off the shelf through the acquisition of commodities that define the identity. The narrative from the interviews may suggest that this was what the Indian physiotherapists did; they were not content with their Indian physiotherapy paraprofessional identity and they looked overseas and saw a different professional physiotherapy identity. They preferred the overseas identity as it was associated with respect and autonomy and attracted a better financial remuneration; the quality of physiotherapy practice and availability of specialism's were important. The market was price sensitive and accessibility (availability of university masters courses, ease of immigration and professional registration) was also important.

> *"So long as you have the money to purchase its obligatory paraphernalia. There is the gear waiting for you in the shops [universities] that will transform you in no time into the character you want to be, want to be seen being and want to be recognised as being. There is also the dilemma, which one of the alternative identities to select and how long to hold on to it once the choice has been made?"*
>
> Bauman (2004 p84)

Whilst this resonates with the participants' narrative and the approach that they appeared to take, the statement is very focused on the external symbols of identity and does not reflect the internal emotional aspects that accompany the transformation. Nor does it capture the financial challenge of a 'third world' national purchasing a 'first world' commodity. It ignores the social sacrifices that Indian physiotherapists make to undergo such a transformation. The consumer approach (compiling a shopping list of essential criteria and identifying where they can meet their personal development needs and long term aspirations) was adopted once the decision had been made to go overseas. It is suggested

here that this was a process of empowerment for the Indian physiotherapists, rather than the right to shop and consumer self-gratification that Bauman suggests (2000; 2004).

"I have just gone through the modules offered by the countries universities in Australia and UK. And another aspect is the money (...) And I felt both the modules and the quality and all the skills of education provided here are equal. So I preferred UK as the best destination."

Joseph, FG1 (just arrived in UK)

6.4.3.3. Contextualisation

All the participants wanted to gain clinical experience as a part of their professional development, to contextualise their academic learning and to learn from the overseas practice context. Such experience would enable them to verify their evolving personal professional identity with the role identity standard of an autonomous physiotherapist, in the practice context. Behaviours would be modified according to feedback, in order to adapt their professional identity to achieve congruence with the identity standard (Biddle 1986). When they self-verify that there is congruence, it would enhance their self esteem and they would internalise the new professional identity and their self-identity (Stets and Burke 2000). It is likely that their transformed professional identity would achieve saliency with their coexisting identities, as it would be associated with more respect and higher pay.

Practical experience underpinned by reflective practice is essential to professional learning and its contextualisation, and is considered to result in experiential knowledge (Field 2004; Eraut 2008). Experiential knowledge is personal knowledge as it is gained through subjective experience, and is dependent upon how information is interpreted and acted upon in the clinical setting (Eraut 1994). It allows an individual to transition from knowing *what* the

theories of treatment are, to knowing *how* to apply them in ways that will achieve a successful outcome for the patient. This knowledge transition is considered to be the major difference between physiotherapy being an application of techniques, or being a successful professional service (Richardson 1999b). Personal experiential knowledge is formed from the multiple contextual cues in the social and professional environment and the problem solving processes that relate specifically to the context. It is elucidated by personal experience of synthesising facts, theories and intuition; it is therefore, key to the development of a new physiotherapy professional identity. Boyes (2004) considers that professional identity is created through discourse between individuals and discourse in the cultural clinical context. Therefore for an Indian physiotherapist, gaining employment overseas as a physiotherapist must be considered an important part of the full transition journey, in order to understand the tacit cultural dimensions of the new professional identity in a non-Indian cultural context i.e. the cultural context in which the profession identity was sought.

By undergoing a journey of travelling overseas, studying and ideally working in the overseas culture, the participants had identified that they felt more knowledgeable, they had developed different skills, they had changed the way that they think, were able to evaluate evidence and practice around them, and importantly they had more confidence in their clinical practice and their ability to justify their practice. They understood and articulated physiotherapy in a different way. Each Indian physiotherapist will have developed a bespoke professional identity according to their self-interpretation of their experiences and discourses. It is suggested that those, who were able to gain employment as physiotherapists overseas, were able to engage with a more complete journey of transformation, practising autonomously and gaining respect together with the financial rewards associated with the new professional identity.

6.4.4. Transferring

6.4.4.1. Globally Mobile

All the participants who travelled stated that they planned to return to India but ideally after a period of working overseas. Some interviewees identified that if they could not find work that they liked after their masters study in the UK, they would move to another country (Canada, New Zealand, Australia) in search of physiotherapy practice, and a life style that they were comfortable with, until they were ready to return to India.

> *"I want to still continue to work over here at least for another 2 years and, but yeah, it seems to be a little bit difficult. So like they said if it doesn't work then I would have to go may be to a different country".*
>
> Sushmita FG3 (UK masters graduate, now looking for work)

Such a transition would entail them taking their newly constructed physiotherapy professional identity to another country's context. It may be inferred that Indian physiotherapists considered that they are constructing a global physiotherapy identity that will be transferrable across national professional contexts. In business and the IT industry such global mobility is the norm (Khadria 2004), but professional registration to practise limits such fluid movement in the health sector. Is there such a thing as a global physiotherapy identity or does a physiotherapy identity have to be a construction within a national context? Disease is not nation specific and does not adhere to national borders and the world's population is mobile (Stalker 2000); however, different professional associations have different codes and ethics of practice and there are differing regulatory demands between countries (Higgs et al 2001). The ontological organisation supporting healthcare systems varies, and many developed healthcare systems have moved away from disease orientation to client centered approaches, in an attempt to empower the patient and reduce the power imbalance between the medical professions and the patient

(Eisenberg 2012). This cultural and contextual diversity will result in different discourses and therefore different professional identities would be constructed. Yet, the terms physiotherapy/physical therapy carry with them a loosely defined knowledge base and a set of role and practice expectations, articulated as a global description of physiotherapy by the WCPT (WCPT 2013a). Individual physiotherapists are bonded via their national associations to the WCPT, but the WCPT is not one homogenous body. Each national physiotherapy association forms a *'segment'* within the WCPT and has its own distinct identity, ideology and mission (Bucher and Strauss 1961). Each national segment is at a different stage of its development towards professional status, with different educational entry criteria and often conflicting priorities, but all are inter-related and codependent. As a collective whole they have a greater global presence and therefore have more influence nationally and internationally. Social identity theorists would consider that the WCPT is an organisation where intergroup (not interpersonal) relations dominate and are dynamically intertwined with the social identity of the organisation (Hogg et al 1995). Therefore it is suggested

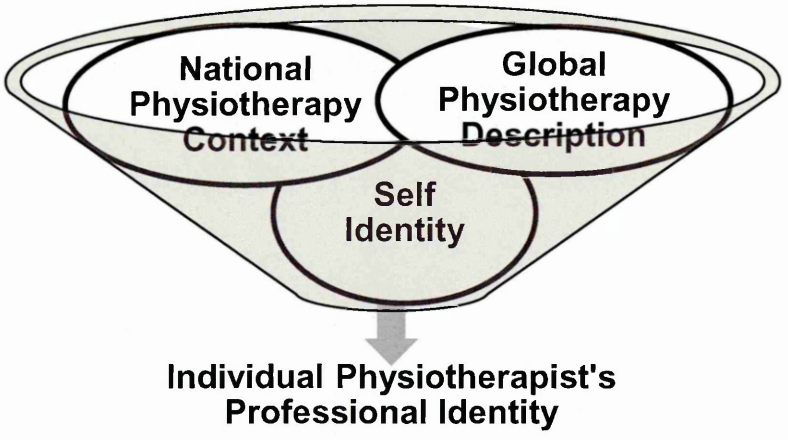


Figure 10: Physiotherapy Professional Identity Global Influences

that the common global understanding of physiotherapy, together with a construction of physiotherapy in a national context, and self-identity informed by

an individual's knowledge and experience discourse, all influence how an individual physiotherapist constructs their physiotherapy professional identity (see figure ten).

An Indian physiotherapist, who has travelled to construct a new personal physiotherapy identity, will have developed a construction of physiotherapy influenced by their Indian physiotherapy origins but based in the nation in which they study their masters degree and / or gain experience. However, they have no ties to the host country and they have experience of reframing their professional identity through global mobility, so moving to a third national context may be viewed as a natural progression and enhancement of their physiotherapy identity construction. Their previous experiences within different national physiotherapy identities, will inform the discourse and interpretations that inform their self-identity. From the interviews it was evident that for further mobility to be acceptable, the profession in the destination nation must be autonomous and respected in order to facilitate the reframing of their personal professional identity, in line with their aspirations for good professional practice and a better life. So whilst there may not be an overall global physiotherapy identity, there are globally mobile physiotherapists, who have developed fluid professional identities based around a common global representation of physiotherapy and an ability to adapt to meet the local national context.

6.4.4.2. Importing Identity

Ultimately the participants interviewed aspired to return to India and highlighted the challenges of returning there. It is suggested that there is an optimum time to stay away, in order to develop and be confident in the authenticity of their overseas physiotherapy identity, which enables them to negotiate and collaborate confidently with others (Richardson 1999b).

"Frankly speaking, I would like to return to India after some period. Because this is the this time period which I can give my potentials to the maximum. After a particular age I think I can't give all my potentials to the world. So I think for 10 to 20 years I will be in this field in somewhere. My plan is to be in a developed country. And after that I'll be going back to India."

Joseph, FG1 (just arrived in UK)

The challenge for a returning physiotherapist is locally to contextualise their overseas professional identity in an Indian physiotherapy environment. It was indentified in the interviews that their overseas transformation had resulted in changed clinical practice, different ways of thinking and amended values. Their transformed professional identities would be based in an autonomous professional context, within a culture where inter-professional practice, patient empowerment and self-determination are embedded. The returnees would resist reverting to their previous practice and the associated identity of a disillusioned physiotherapist. They must at least return to a workplace where new ideas and different practice are welcomed.

"I think there are tensions there, because if you are gone overseas (...), then you obviously doing things a little differently from where it is done hierarchically in India, and if they have to come back and then work in a hierarchical model again, this is very frustrating (...) the persons of the high positions are not very open those concepts or ideas they may not allow them to bring in those practices."

Rani (educator)

It is suggested that successful return to India is dependent an individual's ability to import their transformed professional identity and to achieve identity verification in the role in India. To achieve this the returnee must identify a role and situation that is likely to be in accordance with their transformed, personal, professional identity, or can be modified to ease the journey towards

congruency. A returnee would need to adapt their physiotherapy identity to meet the role identity standard, as contextually it would be different. They may be able to influence the role expectations so that the two identities move towards each other. This appeared to be the case for the participants (Rani, Ashna and Lalit) who had returned to higher level roles or niche roles that had role autonomy. In both scenarios they were more likely to be able to influence the role expectations and identity standards, ensuring successful return, as they could quickly achieve salience with their professional identity (Stryker and Burke 2000).

Those who return to the same work context as they left are perhaps less likely successfully to transfer their identity and achieve congruence, unless they return to a different role, with different expectations. Mindha returned to her previous employment in a large private hospital in Mumbai and had been able to implement what she had learnt, but only within the boundaries of a semi-autonomous context and supported by a head of department who had worked overseas. She reported being constrained by a lack of full autonomy and frustrated by low pay (despite a substantial pay rise upon her return), and was planning to setup in private practice to address these issues. Mindha's case suggests that returnees may be better equipped post identity transformation, than they were prior to travel, to manage identity divergences and to adopt coping strategies, until they can influence a change in the environment, role and associated identity standard.

The educators interviewed identified that quality teaching institutions were malleable environments open to new ideas, knowledge and welcomed the overseas identity, expertise and attributes that returnees bought. However as their overseas masters qualifications were not being recognised as equivalent to an Indian masters due to the shorter study time, their career pathways were limited in these contexts and so further identity development would possibly be

constrained. Return to quality teaching institutions potentially perpetuates the two tier physiotherapy that was discussed in the 'maintaining the status quo' section. Also many who have travelled overseas had developed clinical expertise overseas and they wished to become clinical practitioners in India and not move into education.

Instances were highlighted where friends had returned and tried to settle, but because of the context they had returned to had not changed whilst they had been overseas, or the pay upon return was too low, they had gone overseas again. These returnees appear not to have successfully imported their transformed identity and not to have achieved identity verification in India; their onward travel suggests that they had sought overseas roles that are more likely to align and achieve identity salience.

6.4.4.3. Profession Transformation

The physiotherapists who travelled sought the attributes associated with the overseas physiotherapy professions and left behind their frustrations that were associated with the paraprofession status of physiotherapy in India. They return having undergone professionalisation and developed the attributes associated with an individual's professionalism in the context of an autonomous profession. Professionalisation is dependent upon individuals' demonstration of professionalism and engaging in lifelong learning, so that they may continuously reappraise the professional purpose and respond to societal change (Friedson 2001). Professionalism defines the manner and behaviours adopted by professionals in the conduct and organisation of their work, and is considered essential to maintain the status of a profession (Richardson 2002). A profession is a social group that is a sum of the component members, and the individual professional identities inform the collective profession identity (Evetts 2003). Therefore, as individuals return with their professionalised overseas identity

they should contribute to the gradual change in the Indian physiotherapy profession identity. However they are only a part of Indian physiotherapy, and it was evident from the interviews that there are many physiotherapists who have stayed in India and who engage with the concept of professionalisation. They will have different professional identity discourses to add to the returnees overseas identity discourse but the narrative from FG2 and Manish (none of whom have travelled) suggests there would be a common thread calling for physiotherapy autonomy and respect. However, it was also evident from the interviews that there was a tier of physiotherapists in significant professional positions who showed no evidence of engagement with the professionalisation process and their behaviour perpetuated the status quo.

6.4.5. Summary

Professional identity is fluid and it is theorised that an Indian physiotherapist's professional identity underwent a process of transformation, as they journeyed overseas seeking a better life. The professional identity development and transformation involves four stages, forming, storming, transforming and transferring for those who return or move onto another global context. Figure eleven summarises this journey.

Forming of an individual's nascent professional identity occurs through a process of professional socialisation during their training. The professional identity formed reflects the context in which the education and socialisation occurred. Storming occurs when an individual moves into an employment scenario which is culturally different from what they are familiar with or they are unable to develop as professionally as they aspire. They may be unable to practise autonomously or to utilise the skills and knowledge they have acquired or professional development opportunities may not be available to them.

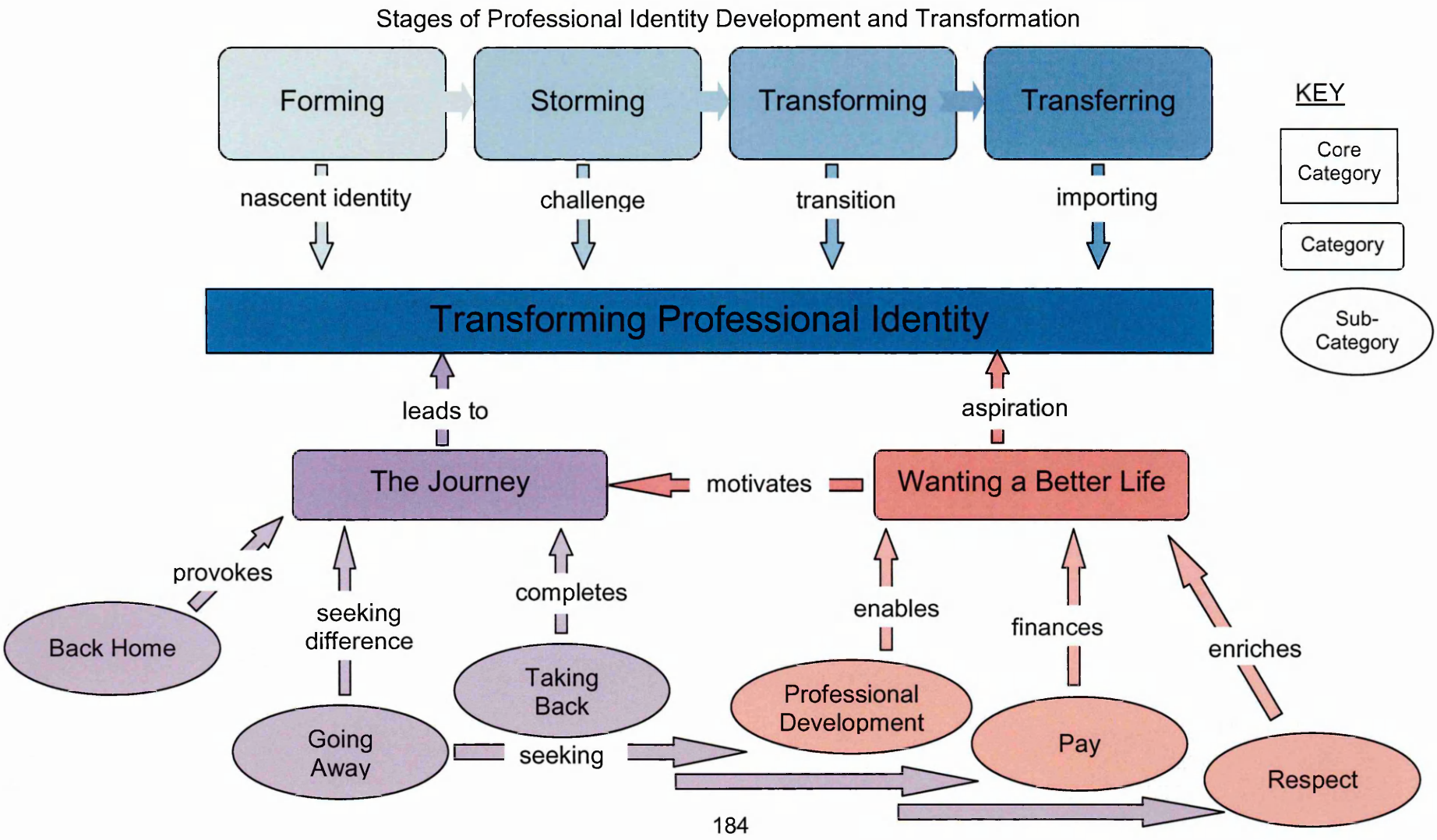


Figure 11: An Explanatory Matrix of the Grounded Theory of a Journey of Professional Identity Transformation

This transition may result in a storming and challenging of professional expectations, local context and professional identity. Transforming occurs through overseas masters education and employment in an autonomous context, they a transition to into autonomous professional and transform their personal professional identity. Transferring occurs when they move into a different employment context, another country or returning home. The success of their return is dependent upon their ability to transfer their identity back to their home country. It is suggested that if they are successful in importing their transformed identity and at reintegrating, they are in a strong position to share their knowledge and influence practice and to transform the profession identity.

Integral to the stages of professional identity transformation is the individuals journey, the context 'back home' that provokes the journey, hearing that the profession and practice is different overseas and 'going away', motivated by wanting a better life. A better life that is sought through professional development, better pay and respect, all of which will enable, finance and enrich the journey. A journey that should be completed by taking back their transformed professional identity and the associated attributes.

7. Chapter Seven: Discussion and Conclusion

This research set out to explore why Indian physiotherapists chose to be globally mobile. The findings suggest a clarity of focus underpinned the aims and aspirations of individual physiotherapists who undertook the journey. They also reflect a complexity in the factors that influenced the decision to seek professional development overseas. Significant challenges associated with successful return were identified. From this research a grounded theory has been constructed that suggests the Indian physiotherapists' global mobility is a journey of professional identity transformation moving through four stages; 'forming', 'storming', 'transforming' and 'transferring'. This chapter summarises the issues and outlines key messages / implications for Indian physiotherapy. The research limitations are identified and suggestions for further research are made.

7.1. Key Findings Underpinning the Theory

7.1.1. Motivations to Go

The findings suggest that physiotherapists who are globally mobile ultimately want a better life. This incorporates being respected for what they do professionally, and being remunerated accordingly. Underpinning this aspiration is the professional drive to be better physiotherapists and to treat patients more effectively; to do this they need to be able to practise autonomously. The participants reported being frustrated that they were only able to practise in a non-autonomous technician role due to the hierarchy in many Indian physiotherapy departments, and they also considered that the continuing professional development opportunities in India did not adequately meet their needs or enable them to achieve their aspirations. Therefore they travelled overseas to destination countries where physiotherapy is a more mature

profession, with a level of practice and associated knowledge, research and skill base that underpins the identity of an autonomous profession. They sought something different in terms of experience, practice, knowledge, respect and pay. Most started their journey overseas with masters level study, but they aspired to clinical work, ideally in a paid capacity, to gain experience of autonomous physiotherapy practice, until they were comfortable and confident with their new professional identity and all that it encapsulated.

This study has constructed a theory of a journey of identity transformation for the physiotherapists. The study findings regarding the motivations to travel, are resonant with the published global mobility literature and theoretical frameworks. The physiotherapists' motivations align more closely with doctors', than nurses' mobility but there are some identified differences.

These findings align with the published literature around global mobility of students. This suggests that students travel overseas for education that is insufficiently provided for at home (Vincent-Lancrin 2008) and the suggestion that an overseas degree is a pre-cursor to employment in the destination country (Cobb-Clarke 2000).

Push factors are the issues that drive an individual to emigrate. The literature identifies that low pay, management and governance issues often drove migration (Buchan et al 2003; Oberoi and Lin 2006; El-Jardali et al 2008). This study suggested that these factors are relevant for Indian physiotherapists, however working conditions and exposure to HIV/Aids was a factor in health professionals' migration in Africa (Buchan and Dovolo 2004; Bach 2006), but was not identified as an issue for Indian physiotherapists. Working style in the context of autonomy and respect was important for Indian physiotherapists. Pull factors affect the selection of destination countries. Pay differential is commonly

discussed in the literature and it was an area of debate amongst this study's participants regarding adjustments for purchasing power parity and whether they would receive more pay upon return. In line with Kingma (2001), and Ross et als' (2005) conclusions, it was not the most significant factor in selecting the destination country, as all paid significantly more than India and the pay was associated with increased respect (Vujicic et al 2004). Khadria's (2004) study identified that for Indian doctors moving overseas the emphasis was on a professional development focus including access to higher education opportunities; working with experts; better professional infrastructure and employment opportunities; better income and quality of life. However, for Indian nurses, whilst they did identify access to training opportunities and career progression there was a greater emphasis on socially focused drivers around income, quality of life and education for children. The findings from this study suggests that the Indian physiotherapists motivations more closely align with those of the Indian doctors than the nurses. Oberoi and Lin (2006) identified that push factors played a greater role than pull factors, the findings from this study do not indicate a balance of importance. However, the push management and governance factors were significant and complex, and seemed to impact upon the success of return migration, and are explored further in the next section.

Brain drain and its impact upon the health workforce has been an emotive issue particularly for nurse migration from Africa (McElmurry et al 2005; Buchan 2006). In this study it was identified that there was insufficient employment for all the physiotherapists that had recently graduated and so this perspective was not considered to be of major importance. Conversely, it was identified that India had a significant need for more allied health professionals to meet its extensive health needs and disease burden but lacked resource to meet the demand. This study's findings suggested that some aspects of brain circulation theory were resonant (Bach 2006; OECD 2008c); the drive for new and different

knowledge would support the increased stock of global knowledge; professional networks and role models were identified as mechanisms for circulating knowledge; returning home was a long term aspiration for all and a short term reality for many. However, although there were challenges associated with return migration, there was evidence of ongoing professional development post return. There was no suggestion in the data that the possibility of migration attracted talent to the profession.

7.1.2. Governance, Medical Power and Social Amplification

Indian physiotherapists chose to migrate overseas within a context of an Indian nation with strong economic growth, and had observed peers in different professions benefit from that growth (OECD 2012). In parallel there was considerable poverty, significant healthcare needs and huge disparities in healthcare provision (WHO 2013), Yet the future direction of the development of India's healthcare provision, and the government's identified aspiration to harness the expertise of the allied health professions in order to address India's workforce requirements and so meet India's health needs (NIAHS 2012), seemed to be stalled by vacillating governance. The two decade chronology of wasted government legislature (appendix one) to provide a legal framework for recognition and regulation of the physiotherapy profession, illustrates the complex power struggles and emotive narrative that appeared to underpin the future of India's healthcare provision.

Given the size of the Indian healthcare market and its continued growth, it was not surprising that the physicians were determined to retain their position as the sole authorised autonomous practitioners in Indian healthcare. The quarrel regarding Indian physiotherapists using the 'Dr.' prefix illustrated their sensitivity to any contamination of their medical identity. This perceived threat of an empowered autonomous physiotherapy identity suggested ambiguity in their

privileged position. The western literature is scattered with discourses that explore the demise of the medical professionals identity and hegemonic authority, through a gradual corrosion of their mechanisms of power, leading to increased autonomy of the allied health professions (Ovreteit 1985; Kenny and Adamson 1992), the emancipation of the patients, and the restructuring of healthcare funding streams (Friedson 1985; Sullivan 2000; Ritzer 2001; Watts 2009). It was therefore not surprising that, given the scale of pending changes and demand, the Indian medical stakeholders wished to ensure that their professional autonomy, identity, practice and livelihood, was not undermined by the autonomy of others.

Foucault considers that identity is a form of subjugation and a way of exercising power over others and preventing them from moving outside fixed boundaries (Turner 1997). The Indian medical dominance, that could be seen as subjugating physiotherapy practitioners only to offer treatments according to a doctor's prescription and adopt a paraprofessional identity, supports Foucault's contention. However, the paraprofessional physiotherapist was also suppressed by societal power relations. Their low status in the medical hierarchy perpetuated a perceived lack of respect and actual low pay. In Indian society the importance of such meagre cultural capital is amplified way beyond comparable significance in the west. Indian societal power plays a central role through symbolic domination and hierarchy and invades many aspects of social life, particularly for men where there are significant familial and societal expectations (Webb et al 2002). Therefore Indian physiotherapists, who travelled overseas to transform their paraprofessional identity into the identity of professional autonomous practitioners, were also seeking to transform their cultural capital. Through professional development and increased cultural capital they would gain respect and be empowered to make the career choices that inform their better life.

Whilst there is a dearth of legislature regarding recognition of physiotherapists, it could be argued that it would be challenging for the profession to move forward. The IAP appeared to retain a focus upon controlling entry to the profession and in lobbying government for physiotherapy autonomy and the council. However, there was reported disillusionment with the old IAP at the lack of legislative progress and the subsequent split within the IAP had reduced the IAP's credibility amongst its members. The public nature of the dispute, with repeated court orders (IAP 2013b) cannot have enhanced its credibility amongst those with whom it would lobby and negotiate to establish Indian physiotherapy's legal position.

7.1.3. Challenges of Return Migration

All the participants who were still overseas indicated that they expected to return. They aspired to return with knowledge, skills and different ways of working, so that they could improve physiotherapy practice in India and personally benefit from a higher status and pay. Brain circulation is one of the theorised benefits for the donor country of overseas highly skilled migrants (Khadria 2004). Based upon the narrative in this study, the grounded theory suggests that there must be a successful transfer of the new overseas identity of the returnee, before successful knowledge transfer can occur. Ghosh (2000, p184) identified that successful autonomous return was dependent upon two factors. Firstly, the returnee must be able to ensure a successful personal return and access "*productive and gainful employment*", and secondly, they should be able to contribute to the economic and social development of their home country. If both these reintegration elements are met, it will set in train a virtuous cycle helping further return in the future. The ability to take new ideas, values and ambitions back home is described as a 'return of innovation' and is considered to be the most valuable type of return to the home country. It is also recognised that this is difficult to achieve (King 2000). Iredale et al (2003)

identified that skilled migrants often do not drive societal change but return following development or social transformation in their countries of origin. They also suggest that, if returnees felt hampered by overly bureaucratic environments and poor working contexts, it would lead to frustration and repeated migration.

Applied to the context of Indian physiotherapy, it is suggested that whilst the complexity of factors associated with the identity storming phase remain, the return environment would continue to be challenging. The returnee participants interviewed, had all successfully effected 'returns of innovation'. They had moved into carefully selected environments where they had autonomy of role and Minda, who had returned to her old employer, was strategically working to build local networks in order to establish a private practice that would afford her autonomy of role. This could suggest that, if a regulatory council were formed that confers physiotherapists autonomy, this may attract returnees.

In the literature it is reported that migrant physicians are beginning to return to India, attracted by the country's economic and associated corporate healthcare sector growth. Some are returning to work in the already established private sector but others, with ten to twenty years of overseas experience, are investing in and setting up specialist institutes. It is considered that such institutions will change the character of medical practice in India and create an attractive environment for nurse and allied health returnees (Hanour-Knipe and Davies 2008). Interestingly the returning doctors identified that they had always wanted to return to India but had been held back because *"they would not have been able to practise medicine the way they had learned abroad*" (Ganguly 2003, in Hanour-Knipe and Davies 2008, p23); previously therefore they were unable to return and utilise in India the professional identity that they had constructed overseas.

7.2. Key Messages for Indian Physiotherapy

The journey of identity transformation and concepts within this discourse, provides a knowledge base upon which Indian physiotherapy can self-reflect and identify a journey to empowerment. Bourdieu suggested that self-critical knowledge that reveals the sources of power, and identifies the reasons that explain social asymmetries and hierarchies, can become a powerful tool to enhance social emancipation (Navarro 2006). Foucault (2002) contended that power is about dynamics; it is not one sided and not always negative, but it is a relationship. Nor is power concentrated in one place or in the hands of particular individuals; there is a multiplicity of power relations at work any time power is exercised. Through a greater understanding of the discourse, the current governance turmoil provides an opportunity for Indian physiotherapy to embrace real power as an alternative to being subjugated to the authoritarian power of the doctors. There is the opportunity to influence and define an identity for Indian physiotherapy that meets India's health needs, and is embedded within India's cultural and societal context. This identity would not be a replica of an overseas physiotherapy identity, as identity is culturally and contextually dependent, but it would need to meet the aspirations and potential of Indian physiotherapists and to embrace autonomy. There are multiple overlapping discourses that will define the future of Indian physiotherapy and this thesis highlights some of the discourses that, if embraced, could influence the direction of the Indian physiotherapy profession.

Throughout the interviews the lack of autonomy of physiotherapy practice and the impact upon the individual physiotherapist and his/her identity was significant. Participants also suggested that when a physiotherapy council is established, the autonomy problem would be resolved and, along with it, all the associated issues. Whilst establishing a council and achieving legitimacy is an essential part of governmental power structures (Nicholls 2012), it is suggested

that there are associated discourses that would not immediately be resolved through the formation of a council. Participants identified that variable quality physiotherapy was also contributing to the lack of respect for physiotherapy; the quality of physiotherapy was in part linked to the culture of a department, and whilst culture is created, defined and altered by Indian physiotherapists (Charon 1995), it will take time and effort to change.

The variable quality of the physiotherapy practice and department culture that was reported by participants creates a significant issue for Indian physiotherapy. The 'parochial' departments appeared to be one of the key causes of the frustration that newly qualified physiotherapists felt. They could also be a potential barrier to overseas migrants returning. In addition, they did not display the professionalism required to uphold an autonomous status and so will continue to impact upon the profile and perceived respect of the physiotherapy profession. The challenge for Indian physiotherapy is to engender professionalism in all its physiotherapists through engagement with continuing professional development, 'evidence based practice', clinical reasoning and a supportive culture of practice innovation. Professional learning could be facilitated to foster a confidence in practice, and to encourage individuals to pursue and explore ideas with their colleagues. This would generate a professional knowledge construction that would be relevant and contextualised within India, which is grounded in individuals' professional practice and self-directed learning (Richardson 1999b).

The Indian physiotherapists identified that they travelled for professional development, different knowledge and education. Some of the difference related to the overseas autonomous practice cultures but there was a clear message that the overseas masters was significantly different to an Indian masters. The participant educators agreed and identified a need to facilitate learning at higher cognitive levels. Indian physiotherapy educational institutions

had close links with clinical departments and this was an important asset, but some participants perceived an imbalance between studying and working during a masters programme and an over dependence on a final examination. Developing a culture and capacity for research was considered to be a significant need for Indian physiotherapy, in order to develop new clinical knowledge and contextualise existing research, both of which would enhance the Indian physiotherapy knowledge base. Indeed the need for more research expertise in Indian higher education generally has been articulated at the highest government levels (Agarwal 2006).

The final discourse that emanates from the grounded theory is the challenge of return migration and ensuring that the return is one of innovation that will contribute to the social context (King 2000). Indian physiotherapy finds itself in a juxtaposition, one image is of too many physiotherapists who are disenchanted, have poor employment prospects in India, and work in a medically controlled hierarchical context; as a result they are losing talented, and motivated physiotherapists overseas, on a journey of professional development, identity transformation and in search of a better life. The other image is of India's huge healthcare needs and the necessity to utilise its invaluable health workforce resource effectively, alongside a profession fighting for autonomy of practice in order to meet its potential. As a result of a decade of migration of physiotherapists, there is a significant potential for talent circulation to enhance the Indian healthcare provision. However, this study's findings are that successful return would be dependent upon being able to import their new physiotherapy identity into the clinical and professional context. If Indian physiotherapy could support returnees in their transition back to India and into employment where their experience and practice would be valued, this would assist an effective transference of their overseas identity, and they would be able to help to support the development and transformation of the profession in India.

7.3. Reflexivity

7.3.1. My Journey as a Researcher

Prior to undertaking this research I had previously only engaged in quantitative research. My career direction had taken me down the path of international work where the research questions that I was asking would have been inadequately addressed using the quantitative methodologies with which I was familiar. I knew that my ontological and epistemological position had moved in the preceding few years and that I appreciated the value of more interpretive approaches. I enrolled on the Professional Doctorate as an alternative to a PhD, in part as it provided a coherent guide for the epistemological and methodological transition into interpretive research. Grounded Theory methods were considered appropriate address the identified research area from a methodological perspective, but I also felt an affinity towards an approach that, itself, has undergone a similar ontological transition; an evolution from structured, formulaic, post-positivist theory generation, to an interpretive, constructivist, collaborative approach to theory generation. This mirror of my ontological maturing also provided security; if I struggled in operationalising my conceptual transition to constructivism, there was an acceptable post-positivist approach to theory generation to which I could have retreated.

However, I was determined to embrace the constructivist approach fully. The transition was initially challenging, as whilst I had read much of the literature on the different approaches, it lacked contextual meaning until I starting doing the research. I frequently reverted back to the textbooks to check that I was 'doing it right'. The transition into different ways of analysing and the creativity felt very uncomfortable at times. I was concerned regarding the rigour of what I was engaged with and felt that I became 'bogged down' in the process of using NVIVO, obsessively recording every coding amendment and thought, to the point where it was constraining the analysis. It was exceedingly time consuming

and I felt like a secretary recording every minute of the research process, I was getting caught up in detail but was unsure that it was the right detail; I was procrastinating over every decision, rather than letting the research process flow. This did however ensure that I reflected upon and recorded the decisions made. At times I was at a loss, going round in circles in the data analysis. As I progressed I refined my recording, memoing and the use of the various NVIVO tools; gradually the data analysis gathered a meaningful and purposeful momentum. When I reflected upon that phase of the research a part of me was frustrated, feeling that I could have used the time more effectively and progressed more quickly but I also realised that the experience of finding my way through was an essential part of my transition to a grounded theory researcher. I also identified that one of the many analytical cycles that I had been caught up in was the constant comparison process that is a characteristic of Grounded Theory and I realised that my skills had gradually become refined along with the theory. The final stage of writing the thesis was an important part of the research journey and the epistemological transition. As I began to articulate the research analysis I was able to reflect and to review the detail of the theory. The process of writing helped me to identify and omit irrelevances and to emphasise the key elements of the discourse, keeping it as focused and as simple as possible. As I utilised quotes to support the narrative, I was able to challenge and question my assumptions, clarifying what was fact gained from my participants and what was theory. However, I found it challenging to articulate a linear discourse for a matrix theory and also to ensure that the participant voice could be heard and to identify how the theory should connect to the narrative in which it was grounded.

The professional doctorate structure, the interpretive approach and the grounded theory methods all facilitated an academic freedom that allowed me to explore a range of sociological, psychological and philosophical literature that I would not have engaged with had I stayed with quantitative methods. Whilst

challenging, this freedom of allowing my reading to follow where the narrative and journey took me, enabled me to develop a breadth of knowledge and a maturity of critical thinking and analysis that I would not have otherwise achieved. Some of this reading has been invaluable in helping me to overcome challenges in my daily professional practice, particularly regarding leadership. Conceptually leadership is an abstract entity, a theoretical enigma and a paradox, and to evaluate and develop the effectiveness of such a construct, one needs to understand the epistemological beliefs and ontological positions that underpin and inform the different leadership behaviours (Tickle et al 2005; Carol et al 2008; Drath et al 2008). Contextually, I found that understanding different philosophical perspectives and sociological theories and reflecting upon them in the context of my day to day challenges, incredibly useful. Some of the reading that I engaged with as a part of this research, particularly around role identity and role conflict, enabled me to step back from my preconceptions and day to day work and consider challenges and solutions in new ways. It also facilitated me to reconceptualise my perception of physiotherapy and emphasised the importance of understanding not only different perspectives but also the significance of the archeology and evolution underpinning the presenting context, and how these may influence the path ahead and decisions that are made.

7.3.2. How I have Influenced the Data Collection and Analysis

My position as a part-time doctoral student presented opportunities to undertake the research that would not have been possible had I studied full time. I was able to use professional networks to identify participants and to conduct interviews whilst I was travelling overseas. However it also created constraints, the most significant of which was a pressure on time and the challenges of part time study aligned with a demanding job. Both undoubtedly influenced the way in which I structured the research data collection and the timing of the analyses.

Constructivism as an ontological perspective reflects that individuals construct meaning out of social contexts, it emphasises the value of an individual's interpretation and unique experiences (Crotty 1998). When applied to grounded theory methods, it gives a voice to the participants but it also embraces the input of the researcher (Charmaz 2012). My professional journey and discourse undoubtedly influenced the analytical decisions that I made. The data was rich with potential analytical themes and I followed those that aligned with my areas of interest and, to some extent, my professional journey. For I, too, have travelled and worked overseas and have returned home, but I recognised that, compared with the Indian physiotherapists' journey, my global journey was driven by very different motivations and accompanied by different learning.

Career wise I have also made various professional identity transformations from clinical physiotherapist, to a physiotherapy academic, to leading on international academic and business developments and latterly a journey of research transition. Hence I am interested in professional and practice development, knowledge transfer and return migration, and in understanding the underpinning contexts. These elements all influenced the analytical decisions that I made when considering the interview narratives.

There were points in the research where had I taken a different analytical fork it would have resulted in quite a different theory. For example the influence of gender; it was important for me to include and to understand its influence on the Indian physiotherapists journey but it did not form a critical part of the resultant grounded theory on professional identity transformation. I could have taken a different analytical path that explored the gender disparities and societal influences much further; this would perhaps have been supported by and resulted in a more critical feminist influenced grounded theory construction.

7.3.3. What I Could have Done Differently

Developments in information technology and its usage as a communication tool offer clear opportunities for refining aspects of the study if I were to repeat it. As I developed the initial research proposal and progressed into the research phase in order to capture 'user' perspectives and input, I set up a secure online portal through which I planned to manage a virtual advisory group (with advisors in India and in the UK) to consult regarding the construction and implementation of the research. I used 'Google Groups' to ensure that the portal was secure but the cumbersome nature of the technology meant that advisors had to set up Google accounts and individual secure passwords. This meant that those who had indicated their support never actually logged onto the portal and just engaged with me individually by email. Google have since removed their 'Groups' function as it was unsuccessful compared to other social networking tools. Conducting the research again, I would revisit the idea of an advisory group in the light of more accessible social medial developments. An interactive advisory group would have added a useful dimension to inform the research planning and implementation.

SKYPE was discounted on two counts as a technology through which to conduct interviews. It has poor reliability at conducting video and audio footage where internet connection speeds are poor and it is more challenging to establish a rapport with a two dimensional image and an audio stream. Internet connection speeds are continuing to improve and I would also reconsider the use of SKYPE, possibly in conjunction with the telephone, to interview the participants that I already knew well. However, for this research I would continue to be cautious about using SKYPE for interviews with participants that I did not already know; it would be very challenging to establish an effective relationship.

The study utilised interviews as the sole source of narrative data. Discussion boards and media reports were monitored to allow me to verify my findings and to help me understand the context of what was happening in India and Indian physiotherapy during the research. As the social media has become more sophisticated and its usage has become more common and accepted, I would explore how they might be used as a primary source of data to inform the research.

I was unsuccessful in a funding application from the UK Chartered Society of Physiotherapy as the research was not perceived to have a sufficient impact upon UK clinical physiotherapy practice. Applying for research funding is time consuming and I made a pragmatic decision not to seek out alternative funding sources but to start the research unfunded. On reflection I wish I had spent a little more time looking for funding from none physiotherapy sources, as this would have eased the conflict of time and work demands that were exceedingly challenging to manage and would have enable the research to be completed more quickly. However, in order to meet the criteria for many sources of funding the research design would have needed to have an Indian partner, which may have been difficult to manage within the confines of the doctorate. This collaborative approach would be considered for any follow up studies.

7.4. Limitations and Future Research

Charmaz (2006) considers that a strong combination of credibility and originality increases resonance, usefulness and the subsequent value of a grounded theory study's contribution. The narrative presented in this thesis establishes the credibility of the observations and argument presented. The analysis renders an original conception of the participants' narrative, and is demonstrated to be resonant with the participants and the Indian discourse. Consideration of the study's limitations and suggestions for further research

would allow the usefulness and the value of the theory to be contextualised and elucidated.

Grounded theory methodology trades the scale and breadth of coverage achieved by questionnaire based studies, for a depth and richness of data that Foucault equated to observing the subject of interest through the glass door rather than through the key hole (Rabinow 1984). The narrative data obtained from this study has allowed an in-depth understanding to be developed and a theory to be constructed that is embedded in the data. However, the theory presented is the researcher's interpretation of the participants' story and this must therefore be perceived as a limitation. To ensure resonance, at the outline theory stage, participant feedback confirmed that the theory captured their perspective, and it was subsequently fine tuned to reflect the additional comments.

> *"I think a lot of the focus around changing Physiotherapy identity is around autonomous practice and practice development and I think another aspect of it is research as well"*
>
> Adeeb (verification interview)

Different participants had different perspectives, but it is considered that the theory does take into account all the participants' journeys. Nonetheless, it is acknowledged that this is one construction of the phenomenon of Indian physiotherapists' global mobility and that many other theoretical conceptions, could have been generated from such rich data. A characteristic of the grounded theory method is that it facilitates an understanding of the emerging narrative and enables a direction to be taken (in this case around identity transformation) that was not anticipated at the start of the study (Charmaz 2006). Therefore, the findings and theory have not been constrained by what

has already been published, they had been directed by the participants and interpreted by the researcher. *"Progress lies not in enhancing what is, but in advancing towards what will be."* (Harms 2004). However in considering one research question, many more are raised; Charmaz (2006) considers that analysis that sparks further research is an indication of the usefulness of the grounded theory investigation. This section highlights the limitations of the research and the associated areas for further research.

The theory is a substantive theory and is grounded in the interview narratives and the Indian physiotherapy context, so it can be used to interpret and explore behaviours and activities in that context, but it cannot be generalised. However, it does identify common issues and so can say things that might provide useful insights in other contexts. The suggested transference is only possible if the discourse behind the theory is understood in the context in which it arises. Only then might it provide a link between local and global (Boyes 2004). The journey stages from the transforming identity theory may provide a useful discourse to consider migration of other healthcare professionals from other developing countries to more developed countries; however, the context from which they were migrating and the motivations underpinning their migration, must be considered carefully for resonance with the Indian physiotherapy context. The findings regarding the mismatch of professional expectations resulting from the undergraduate education not being met by the employment context has been identified previously in the literature (Castledine 2002), but the link with it fuelling global mobility has not previously been identified and may provide a useful frame for analysis in similar contexts. The concept that may have most transference to other contexts, is the theorised conception that, for successful return migration to occur there must be a successful transference of the professional identity developed whilst the migrant was overseas. It is suggested that this concept may be pertinent to the return migration of any professional who has engaged in significant professional development overseas.

Over the timeframe of the data collection and analysis, there were changes across the globe that influenced Indian physiotherapy migration behaviour and the choice of destination. The UK changed its visa system, the Australian Physiotherapy overseas registration process changed, the IAP election resulted in turmoil and the subsequent split, there was rejection of Indian government legislature that effectively denied Indian physiotherapy coherent autonomy and formal recognition of their existence and global economics influenced the rupee exchange rate. What did not appear to have changed significantly was Indian physiotherapy itself, how it was practised and the factors influencing the identity transformation journey; therefore it is contended that the resultant grounded theory still adequately reflects the Indian physiotherapy context.

There was a strong bias towards interview participants with UK overseas experience, that reflected the origin of the research; nevertheless, the narrative was very much a global one. The consumerist approach that was discussed regarding the selection of where to study and work, illustrated that the Indian physiotherapists' mobility is global and physiotherapy migration flows align with destinations where physiotherapy has professional autonomy and English is the main language. The secondary consideration relates to ease of access, to enter and register to practise in the destination countries.

The IAP turmoil meant that it was difficult to engage and interview the IAP key role holders as had been planned. The stage at which the interviews were scheduled coincided with the election results and were cancelled at short notice. Once the split was evident, it was considered important not to become drawn into the dispute by interviewing one side or another. However participants were interviewed who had held IAP positions in the recent past and had links with both segments of the IAP, so it was felt that the interviews did adequately capture perspectives and issues at the highest levels of Indian

physiotherapy. Further elections are due in February 2014 and it is considered essential to engage the newly elected IAP in the dissemination of the study findings.

The study identified that there were two tiers of physiotherapy in India. All the participants interviewed would be categorised as in the 'second' or 'upper tier' displaying characteristics of professionalism. The fact that they were engaged in further educational development and lifelong learning, and had consented to participate in a research study conducted by a foreigner, demonstrates a certain openness and engagement with the development of the profession. No one was interviewed who had not engaged with postgraduate study and had only a bachelors degree or diploma, so their perspectives have not been captured. The purposive sampling that is a characteristic of grounded theory methodology, did not indicate how this group of physiotherapists, would have contributed to the development of the categories and theory derived from the study. However they would be a group of interest in further research around structures and behaviours, and the development of physiotherapy practice in India.

The study discourse explored the notion of a global physiotherapy identity and identified that Indian physiotherapy migration was global with participants referring to onward mobility from one destination country to another. What this study did not capture were the patterns of onward migration. Do Indian physiotherapists really move as they indicated, are there any patterns of migration routes, for example masters study in one country, leading to employment in another? The available migration data at a professional level globally was extremely poor, only the UK HCPC via a freedom of information request, was able to supply any meaningful statistics. The same data request

was sent to Australia, New Zealand, Canada and the USA professional and registration bodies and none was able to supply the requested information.

Returning home and transferring knowledge is an area that this study has only touched upon. This research suggests that the key to successful return is the ability successfully to 'import' and to integrate the returnees' transformed professional identity. The returning professional identity is fluid and would need to be adapted according to the local context, but it is suggested that some aspects can be compromised and others cannot. What are the best employment scenarios for returnees to seek out? What can Indian physiotherapy and indeed the Indian government do to help facilitate successful return? Return migration is not well researched, especially in relation to healthcare professionals, anecdotal reports centre on return-migration of nurses to Africa and physician migration to India. Given the talented Indian physiotherapy resource that is overseas and the significant health workforce needs that India has, these areas of research should be prioritised.

7.5. Conclusion

This study is important, as the findings, analysis and resultant theory provide new knowledge, and offers an original consideration of a phenomenon that affects Indian physiotherapy and physiotherapists across the world. This research provides an understanding of the global migration of Indian physiotherapists that could inform access to and delivery of overseas higher education provision. More effective workplace integration and enhanced collaborative working with migrant physiotherapists, could improve healthcare provision in the host countries. Understanding physiotherapy global migration should be important to the WCPT and those engaged in the national registration and regulation of migrant physiotherapists. The IAP could use the analysis to

inform future strategic priorities and the journey towards meaningful professional autonomy in India. The findings could be valuable to stakeholders in Indian healthcare, as the articulation and illumination of the current discourse may firstly, support progress on the current legislative challenges, and secondly, be used to ensure that the knowledge, skills and professional practice acquired by the migrant Indian physiotherapists are effectively utilised upon their return to India. The Indian physiotherapist who has migrated may utilise the analysis and theory to inform their return to India. More effective return of overseas migrant physiotherapists to India could enhance the Indian physiotherapy profession and the provision of physiotherapy to an Indian population with significant healthcare needs. Finally, insights from the study findings and theory may be of value to other professions or other nations where migration is underpinned by similar contexts.

The Indian physiotherapists global mobility is theorised to be a journey of professional identity transformation. The journey consists of four stages, forming a nascent identity in training, storming the professional identity following the transition into employment and identifying the challenge of practising and developing professionally in line with aspirations, transforming professional identity through travelling overseas to engage in masters education and autonomous practice, and transferring the new professional identity back home. Integral to the stages of professional identity transformation is the context 'back home' that provokes the journey, the 'going away' seeking difference, motivated by wanting a better life. Professional development, better pay and respect, are all key elements through which a better life can be achieved. The journey is completed by taking back their transformed professional identity and the associated attributes.

The findings suggest that behind the motivations for travel is a picture of challenge and turmoil for physiotherapy in India, the physiotherapists are unable to practice as they would wish, the lack of professional autonomy is a significant issue, and they do not feel respected or adequately paid. Indian societal values amplify the importance of pay and respect, especially for males, whereas females have a greater focus on the professional development aspects.

The developed nations' physiotherapy professions enjoy professional autonomy and all its associated rewards. This was what individual Indian physiotherapists sought and to which the Indian profession aspired. Those who travelled engaged in a journey of professional transformation, from a non-autonomous paraprofessional identity to one of an autonomous professional, with the associated knowledge and skills. When the physiotherapists return to India, there are significant challenges associated with transferring their new professional identity into clinical practice, in an Indian medical system that is under the patronage of a hierarchical medical model. Practice has not evolved sufficiently to accommodate the overseas autonomous physiotherapy ways of working, and returnees must be selective in locating and timing their return to ensure successful reintegration.

Significant challenges for Indian physiotherapy remain and it is suggested that they need to unite and focus on strategies that establish legitimacy for the profession and enhance the quality of educational and clinical provision. There is significant talent within Indian physiotherapy constrained by hierarchical medical practice. There is also a significant Indian physiotherapy resource overseas, which has embodied the identity of autonomous physiotherapy, an identity that the profession in India seeks. Both groups of physiotherapists, given the right conditions and working alongside each other could help to fast track Indian physiotherapy to achieve their objectives. The future is uncertain,

but bright, and the words of a poem (see appendix eight for the complete text) written to promote physiotherapy in India on World Physiotherapy Day, illuminate the Indian physiotherapy spirit to establish an identity to be valued and respected.

" I Am A Physiotherapist

I am a physiotherapist & I am proud to be one,
I am competent, confident and second to none.

(...)

I am not bothered about a title before my name,
An indomitable will to help you recover is my aim.

A PT after my name is my identity,
Committed I remain to serve the ailing humanity."

Physiotimes World Physiotherapy Day Poem 08/09/13

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Appendices

Appendix 1: Waiting for a Council

Over the last couple of decades there has been much debate, and four different draft legislature, two parliamentary standing committee reports and various other government commissioned reports regarding the formation of a Council that will effectively govern and regulate physiotherapy and other allied health professions in India. To date none of the proposed government level legislature has been enacted and so there is still no regulation of physiotherapy or physiotherapists in India. Below is a synopsis of the legislative journey taken primarily from the Indian PRS Legislative Research website.

1992 - Rehabilitation Council of India Act was passed to regulate the training of rehabilitation professionals who work with the disabled and to maintain a central register of them. The professionals included audiologists, speech therapists, clinical psychologists, rehabilitation engineers and technicians, and multi-purpose rehabilitation therapists amongst others; but it did not include physiotherapists or occupational therapists.

1998 - A government notification that it will include physiotherapists and occupational therapists under the Rehabilitation Council of India Act, 1992. A subsequent notification in 1998 reversed that decision.

2007 - The Paramedical and Physiotherapy Central Councils Bill 2007 proposed the set up three councils to regulate 1) physiotherapists and occupational therapists 2) medical laboratory technicians and 3) radiology technicians. The central council was to be responsible for the educational standards for the profession it regulated, maintained a register of qualified practitioners, specify the standards of professional conduct be responsible for disciplinary action. The bill grouped physiotherapy and occupational therapy together and defined them

as 'medically-directed' treatments which imply that practitioners in both professions may be able to treat only those patients referred by a doctor.

21/10/08 - A Parliamentary Standing Committee reported on the 2007 bill, amongst the recommendations were that Occupational Therapy should be treated as a separate discipline to Physiotherapy and that each should have a separate council. It recommended an addition that specified that 'Physiotherapists cannot take over the responsibilities of a doctor and cannot prescribe drugs', therefore physiotherapy autonomy was inferred. It also called for inclusions to ensure uniform standards of education across states and the establishment of state-level councils for the maintenance of such standards; it was not in favour of restricting the registration of professionals to the central level. The Physiotherapists and Occupational Therapists were pleased with these recommendations and the proposed 2007 bill. However, the draft bill was not implemented and has now lapsed.

2009 - National Council for Human Resources in Health 2009 Bill was drafted as an overarching regulatory body to replace the Medial Council of India, the Indian Nursing Council, and the Pharmacy Council and to include the unregulated 'paramedical' professions. Within the council seven departments were proposed Medicine, Nursing, Dentistry, Pharmacy, Rehabilitation and Physiotherapy, Public Health and Hospital Management, and Allied Health Sciences (to include paramedics, lab technicians, optometrists, radiologists etc). The Departments would act as the principal implementing agencies, responsible execution and monitoring of the standards, so established by the Council, within their respective streams.

The Physiotherapists did not want to be grouped with Rehabilitation and this would include Psychiatry which being medically lead would result in

professional domination. In addition there appears to have been a 'turf war' between two ministries over the jurisdiction of medical education which lead to delays and a substantial restructuring and redrafting of the bill.

2011 - National Commission for Human Resources in Health (NCHRH) 2011 Bill draft seeks to set up the National Commission for Human Resources for Health (NCHRH), National Board for Health Education (NBHE), and the National Evaluation and Assessment Council (NEAC) in order to determine and regulate the standard of health education in India. It separates the regulation of education from that of the profession, and establishes professional councils at the national and state levels to regulate the profession and recommends that the government appoint various professional Councils at the national and state levels, three are proposed: Medical, Nursing and Paramedical Councils responsible for the registration. There is no explicit mention of Physiotherapy who are now included within paramedicals. It also proposes renewal of membership every ten years subject to evidence of continuing professional development. Individuals will register with the National Council and with the State Council where they intend to practice. The bill also puts in place regulation for recognition of overseas education providers qualifications and a requirement for those who seek to study overseas to work in India for 3 years first if they were trained at a government institution and for all registrants to keep the registering body informed of their whereabouts if they work overseas post studying. The sanction for none compliance would be loss of registration.

Due to the range of characteristics and educational background of the professions included within the paramedical group, physiotherapists' are not confident that they will gain autonomy of practice; and there is concern that pay revisions and professional development will also be detrimentally affected due

to the grouping with professions who are at a lower education standard and who practice with no autonomy.

30/10/12 - A Parliamentary Standing Committee Report does not support the NCHRH 2011 bill. The Committee noted the concern of the Medical, Nursing and Pharmacy Councils that their autonomy and democratic setup would been taken over by the Bill, and recommended that the democratic functioning of these National Councils should be protected even if they are brought under an overarching body. The Committee expressed concern over the acute shortage of qualified health workers in the country as well as variations between states and between rural and urban areas. They rejected the make-up of the NCHRH, NBHE, NEAC and recommended that the powers of the three bodies be clearly demarcated, in addition to directing that the states should be consulted over the proposals.

21/12/12 - The Union Minister of Health and Family Welfare released a report from the National Initiative for Allied Health Sciences (NIAHS) on status of allied health professionals in India "From Paramedics to Allied Health Professionals: Landscaping the Journey and Way Forward", identifying a total national shortage of approximately 6.4 million Allied Health Professionals (AHP) across India and recommended that the term paramedical be replaced with a comprehensive definition of AHP, along with defined career pathways, salary structures and cadre formation to ensure their growth prospects. It identified that the lack of regulatory framework and centres of excellence for professional development and training were problematic. The report recommends a National Board for Allied Health Sciences, with National and Regional Institutes of Allied Health Science be established as an interim measure to undertake the work of capacity augmentation and re-organisation for AHP's, until an Act of parliament can be enabled to implement a regulatory Council. It identified that new

methods of teaching and training should be introduced in the public sector to keep up with changing technologies and educational methods such as e-learning and web-tools etc. It also identified that AHPs need to develop skills to undertake traditionally medical roles in the healthcare delivery system as this will address gaps in healthcare delivery.

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Appendix 2: Sample Participant Information Sheet

INDIAN PHYSIOTHERAPISTS' GLOBAL MOBILITY

INFORMATION ABOUT THE RESEARCH

October 2010

You are invited to take part in a research study which forms part of a Professional Doctorate (similar to a PhD) at Sheffield Hallam University in the UK. This study has been reviewed and approved by the Research Ethics Committee at Sheffield Hallam University in the UK.

The research aims to examine the motivations and aspirations of physiotherapists who choose to study or work overseas, and to identify the effects of the migration upon Indian physiotherapy practice and the profession.

Before you decide whether to take part in the study it is important that you understand what the research is for and what you will be asked to do. Please take time to read the following information and discuss it with others if you wish. It is up to you to decide whether or not to take part. You are welcome to phone me or email me if you would like any further information. If you agree to take part in the study you will be asked to sign a consent form. You can change your mind at any time and withdraw from the study without giving a reason.

The purpose of the research study is to examine why Indian physiotherapists are choosing to study or work overseas and to identify the effects of the migration upon Indian physiotherapy practice and the profession. In the interview we would explore the structure and status of the Indian physiotherapy profession; its autonomy, the political direction and the drivers underpinning the educational systems. I am also interested in the value of masters education in Indian physiotherapy (both Indian and overseas). Your current position and past experience mean that you are uniquely positioned to be able to provide an informed perspective on these issues.

The study will involve approximately 30 physiotherapists from India, some will have travelled overseas and some will have not. The interviews will occur either through a focus group or on an individual basis. I will be conducting some

interviews in India and some in the UK. The interview will take approximately 1 hour and will be organised at a location convenient to you.

The information gained from this research will be shared with physiotherapists in India and across the world. It is important for physiotherapists, employers, universities and the professional bodies to know why physiotherapists from India choose to move overseas and what the perceived effects are upon physiotherapy in India. Recommendations will be made according to the findings. There is no other published research that explore the global mobility of Indian physiotherapists; the results of the study may also lead onto further studies in India or other countries.

The interview will be digitally recorded and then transcribed into an electronic document. The recording and transcripts will be anonymised and identifiable only by code. Any identifiable data will be stored in an encrypted format or on a secure server. The digital recording will be destroyed at the end of the study. The recordings will be subject to UK copyright law (the spoken words belong to you, the recording and transcript will belong to Sheffield Hallam University).

Your response will be treated with full confidentiality and anyone who takes part in the research will be identified only as code numbers or false names. If you choose to tell me something in complete confidence, the relevant section will be removed from the transcript and will not be included in the research. You can request a copy of the interview transcript if you wish. The interviews will be analysed by me using the NVIVO computer package. At the end of the research I will write my thesis and the results may be published in journals that are easily accessible in India and at conference presentations. No research participant will be identifiable from any publications.

Please do not hesitate to contact me if you need further information and thanking you for taking the time to read this information sheet.

Kate Grafton
Faculty of Health and Wellbeing
Sheffield Hallam University
Sheffield S10 2BP UK
k.grafton@shu.ac.uk +44(0)7768022125
www.shu.ac.uk

Appendix 3: Sample Participant Consent Form

INDIAN PHYSIOTHERAPISTS' GLOBAL MOBILITY

CONSENT FORM

Participant Code:

Name of Principle Investigator: Kate Grafton

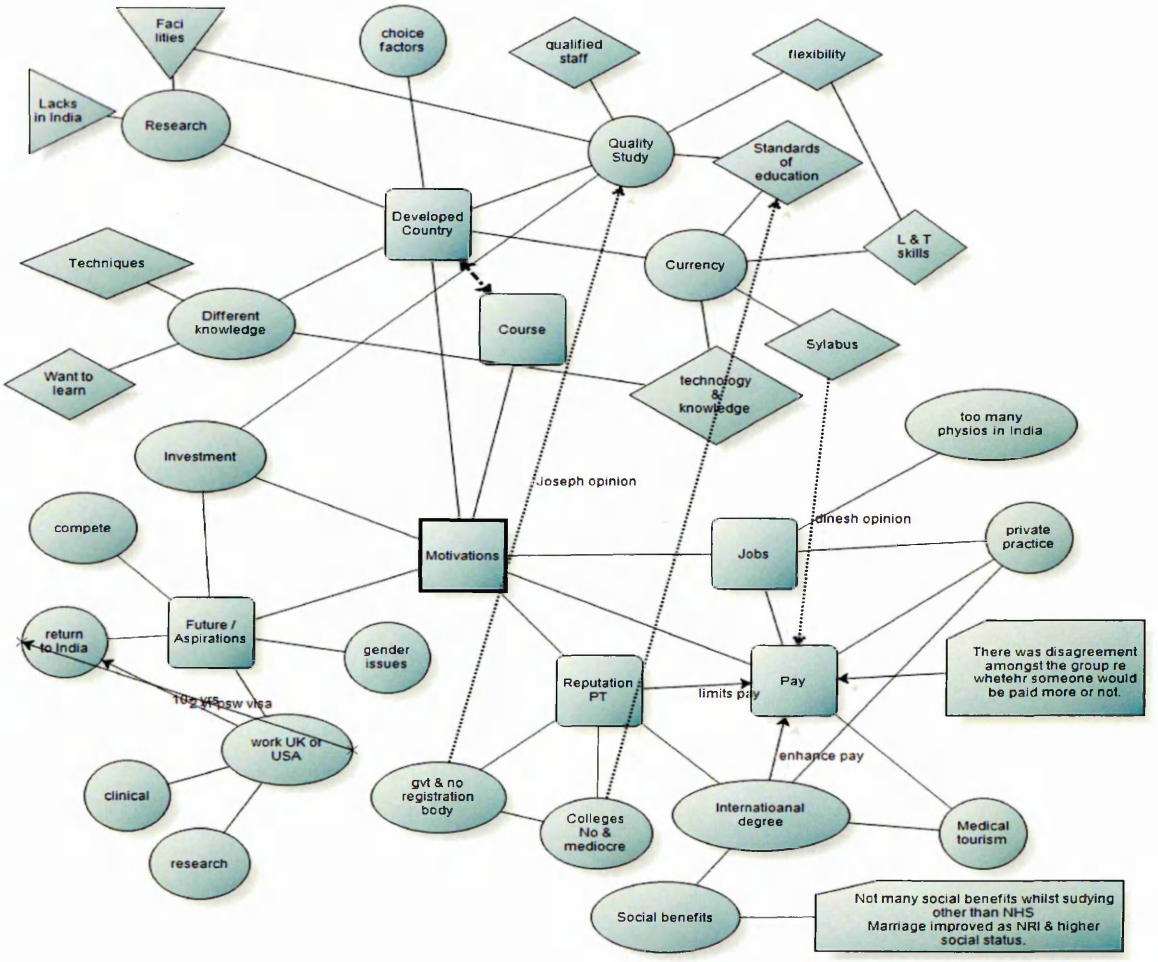
	Please Initial Box
1. I confirm that I confirm that I have read and understand the information sheet dated December 2010 version 5 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	
4. I understand that data collected about me during this study will be anonymised before it is submitted for publication.	
5. I agree to take part in this study.	

Name of participant Date Signature

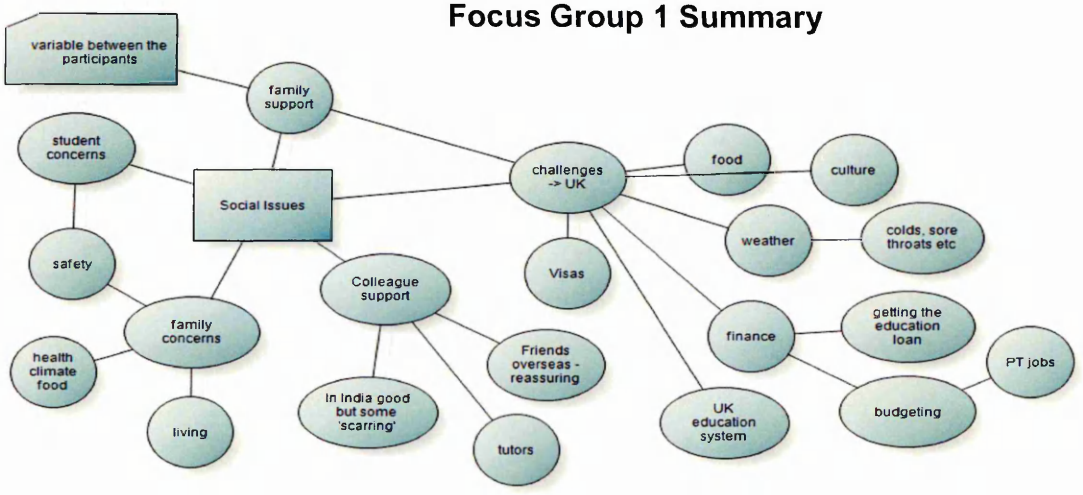
Kate Grafton

Researcher Date Signature

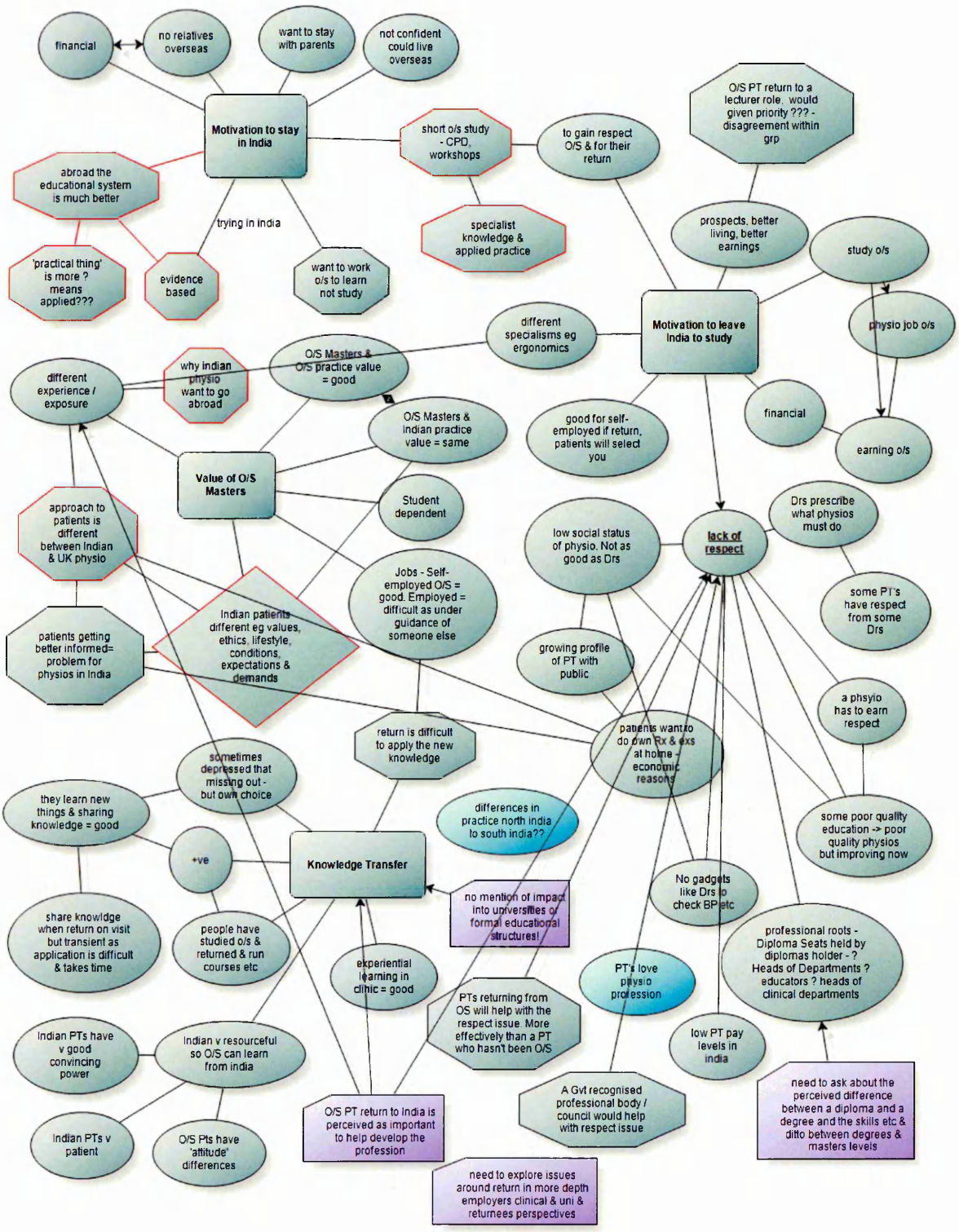
Appendix 4: Post Interview Mind Map Summaries



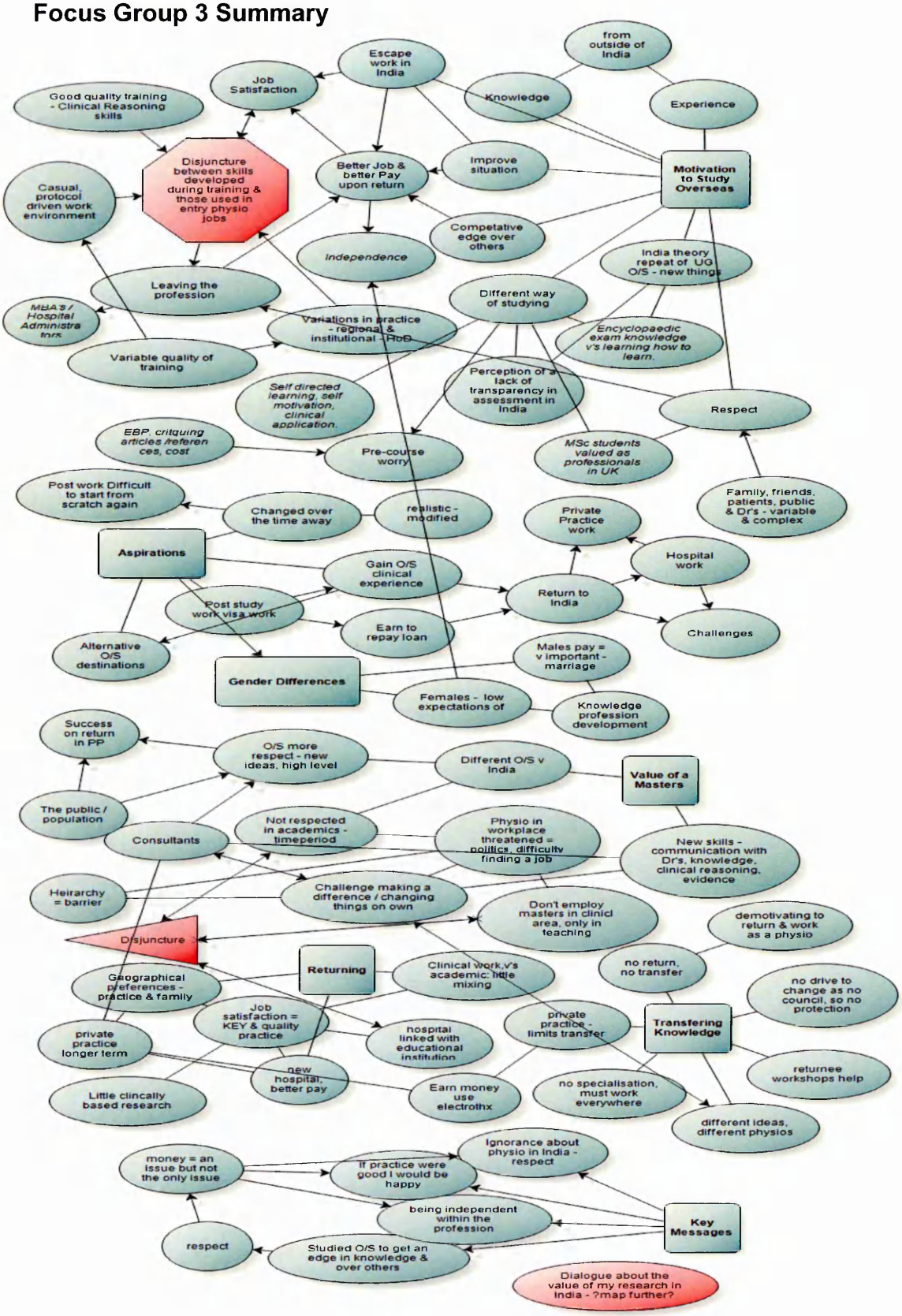
Focus Group 1 Summary



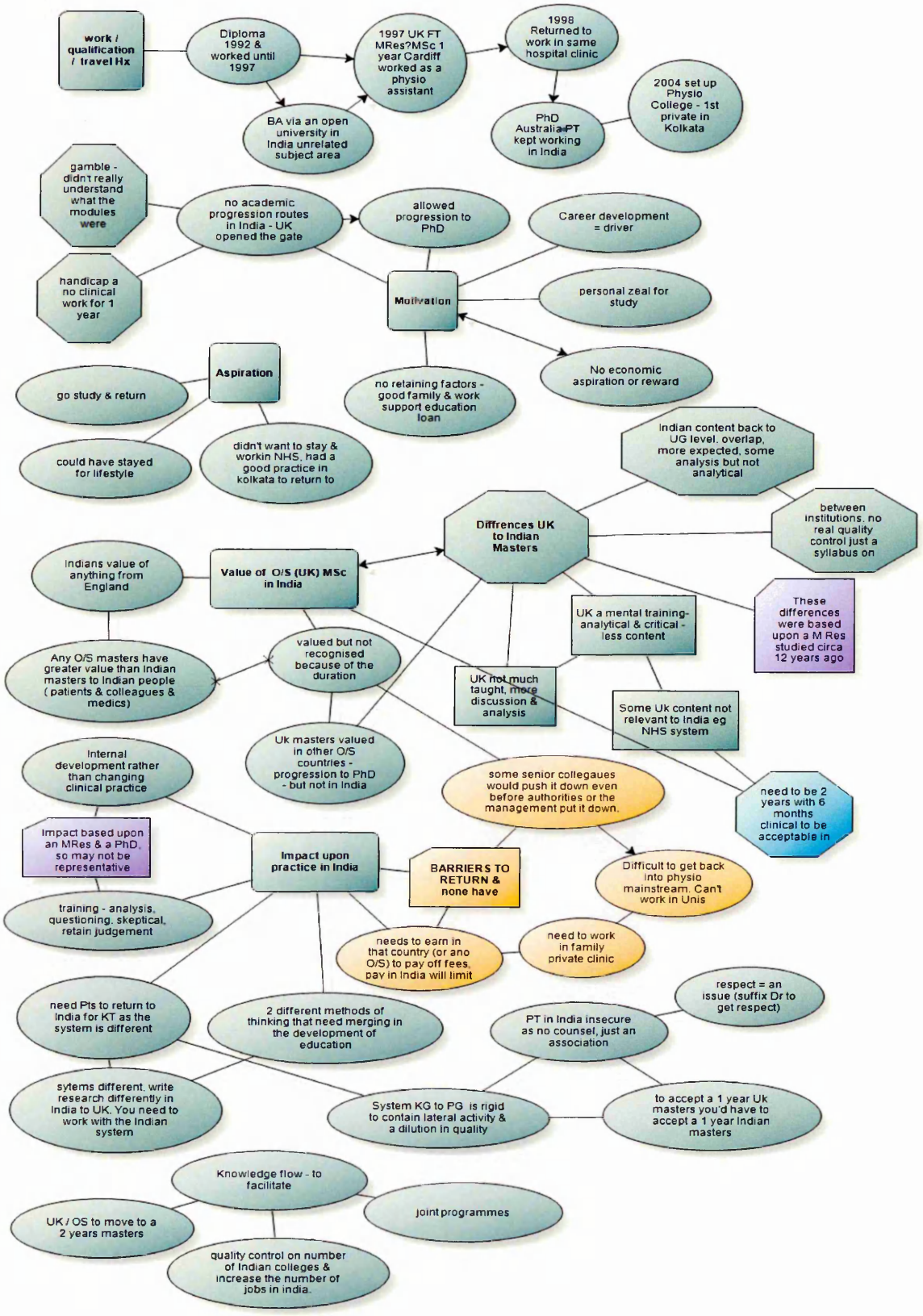
Focus Group 2 Summary



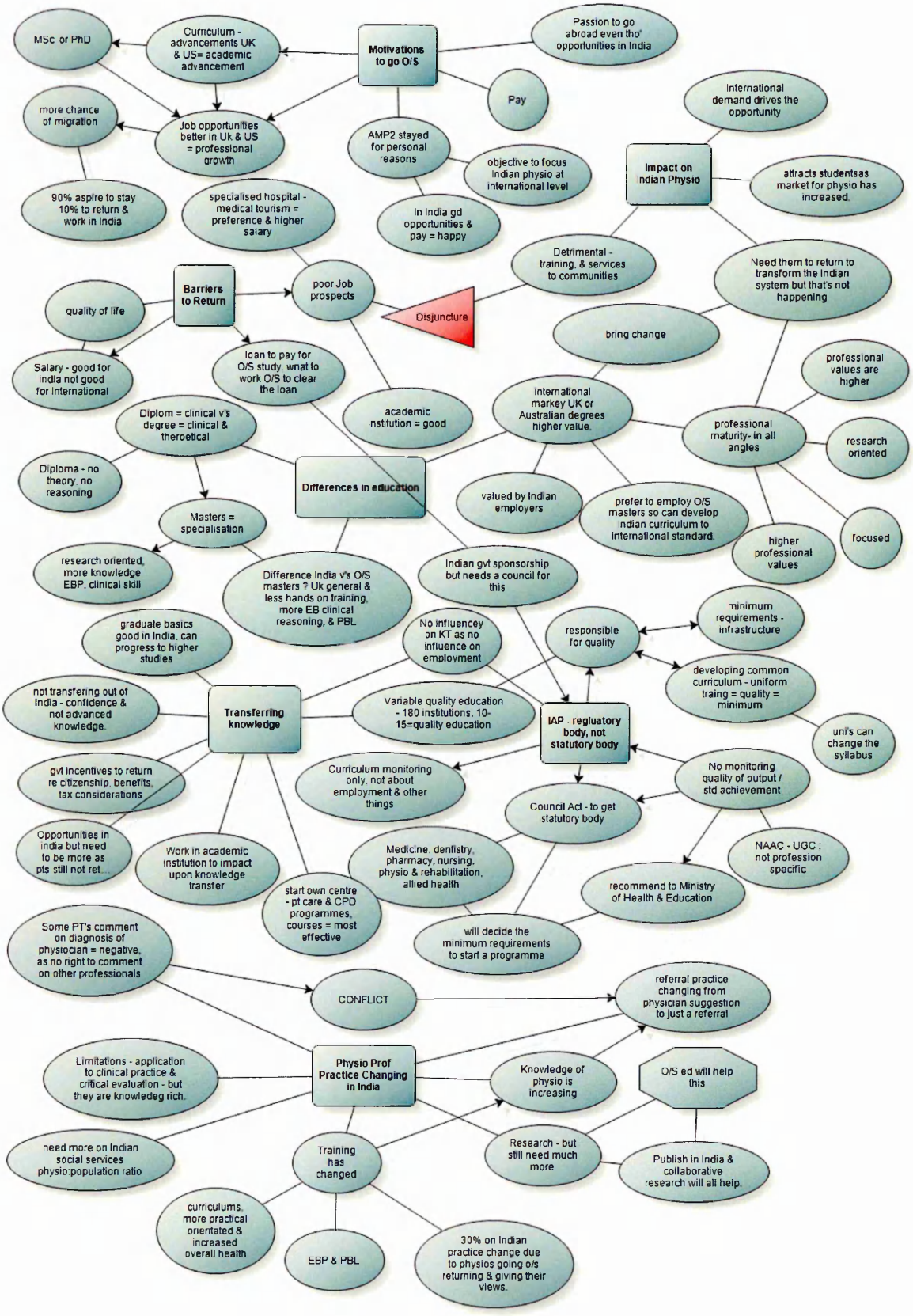
Focus Group 3 Summary



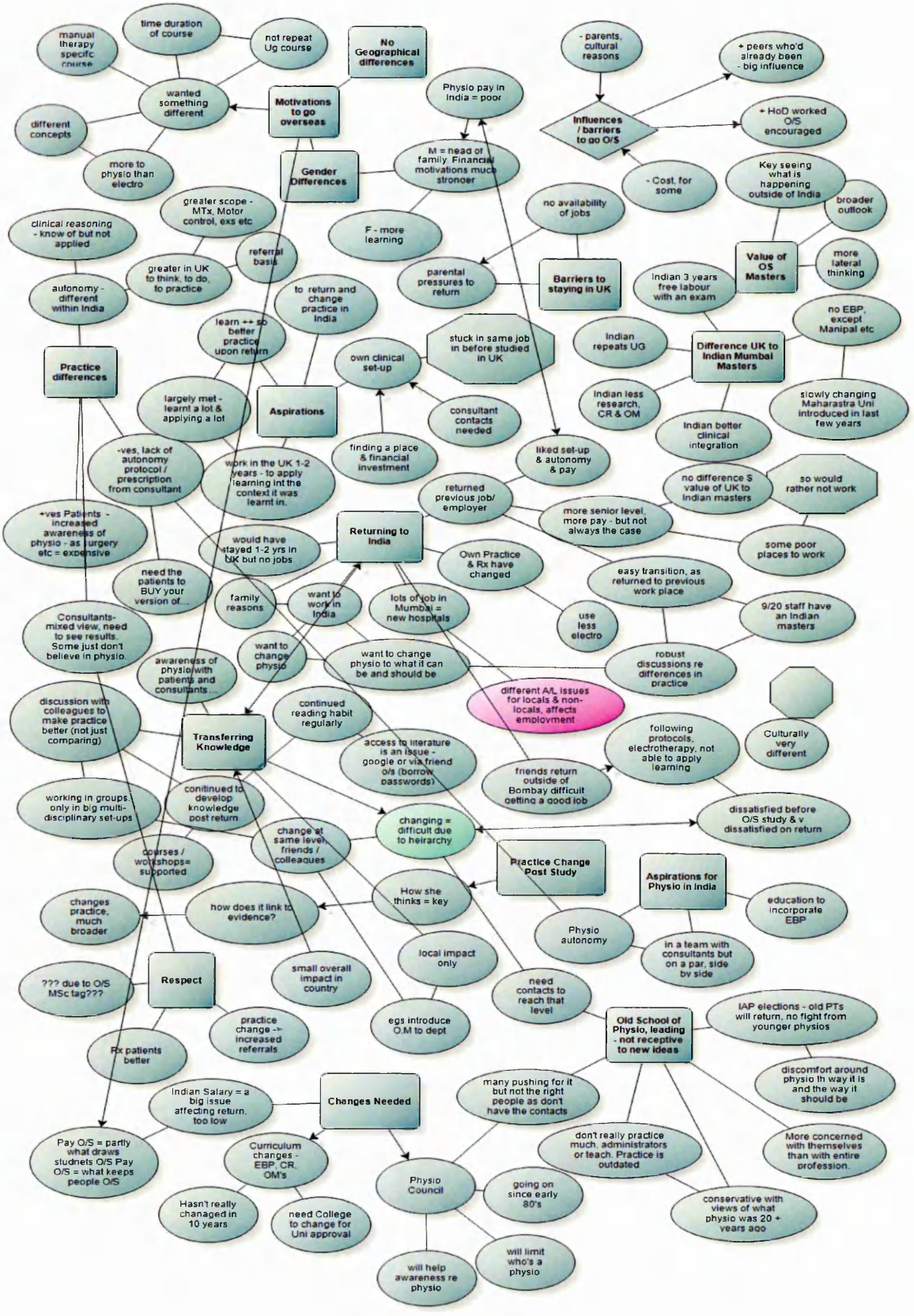
Ashna Summary



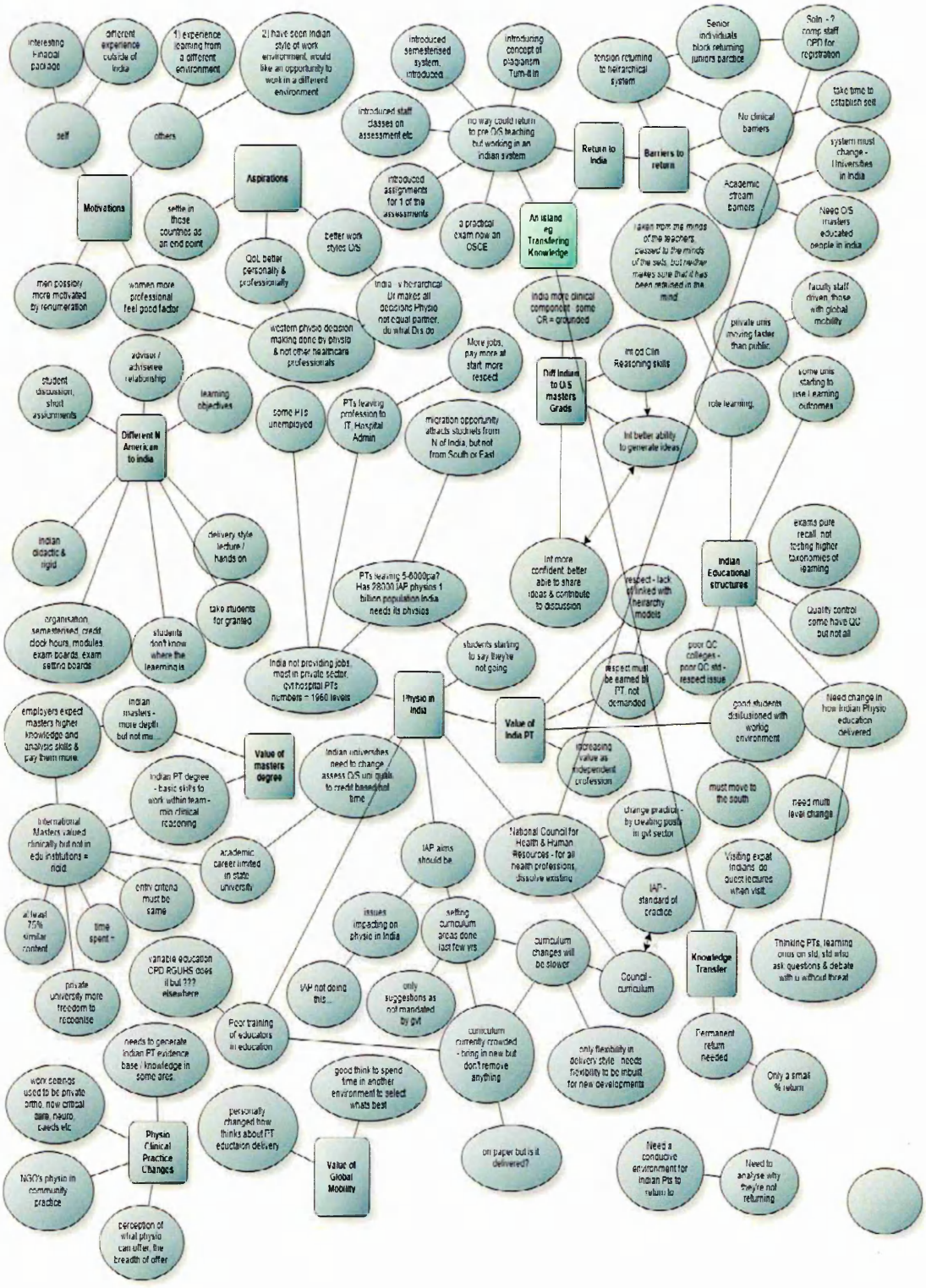
Manish Summary



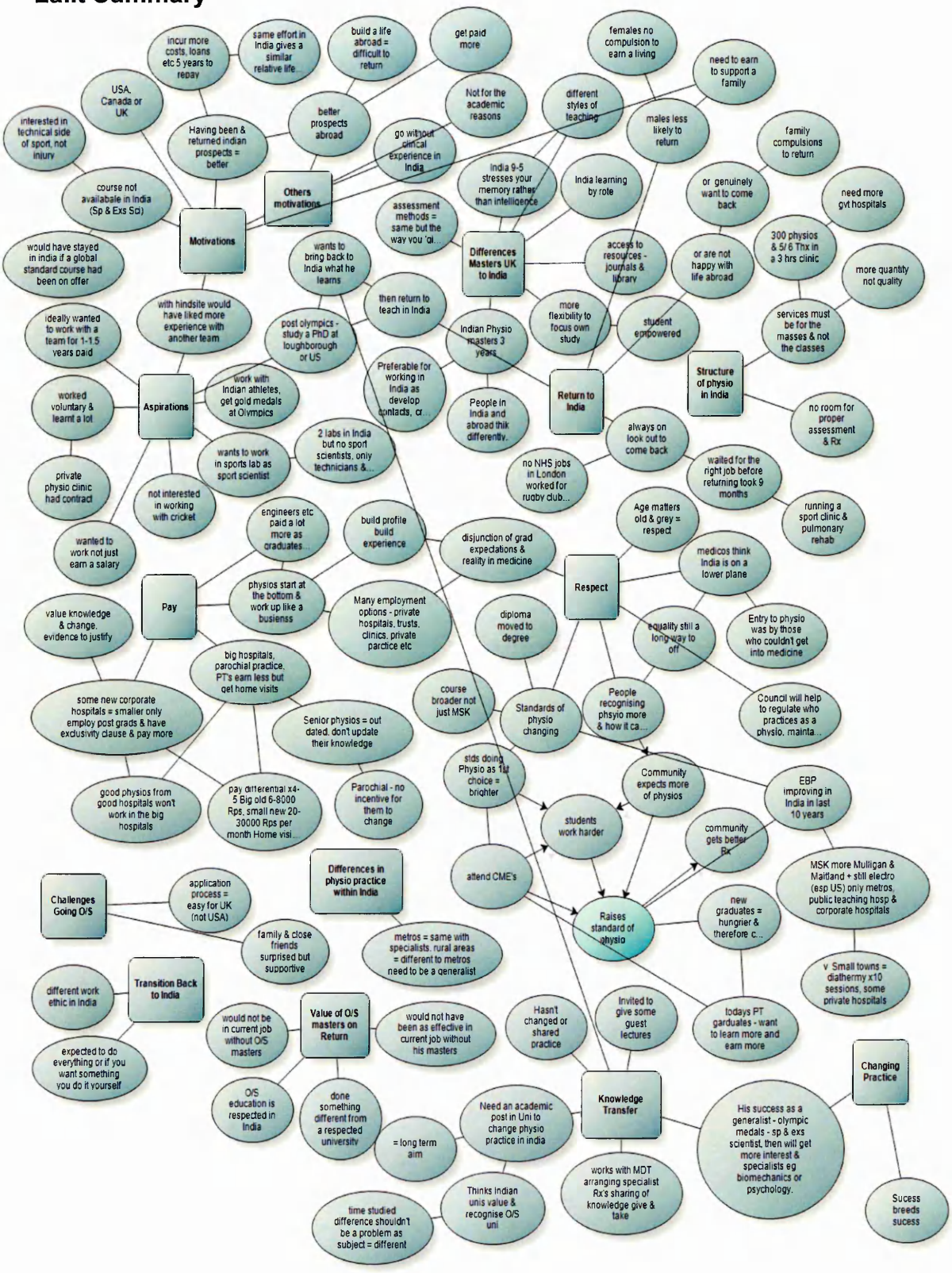
Minda Summary



Rani Summary

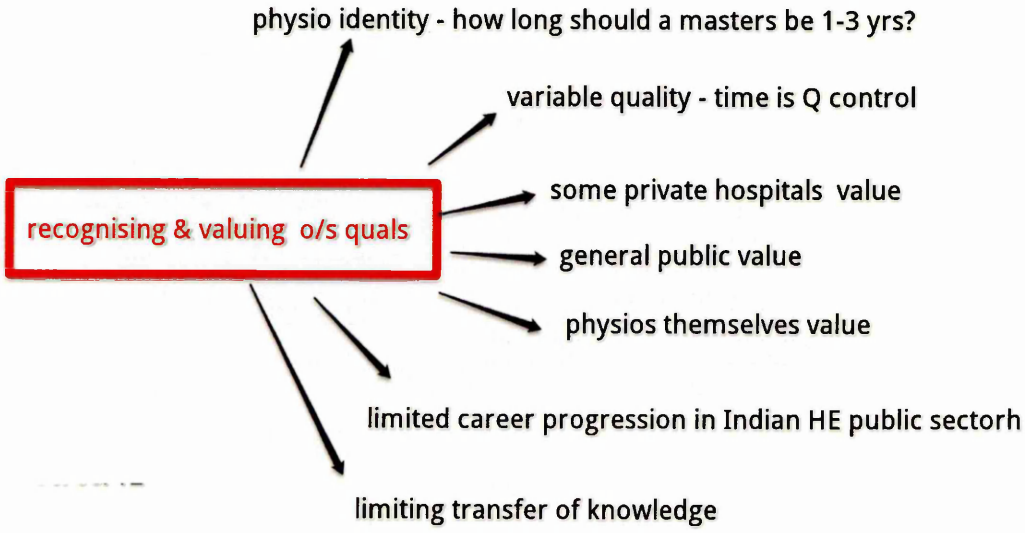


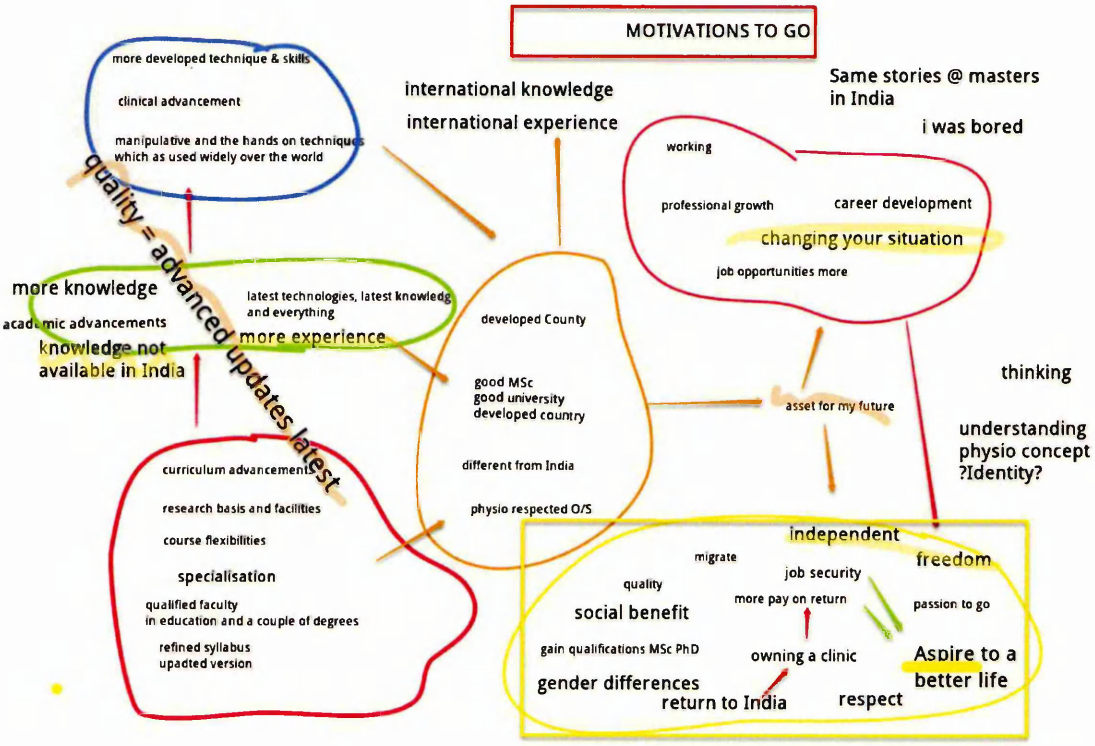
Lalit Summary

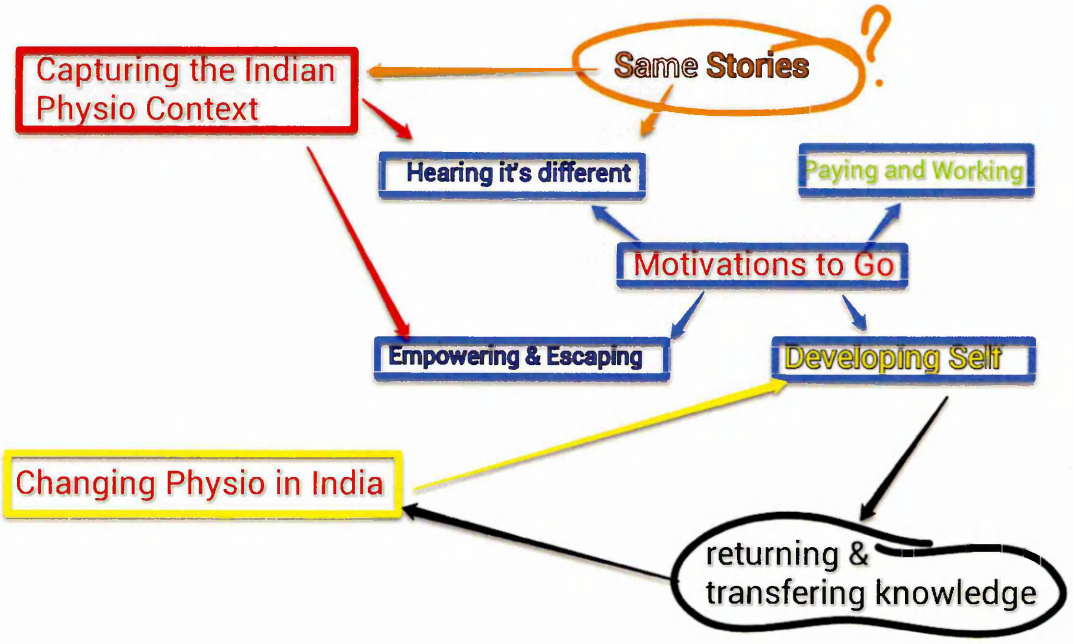


Appendix 5: Free Form Diagram Examples

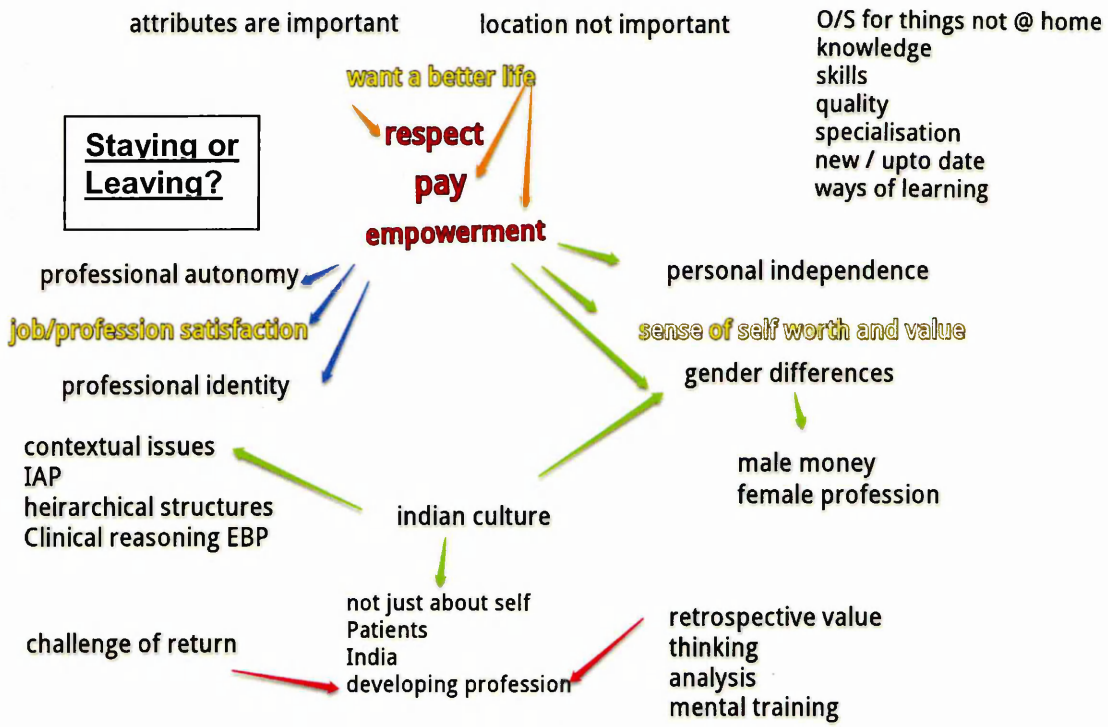
Interview Cycle 1

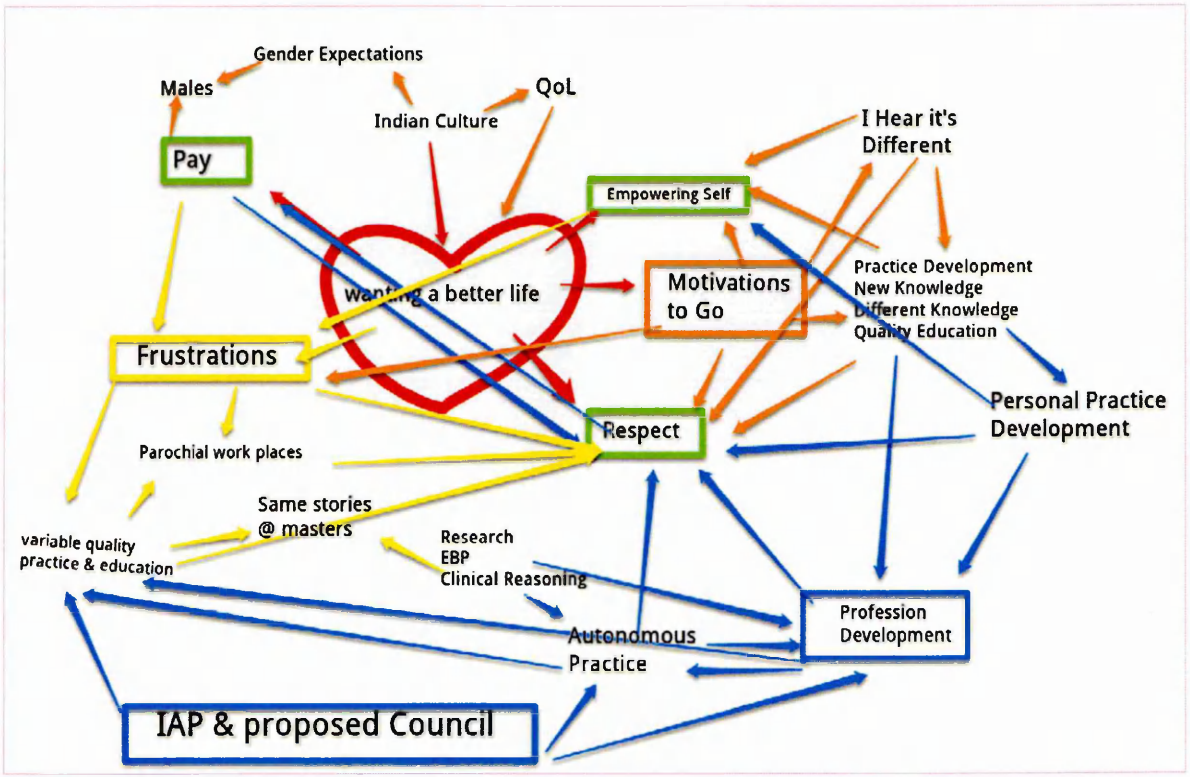



MOTIVATIONS TO GO
more developed technique & skills
clinical advancement
manipulative and the hands on techniques which as used widely over the world
quality = advanced updates latest
international knowledge
international experience
Same stories @ masters in India
i was bored
working
professional growth
career development
changing your situation
job opportunities more
more knowledge
academic advancements
knowledge not available in India
latest technologies, latest knowledg and everything
more experience
developed County
good MSc
good university
developed country
different from India
physio respected O/S
asset for my future
thinking
understanding physio concept ?Identity?
curriculum advancements
research basis and facilities
course flexibilities
specialisation
qualified faculty in education and a couple of degrees
refined syllabus upadted version
independent
migrate
freedom
job security
quality
social benefit
more pay on return
passion to go
gain qualifications MSc PhD
owning a clinic
Aspire to a better life
gender differences
return to India
respect


Capturing the Indian Physio Context
Same Stories
?
Hearing it's different
Paying and Working
Motivations to Go
Empowering & Escaping
Developing Self
Changing Physio in India
returning & transfering knowledge

Interview Cycle 2





maintaining the status quo

masters physios
- academia teaching & not clinical
- threat in clincal depts resistant to change in practice & income

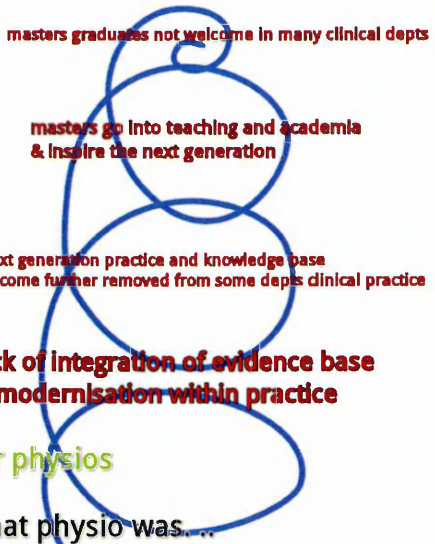
2 tier development of clinical practice?.

lack of confidence in developing practice

what works for the individual
v
whats good for physio in India

senior clinicians threatened

who is on the IAP
OLDER physios v the younger physios



lack of integration of evidence base & modernisation within practice

concept of what physio was...
struggling with its identity?

2 streams to Indian physio
- those driving and clamouring for change & development
- those resistant to change as the status quo suits them

maintain status quo
v
developing physiotherapy identity & practice

Interview Cycle 3

Ideas re how the subcategories link to categories and how do themes link with this?

red = possible categories

Leaving India / Why Go

Understanding Indian Physio

Coming Home bringing gifts

Staying away

Wanting a Better Life

Seeking a Different Physio identity

Making it work short-term

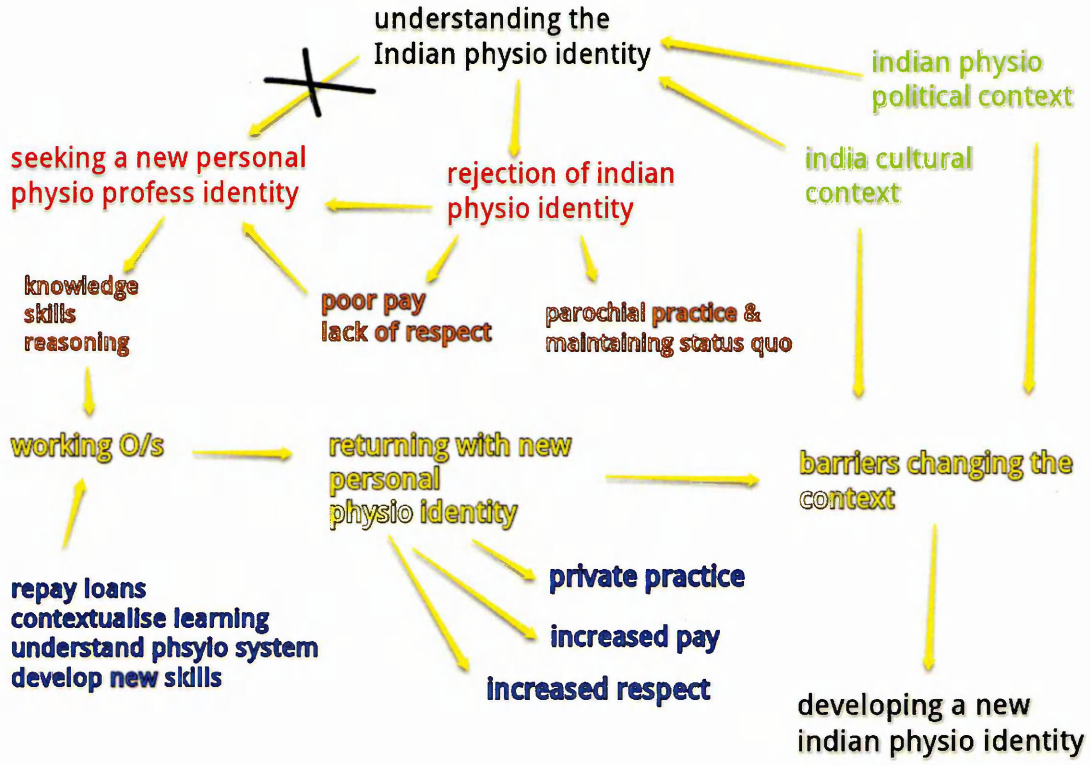
longer terms aspirations

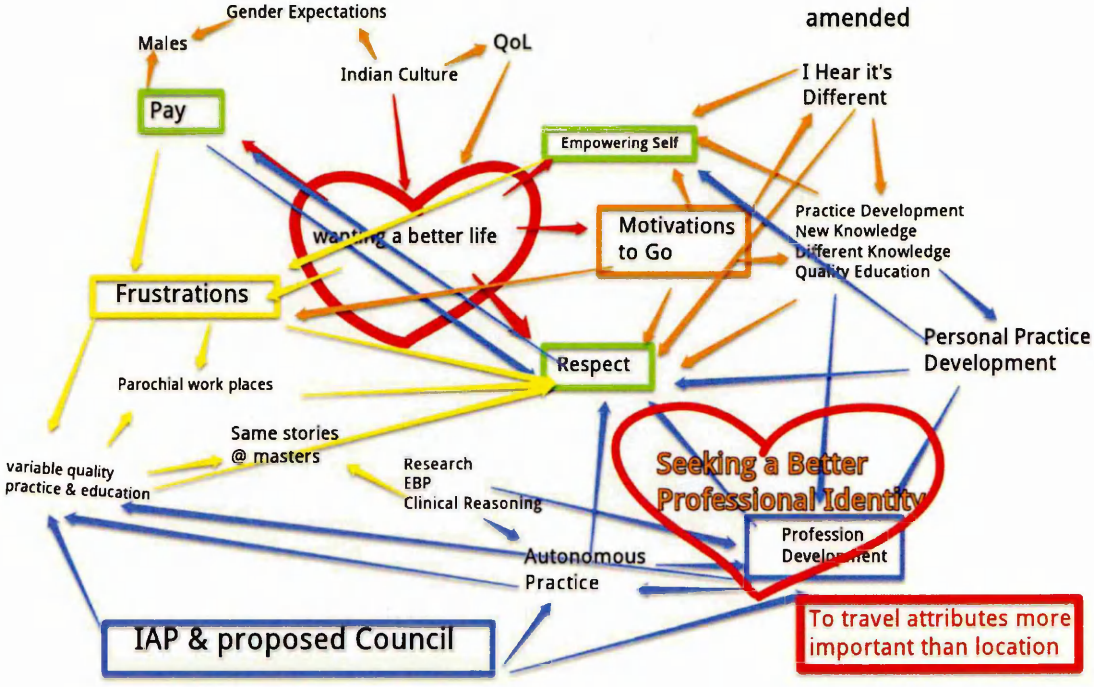
very crude possible themes

green top level theory items????

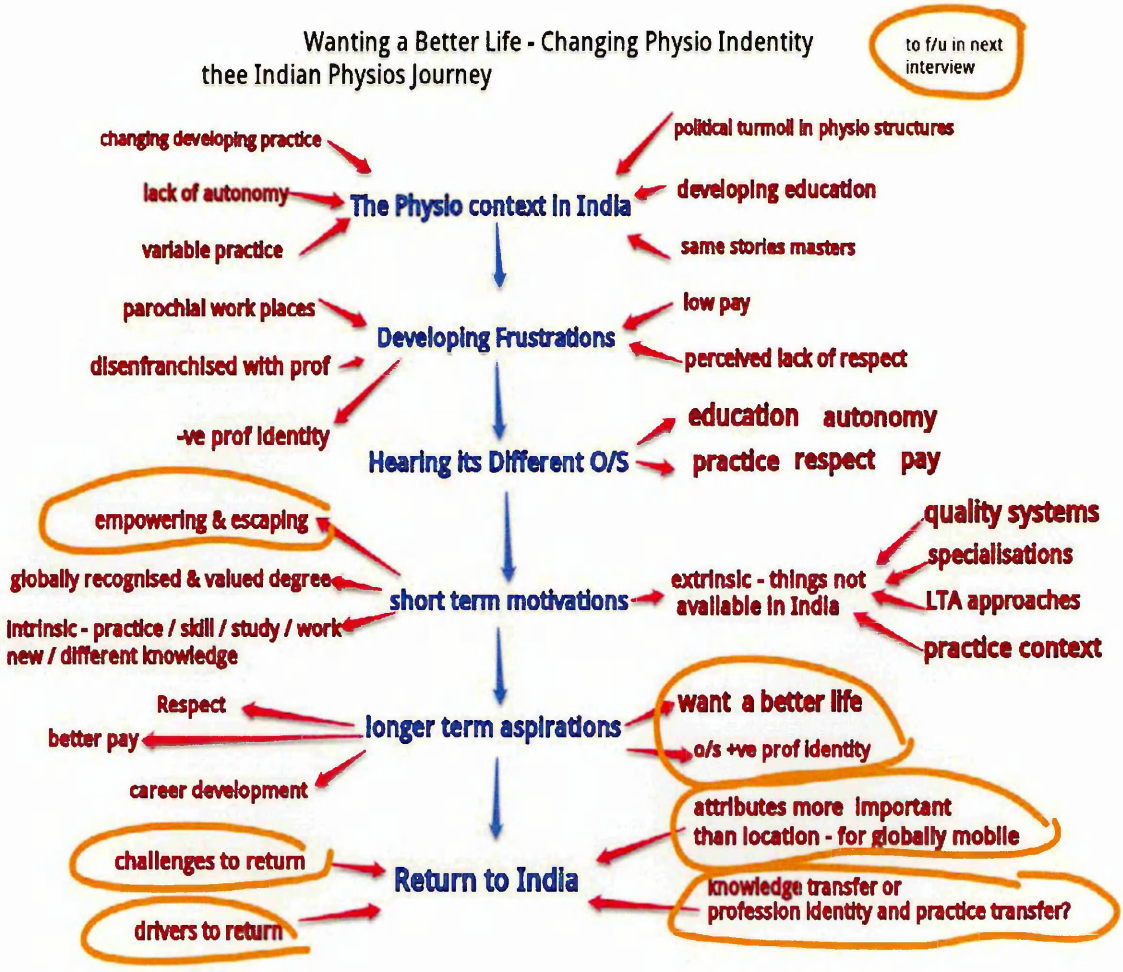
WANTING A BETTER LIFE

WANTING A BETTER InDIAN PHYSIO PROFESSION IDENTITY

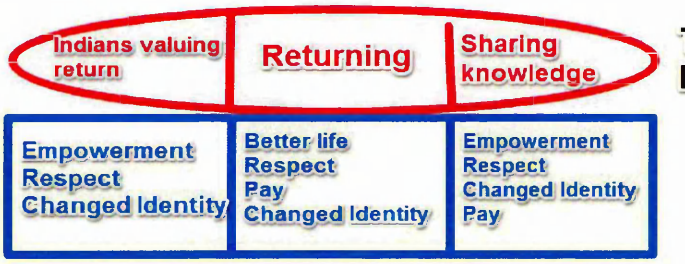

understanding the
Indian physio identity
indian physio
political context
india cultural
context
seeking a new personal
physio profess identity
rejection of indian
physio identity
knowledge
skills
reasoning
poor pay
lack of respect
parochial practice &
maintaining status quo
working O/s
returning with new
personal
physio identity
barriers changing the
context
repay loans
contextualise learning
understand phsyio system
develop new skills
private practice
increased pay
increased respect
developing a new
indian physio identity

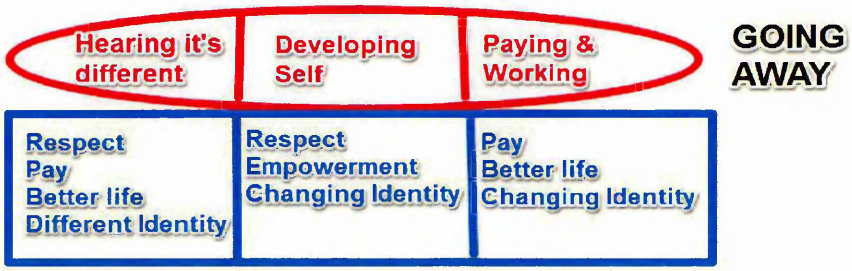

Gender Expectations
Males
Indian Culture
QoL
amended
I Hear it's
Different
Pay
Empowering Self
wanting a better life
Motivations
to Go
Practice Development
New Knowledge
Different Knowledge
Quality Education
Frustrations
Personal Practice
Development
Respect
Parochial work places
Same stories
@ masters
variable quality
practice & education
Research
EBP
Clinical Reasoning
Seeking a Better
Professional Identity
Profession
Development
Autonomous
Practice
IAP & proposed Council
To travel attributes more
important than location

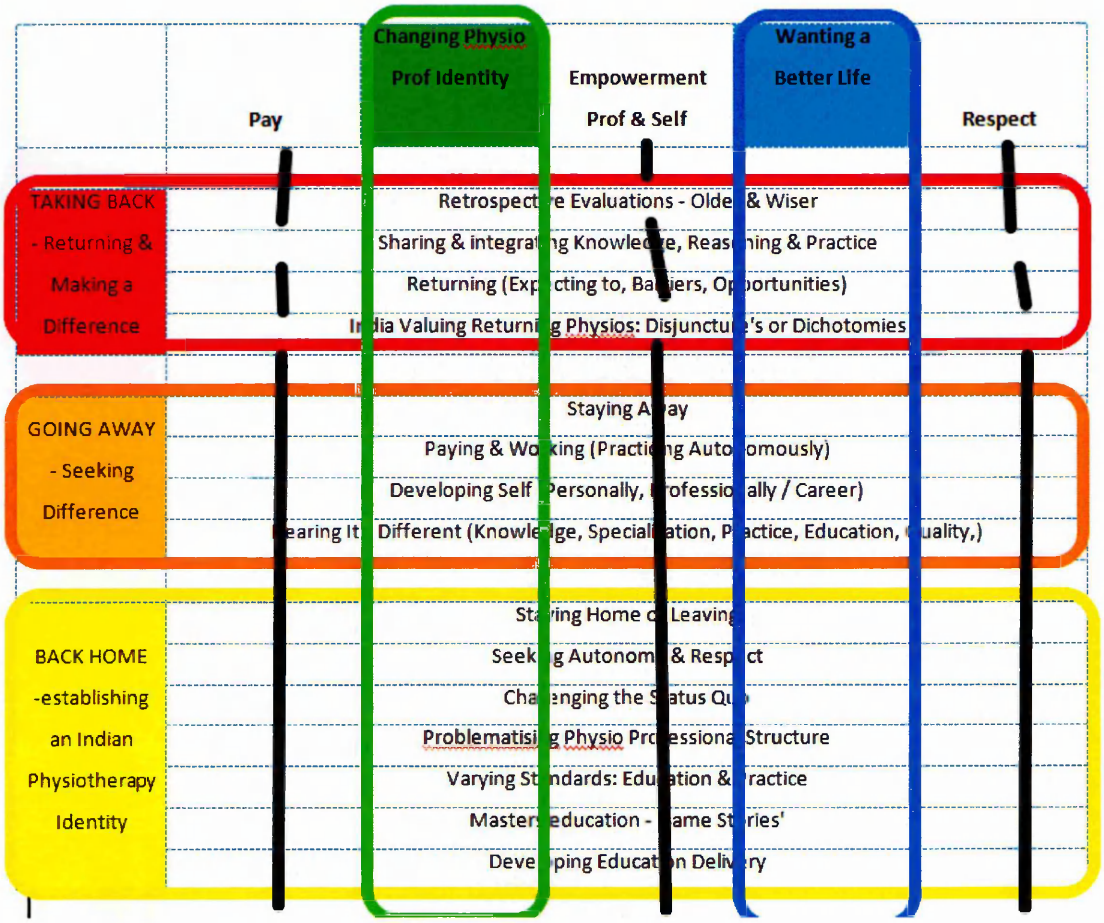

paying and working
empowering and escaping
wanting a better life
developing self
hearing its different
profession development
seeking a new professional identity
competative edge
shopping / consumer - where can I get what I want from?
attributes more important than location in a globally located profession.

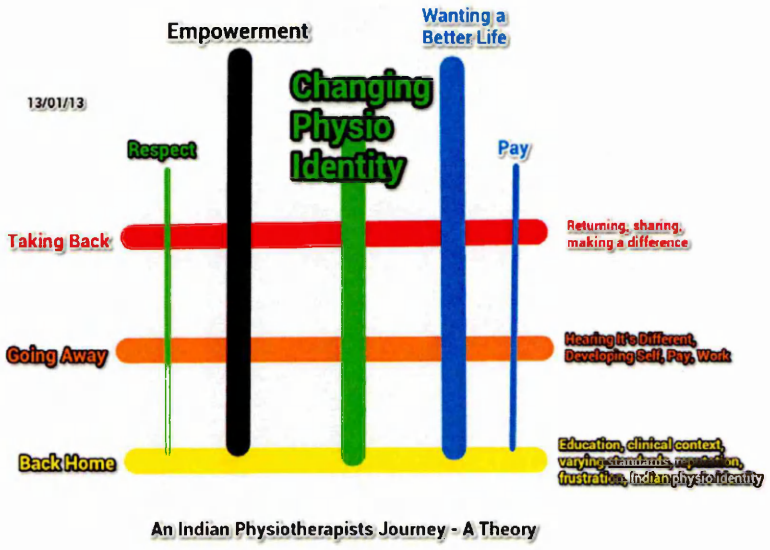

Wanting a Better Life - Changing Physio Indentity
thee Indian Physios Journey
to f/u in next interview
changing developing practice
lack of autonomy
variable practice
The Physio context in India
political turmoil in physio structures
developing education
same stories masters
parochial work places
disenfranchised with prof
-ve prof identity
Developing Frustrations
low pay
perceived lack of respect
Hearing its Different O/S
education autonomy
practice respect pay
empowering & escaping
globally recognised & valued degree
intrinsic - practice / skill / study / work
new / different knowledge
short term motivations
extrinsic - things not available in India
quality systems
specialisations
LTA approaches
practice context
Respect
better pay
career development
longer term aspirations
want a better life
o/s +ve prof identity
challenges to return
drivers to return
Return to India
attributes more important than location - for globally mobile
knowledge transfer or profession identity and practice transfer?

Validation and Refining

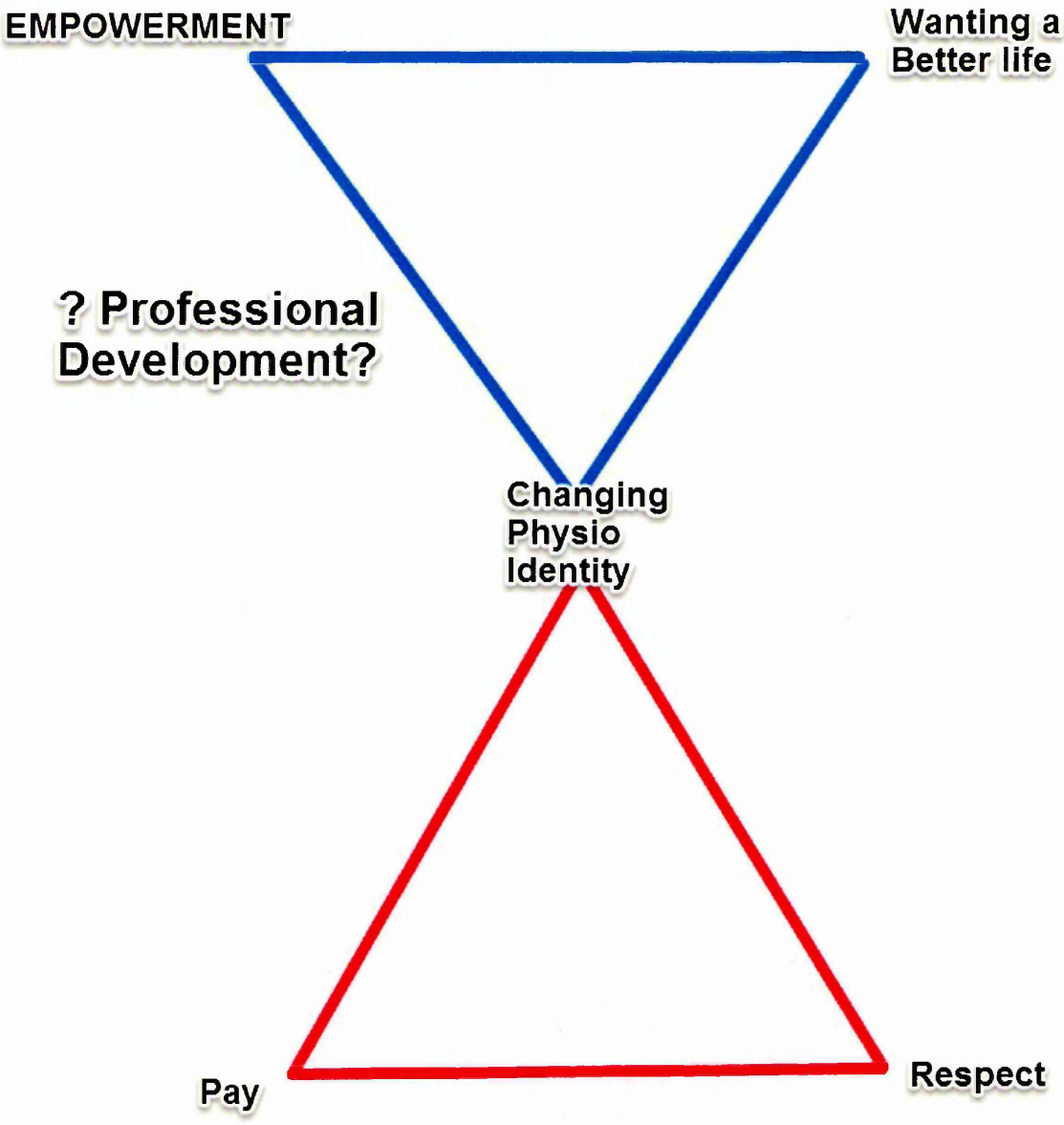






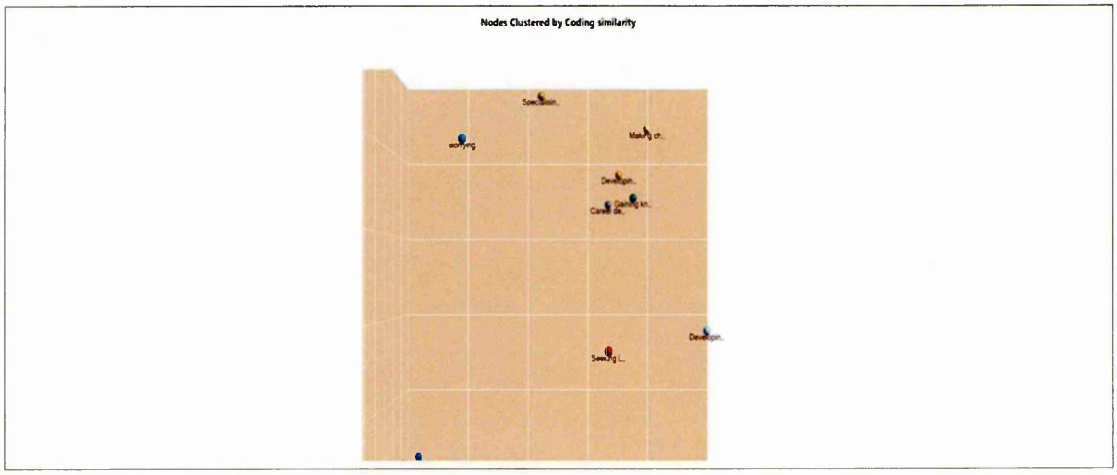


An Indian Physiotherapists Journey - A Theory



Possible Inter-realtionships
Between Core Theoretical Categories v2

Appendix 6: Examples of the Output of NVIVO Analytical Tools



Appendix 7: Ethics Approval

Faculty of Health and Wellbeing Research Ethics Committee
Health & Social Care Research Ethics Review Group
Report Form

Title: An Exploration of Indian Physiotherapists' Global Mobility: motivations, practice and profession development

Principal Investigator: Kate Grafton

Recommendation:

Acceptable:	
Not acceptable, see comments:	
Acceptable, but see comments:	X

Comments: See attached Review sheet

Please remember that an up-to-date project file must be maintained for the duration of the project and afterwards. The project file might be inspected at any time.

Signature : PP Chi..... Date: .....02/11/09.....

Peter Allmark,
Chair
HSC Research Ethics Review Group

Note: *Approval applies until the anticipated date of completion unless there are changes to the procedures, in which case a major amendment form should be completed and approved by the Committee*

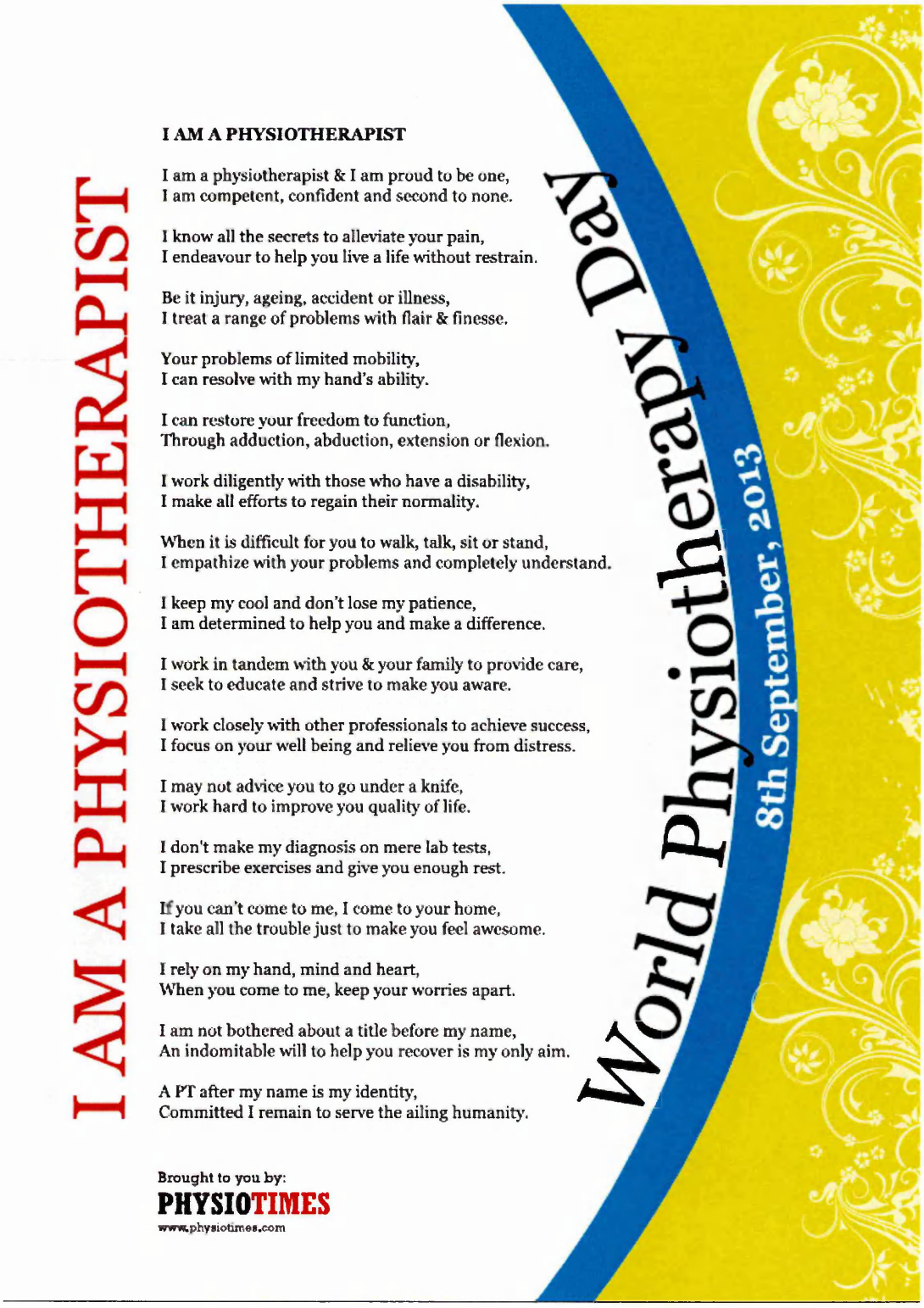
Comments from the Ethics Committee have been addressed.

Signature of Tutor / Director of Studies / Supervisor :

.....M.F.Gordon..... Date: ...18-12-09

Name of Tutor / Director of Studies / Supervisor :

Appendix 8: Physiotimes World Physiotherapy Day Poem



I AM A PHYSIOTHERAPIST

I AM A PHYSIOTHERAPIST

I am a physiotherapist & I am proud to be one,
I am competent, confident and second to none.

I know all the secrets to alleviate your pain,
I endeavour to help you live a life without restrain.

Be it injury, ageing, accident or illness,
I treat a range of problems with flair & finesse.

Your problems of limited mobility,
I can resolve with my hand's ability.

I can restore your freedom to function,
Through adduction, abduction, extension or flexion.

I work diligently with those who have a disability,
I make all efforts to regain their normality.

When it is difficult for you to walk, talk, sit or stand,
I empathize with your problems and completely understand.

I keep my cool and don't lose my patience,
I am determined to help you and make a difference.

I work in tandem with you & your family to provide care,
I seek to educate and strive to make you aware.

I work closely with other professionals to achieve success,
I focus on your well being and relieve you from distress.

I may not advice you to go under a knife,
I work hard to improve you quality of life.

I don't make my diagnosis on mere lab tests,
I prescribe exercises and give you enough rest.

If you can't come to me, I come to your home,
I take all the trouble just to make you feel awesome.

I rely on my hand, mind and heart,
When you come to me, keep your worries apart.

I am not bothered about a title before my name,
An indomitable will to help you recover is my only aim.

A PT after my name is my identity,
Committed I remain to serve the ailing humanity.

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World Physiotherapy Day
8th September, 2013