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RESEARCH ARTICLE

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A grounded theory study of the narrative behind Indian physiotherapists global migration

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Summary

It is estimated that an additional 6.4 million allied health professionals are required to address India's health challenges. Physiotherapy is amongst the largest of these professions. Over the last decade, thousands of Indian physiotherapists have sought to study and work overseas. In this study, 19 physiotherapists from across India were interviewed. Data were collected and analysed using construct+ivist grounded theory methods. The findings indicate that the Indian physiotherapy profession faces many political and clinical hierarchical challenges within the Indian healthcare infrastructure. The profession's education provision has developed, and the private clinical sector has grown, but there are significant disparities in quality and standards across the sector. The profession in India has variable autonomy, is not nationally regulated, is poorly paid, and the leadership has been divided. The political, educational, and clinical context in Indian physiotherapy impacts upon physiotherapists' ability to practise effectively to their professional satisfaction. Individual physiotherapists are frustrated by their workplace and travel overseas where they hear that the physiotherapy profession and practice is different. Whilst the disjunctures influencing these factors continue, and overseas physiotherapy practice is perceived as different and superior, Indian physiotherapists will continue to seek to migrate overseas, and facilitating their return will be challenging.

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KEYWORDS
autonomy, identity, India, migration, physiotherapy

1 | BACKGROUND

1.1 | India's healthcare

India's 1.2 billion people is a sixth of the world's population, but it contains a third of the world's poor.[1] Significant progress towards achieving the Millennium Development Goals have been made, but health outcomes inequality remains.[2] Over the last 25 years, governments have incentivised investment in the private health care industry, which has experienced exponential growth, but the resultant variable quality, provider-driven provision has not addressed the significant health challenges.[3] Per capita, health expenditure grew from US$18.6 in 2000, to US$63.3 in 2015.[4] In 2013 to 2014, the total spending on healthcare was 4.02% of gross domestic product (GDP), the government public sector making up 33% and the private sector 67%.[3] Despite this investment, an additional 6.4 million allied health professionals are required to address India's significant healthcare needs.[5] Public health expenditure is, therefore, proposed to be increased from the existing 1.15% to 2.5% of GDP by 2025.[6,7]

1.2 | Physiotherapy in India

The Indian Association of Physiotherapists (IAP) became a member of the World Confederation for Physical Therapists (WCPT) in 1967, and Indian physiotherapy has since evolved alongside the global profession. Indian physiotherapy education levels are high with a 4.5-year bachelor degree entry level and post-qualification masters and PhDs available. However, significant challenges remain in contextualising learning to India's needs and in ensuring quality across educational institutions.[8,9] There are calls from within the profession for more evidence-based practice,[10,11] more research,[12] and more engagement with continuing professional education.[13,14]

Physiotherapy in India is dominated by the medical profession and, despite protestation from physiotherapy, prescribes specific physiotherapy treatments.[15,16] Doctors often oversee physiotherapists considering them to be technicians, and there is dispute regarding whether physiotherapists in India should be able to practise autonomously without medical supervision.[17] Further to this, the medical profession strongly object to the use of the title Dr by physiotherapists.[14] There has also been discontent and conflict within physiotherapy itself.[18] A contested electoral vote for leadership of the IAP occurred in 2011 that resulted in a series of court actions. This dispute has recently been resolved, but for over 6 years resulted in there being two IAPs with different leaderships purporting to undertake the same functions of representing circa 30 000 physiotherapists' interests in India; maintaining a register of members; approving educational institutions for the delivery of physiotherapy courses; and setting and ensuring ethical professional practice and standards of independent practice by members. The IAP membership of the WCPT was terminated in 2015 because of unpaid subscriptions and to date has not been reinstated.[19] Indian physiotherapy aspires to recognised professional autonomy[18] but has been hampered by a lack of professional regulation, despite rafts of government legislature over the years (see Table 1).[16]

It is against this backdrop of health sector growth, potential employment opportunity, professional political strife, and a struggle for recognition that thousands of Indian physiotherapists have sought to study and work overseas over the last decade. The research reported here investigated the factors underpinning global migration of Indian physiotherapists. The findings present a complex narrative behind the influences that “push” Indian physiotherapists to migrate overseas for study and/or work.

TABLE 1 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.
December 2012	Union minister of health and family welfare report—recommends enhancing allied health professions roles and effectively autonomy.
2015	The allied and healthcare Professional's central council bill—draft for consultation. Aims to regulate over 50 types of allied and healthcare professionals and to set standards for their education and practices
February 2017	The allied and healthcare Professional's central council bill—draft amended and sent for interministerial consultations.

2 | METHODS

The study was undertaken from an interpretivist perspective utilising constructivist grounded theory methodology (CGTM). CGTM has an emergent structure with an open and flexible approach and is dependent upon co-construction of data between the researcher and participant. The interpretative actions of the researcher construct categories of social meaning that are derived from the actions and behaviours of those involved.[20] The distinctive strategies of CGTM are synchronous data collection and analysis of data; two-step data coding; constant comparative methods; memo writing to aid conceptual analysis; sampling to refine theoretical ideas; and integration of a theoretical framework.[21] This systematic and emergent approach ensured that the data collection and analysis were able to capture and interpret multiple perspectives.[20] A substantive theory was developed that comprised a core category of professional identity transformation incorporating two key categories of the journey and wanting a better life. Nineteen Indian physiotherapists consented to be interviewed once in English. Thirteen of these participants were less experienced (mean age 25 years) and were interviewed via focus group. They had all worked in India and were studying master's degrees either in the United Kingdom or India. Individual interviews were conducted with the remaining six more experienced physiotherapists (mean age 37 years), who had all worked or studied overseas. Table 2 shows participant details. Interviews were conducted in the United Kingdom or India at locations convenient to the participants (universities, clinics, and hotels), they were recorded and transcribed verbatim, pseudonyms were used to ensure anonymity.

Professional networks across India were used to recruit the participants, who were contacted by email with information regarding the study and why they had been contacted. Initially, purposive sampling and subsequently theoretical sampling were used to select participants and to shape subsequent data collection across interviews in accordance with Grounded Theory methods. Data collection and analysis were concurrent, facilitating coding, constant comparison, and the initial development of conceptual categories. Memos were used to capture the researcher's interpretation of the data. This iterative approach ensured that the resultant categories were grounded in the interview data. Data saturation was considered achieved when no new codes were noted, and a final explanatory matrix and conceptual theory was constructed. The rigour of the analysis was assured by adhering to the

TABLE 2 Participant characteristics

Participants	Interview location and Sampling Characteristics
Focus group 1: Dinesh (m), Suhani (f), Joseph (m), George (m), JK (m)	New to UK to study a physiotherapy Master's degree. All arrived in the United Kingdom less than 1 month prior to the interview that occurred in a UK university.
Focus group 2: Madhuri (f), Anuja (f), Shrishri (f), daisy (f), Monica (f)	All studying for a physiotherapy Master's in same institution in Delhi, India, some year 1 and some year 2, interviewed in India
Focus group 3: Sushmita (f), Bipasha (f), Lara (f)	Completed Master's in the United Kingdom Looking for physiotherapy work in the United Kingdom, had not returned to India. Interviewed at a UK university.
Ashna (f)	Senior clinician and educationalist. Studied Master's and PhD overseas. Interviewed in Indian physiotherapy clinic
Manish* (m)	Senior member of a high profile physiotherapy institution. Career academic, strong clinical research interest. Connections with IAP. Bachelor's, Master's & PhD education all in India. Participated in several overseas study visits with a range of global universities. Interviewed at an overseas conference.
Minda* (f)	Worked clinically in India prior to recent Master's study overseas. Recently returned to Indian clinical practice with previous employer. Interviewed in India.
Lalit (m)	Worked clinically in India prior to recent Master's study overseas. Returned to India in a non-traditional physiotherapy clinical role. Now a clinical director working in sport. Interviewed in India.
Rani* (f)	Senior member of a high profile physiotherapy institution. Has worked in education overseas. Influential in physiotherapy political circles, and Indian physiotherapy education. Previous IAP role. Bachelor's, Master's & PhD education all in India. Interviewed in India.
Adeeb* (m)	Clinical work in India and United Kingdom. Master's and PhD study overseas. Good Indian physiotherapy networks. A writer and activist in the profession in India—not associated with the IAP. Has not returned to India but aspires to do so. Interview at a UK university.

*Participants known to researcher prior to interview. IAP, Indian Association of Physiotherapy. m = male, f = female.

constant comparison grounded theory methods; the analysis was shared with two qualitative experts within the research team to ensure the interpretations were upheld by the data. The participants' narrative was triangulated with data from Indian physiotherapy publications, web forums, and newspaper reports. A final validation interview was undertaken to ensure the interpretation of the data made sense to someone experiencing the phenomenon. See Figure 1 for data collection and analysis stages.

Ethical approval to conduct the study was gained from the researcher's host University Ethics Committee in the United Kingdom. Approval to conduct the interviews in India was gained from the institutions where the interviews occurred.

3 | FINDINGS

Two key categories were developed: "Wanting a Better Life" and "The Journey." Figure 2 shows the relationship between them. The "Wanting a Better Life" category findings are published elsewhere.[22] "The Journey" category will be presented here and captures the narrative concerning factors in India that "push" Indian physiotherapists to migrate overseas for study and work.

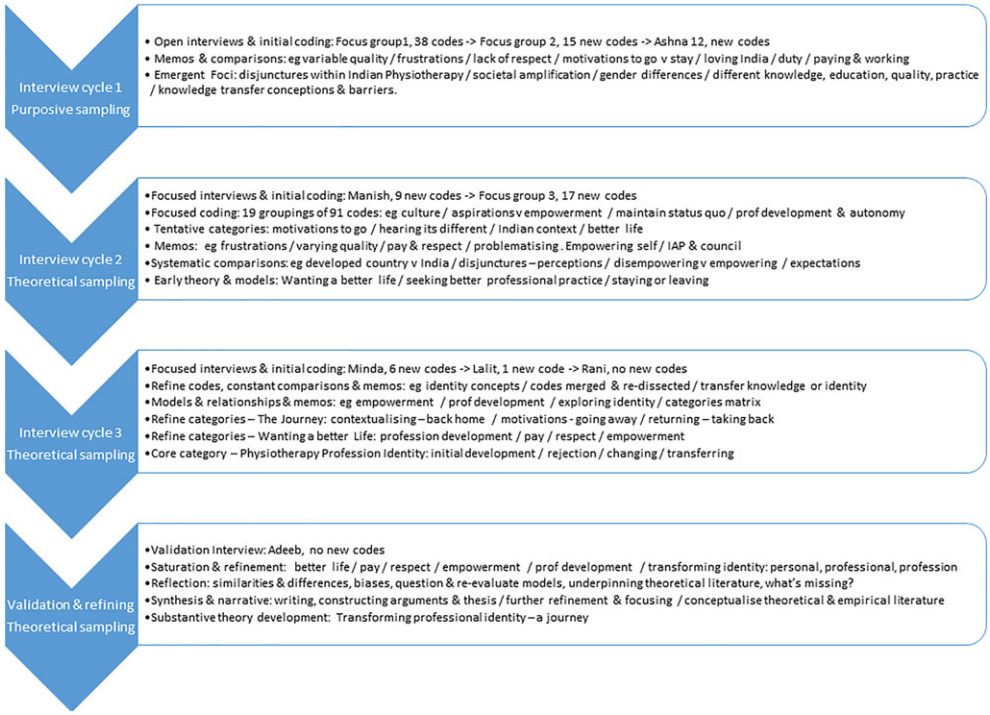

FIGURE 1 Data collection and analysis developmental stages [Colour figure can be viewed at wileyonlinelibrary.com]

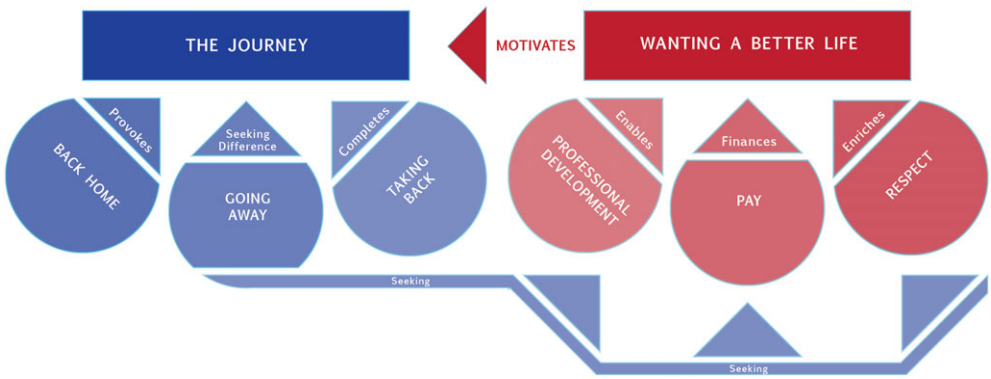

FIGURE 2 Relational matrix of the categories and subcategories underpinning the motivations Indian physiotherapists migrate overseas [Colour figure can be viewed at wileyonlinelibrary.com]

3.1 | The journey category

The journey category captures the complexity of factors that initiate the physical and personal and professional development journeying of migrants.

> *"I am a better physiotherapist after I have come back from there; so yeah I think* ***it's been quite a journey****."*
> *Minda (returned to Mumbai post UK Masters study)*

The subcategories capture the stages within the journey; "Back Home" describes the context of Indian physiotherapy, "Going Away" the elements underpinning the travel and "Taking Back" highlights the issues associated with return to India.

3.2 | Back home subcategory

The developmental experiences and perceptions of the participants are presented in interrelated groupings, selected evidence supporting the narrative is presented in Table 3.

TABLE 3 Narrative evidence underpinning the "back home" subcategory

Group	Narrative Evidence Examples
Being Indian	"Indians are very class conscious people." Ashna (overseas returnee, clinician and educator) "There is a very major senior-junior thing in India" Bipasha, FG3 (masters in UK) "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." Lalit (male, studied in the United Kingdom, returned to India) "Fighting for themselves" (Lara FG3), "survival of the fittest" (Joseph FG1), "you've got to fill your own pocket first" (Adeeb), '"need to be the best" (Joseph FG1). "a duty to serve India" "a duty to improve" Suhani, FG1 (female, just arrived in UK) "my people to serve them" Madhuri, FG2 (female, masters in India)
Educating India's physiotherapists	"...overall the reason is research or evidence-based practice are not well incorporated in all the universities of India." Manish (educator) "...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) "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) "In India we are getting bored of learning same thing, and same thing, always same stories." Suhani, FG1 (studying UK masters) "So most of the students actually spend their first year repeating what they did at the undergraduate level." Ashna (studied overseas, educator)
Under doctors orders	"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 (...)" Rani (educator, worked overseas) "Because of the knowledge of the physiotherapist is increasing now. (...) the interaction between the physio and the physician has improved a lot." Manish (educator)
Great expectations	"...they [IAP] 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)"... a Council will not sort out anything really." Adeeb (UK PhD student) "... if we get a council that will help quite a bit" Lalit (studied in UK, returned to India)
Challenging status quo	"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 work scene is very different from the studying scene." Bipasha FG3 (masters in UK) "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) "Working in India can get a little frustrating (...) you get disillusioned, you get de-motivated, & then you feel that you need to do something about that situation." Bipasha "...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)

3.2.1 | "Being Indian"

Indian social and cultural influences amplified the importance of factors that may be of less significance in other cultures. Hierarchical status influenced the thinking and decisions that individuals made. Societal gendered expectations, where females follow their husband's wishes and look after the family and males support their wife and children, were evident. The importance of education differed along gender lines. For females, it is about societal expectations and social status; for males, it is about marital value, financial drivers, and career prospects. The issue of low-physiotherapy pay in India is therefore more pressing for men. Family and parental wishes play a significant role in Indian society, influencing not only decisions to migrate but also the desire to return. The competitive Indian environment sat alongside a strong sense of duty to serve India and family.

3.2.2 | "Educating India's physiotherapists"

The Indian physiotherapist's journey starts with undergraduate education, where an understanding of whom he/she is professionally, and what can be offered as an individual within a professional construct and context is developed. Participants suggested that undergraduate physiotherapy education in India had evolved and was influenced by migrant returnees bringing back different practice and ideas. It was identified that change was difficult to achieve, and more was needed: less content; less rote learning; more clinical reasoning, critical evaluation, and research skill development. All participants referred to a substantial variation in the quality of undergraduate physiotherapy education, explained by a rapid expansion in physiotherapy colleges, with associated poor regulation and lack of quality control. All the educators agreed that there may be minimal variation in the curriculum but notable difference in the standard and method of delivery.

There were mixed perspectives regarding the Indian master's physiotherapy degree, with comments relating to variable quality and didactic delivery methods. The strength of the master's degree was the requirement to practise and contextualise learning throughout the course. However, the balance between work and academic study could be skewed towards all hospital work with minimal teaching, the education becoming secondary. Others perceived the master's to be very theoretical. This apparent disjuncture may be due to examinations being the prime assessment method. The main criticism was that a physiotherapy master's degree in India repeated the bachelor's degree with very little new material, just more depth. This issue of repetition between academic levels was acknowledged as problematic by the educators. Aspiring master's students were often advised by peers and teachers that if wishing to learn new skills and knowledge, then they needed to go overseas, but if they wanted to build up networks, they should stay in India.

3.2.3 | "Under doctors orders"

Participants described two types of workplace. Firstly, the "non-autonomous" department where it was difficult to implement the practice learnt in training. Practice was based on prescriptive doctors' referrals that frequently demonstrated a lack of understanding of physiotherapists' skills. Exercises or electrical modalities would be "given" dependent upon the patient diagnosis. The doctor determined the diagnosis. Some attributed this department practice to diploma qualified senior staff whose lack of knowledge meant they adhered to the conventional treatments prescribed. Hierarchical structures ensured dialogue was not encouraged, junior physiotherapists should not question or offer their own opinion; they should follow the leadership and protocol in the same way as the senior staff. These departments were described as "parochial" with "no incentive for them to change." "Good physios from good colleges won't work in these hospitals which pay less, so then the standard of physios in these hospitals remains low" (Lalit). These departments would not employ master's graduates who it was considered should work in academic institutions. The participants who had worked in the "non-autonomous" departments were dissatisfied, had not felt respected, and had not felt confident to engage the doctors in debate.

Secondly, in "semi-autonomous" departments, the work culture was more progressive, the department heads were better qualified, proactive, and encouraged staff development. Physiotherapists were allowed to engage in dialogue with doctors to suggest alternative, more beneficial forms of treatment. Once the doctors had seen the results, when referring the next case, they just prescribed "pain management" and left the physiotherapist to decide the modality. Hence, these clinical environments had evolved to adopt "semi-autonomous" ways of working, and job satisfaction was better. This mutual respect between medics and physiotherapists had been "earned" through good knowledge of physiotherapy, good clinical practice, and effective communication. These departments were often in large corporate hospitals or were linked to academic institutions. They employed master's graduates as they were more knowledgeable, more critical, and more embracing of innovation.

3.2.4 | "Great expectations"

As the IAP is not a regulatory or statutory body, it was considered powerless and was not paid attention to by universities. There was a sense of frustration regarding the effectiveness of the IAP, but some participants had sympathy for the challenges it faced. There was an optimism that things were slowly changing despite government delays in establishing a regulatory council. There was an expectation that once the council is in place that the challenges facing Indian physiotherapy would be resolved, there would be increased respect, pay, and clinical practice would improve. Others were sceptical, identifying that unless the council enables physiotherapists to practise autonomously in a regulated system that nothing would change. Legislative clinical autonomy was considered essential to enable physiotherapists to practise effectively and not just administer a modality prescribed by a doctor.

3.2.5 | "Challenging the status quo"

Shortage of employment opportunities had resulted from the increased number of physiotherapy colleges and thus graduates. Many graduates, therefore, had limited choice in where they worked. Those employed in the "semi-autonomous" departments worked in environments where practice and workplace culture were similar to their student environment. Graduates working in "non-autonomous" departments experienced a mismatch between the expectations developed during training and the reality of clinical employment. They had learnt to practise in a semi-autonomous culture, where dialogue and contemporary techniques were encouraged; however, the expectations of their employed clinical role were quite different, and for many, it jarred with the professional identity to which they aspired. As new graduates, they were the sole carriers of more contemporary physiotherapy ideas and practice to these workplaces, but hierarchical structure and departmental cultures did not empower them to implement or share these developments. Continuous professional development was not encouraged, and there was no impetus to develop clinically or professionally. Participants described workplace cultures lacking in personal professional development, perpetuated by poor role models and the predominance of female physiotherapists waiting for marriage and stopping working, as their husbands would earn the money. These all resulted in frustration and disillusionment with physiotherapy.

Wherever physiotherapists worked, however, there was frustration with low-pay levels that were felt incommensurate with degree level qualification and compared unfavourably with those of similarly qualified peers. Individuals felt that the low pay resulted in a lack of respect for physiotherapy as a profession and were studying for an MBA in order to change profession, hospital administration being a commonly cited career move for physiotherapists.

Lack of job satisfaction, pay, and respect culminated in frustration with their career. Some of the participants who did not travel overseas and had elected to study their master's in India reported their decision to study in India resulted from parental pressure, lack of finances and, for some, a lack of confidence about their ability to adjust to the difference in study, living, and generally coping overseas. Others stated that they simply had no desire to travel. Those choosing to migrate believed in physiotherapy as a construct, enjoyed being with patients, and had proud supportive relatives. However, the lack of governance and professional leadership meant uncertainty regarding the future direction of the profession in India, with little prospect of changes to practice and achieving job satisfaction.

The decision to migrate was not about leaving physiotherapy or leaving India, it was about leaving Indian physiotherapy.

3.3 | Going away subcategory

The "Going Away" subcategory captures the aspects of the journey associated with moving overseas. Examples of the narrative around what draws Indian physiotherapists overseas are shown in Table 4.

3.3.1 | "Hearing it's different"

Throughout the interviews, participants referred to perceived differences between Indian and overseas physiotherapy in three key areas: knowledge, education, and clinical practice. By travelling overseas, they sought knowledge that was either not available or of a sufficiently high standard in India. This knowledge comprised the "latest techniques" and "technologies," the most "updated" skills, clinical reasoning, evidence-based practice, conceptual approaches, or specialism. Educationally, differences were in quality, facilities, research, evidence base, syllabus, assessment, and pedagogical approaches. Clinical practice differences focused around autonomy of the profession and, hence, practice. This autonomy was associated with knowledge and skills that were valued and respected by doctors and the public and were rewarded with better pay. The Indian physiotherapists sought different experiences and wanted to see physiotherapy practised differently. Overseas Indian physiotherapist role models were important in not only communicating that education and practice was different but also in conveying images of success and professional satisfaction that were accessible and could be emulated.

TABLE 4 Narrative Evidence Underpinning the Going Away Subcategory

Group	Narrative Evidence Examples
Hearing it's 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, Focus Group 1 (just arrived in UK for masters study) "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 (....) 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) "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 have 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) "...very different style of teaching compared to India (...) there is a lot of flexibility." Lalit (overseas returnee)
Developing self	"So to learn skill techniques and I want to gain more knowledge. That's why I am here." *Suhani (MSc UK)* "The aspiration 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 (...) & basically just getting as much as knowledge as I could so that I could come back here and practise better." 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) "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)
Working overseas	"I am still like really trying to get a job or an observership somewhere just to see how it is, how physiotherapy is practised over here; just to get some kind of work experience (...) attend some workshops and courses, short courses." Lara, FG3 (masters in UK) "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 arrived in UK)

3.3.2 | "Developing self"

Self-development was the principal motivator for migrating. The experienced participants reflected on their development overseas and described "mental training" and "learning to think" rather than just skills, "you learn to learn," becoming "more questioning," "more analytical," "more critical," and "more sceptical." However, less experienced participants, just starting their journey, considered what they had heard was different overseas was the focus of their self-development. Gender differences were identified. The key motivation behind this self-development for females was to enable them to practise better, to be a different physiotherapist and for personal growth. Males considered they would be enabled to progress their careers and get ahead in competitive work environments; their emphasis was on longer term and externally focused career rewards. Clinical skills and knowledge development were mere stepping stones towards a successful career and increased earnings.

3.3.3 | "Working overseas"

Gaining international clinical exposure was identified as a significant part of the journey. Participants wanted to experience the different autonomous physiotherapy practice they had heard about. Whilst clinical work with pay was preferred, clinical work without pay was highly valued, and at a very minimum, clinical observation opportunities were sought. Securing paid work to contribute to living costs and fees was important for those studying master's degrees. Several participants identified that if there were no jobs in the United Kingdom upon graduation or if they did not like the work context, they would seek to practise elsewhere. The United States, Canada, Australia, and New Zealand were recognised as places physiotherapy was respected and clinical practice good. This onwards global mobility was acknowledged as being about a better place to work to gain quality experience, respect, and pay.

3.4 | Taking back subcategory

The final stage on the globally mobile Indian physiotherapists' journey is about going home and transferring their learning and professional practice to the Indian context. The "Taking Back" subcategory captures the value and challenges associated with returning; Table 5 presents some narrative evidence.

3.4.1 | "Returning"

All the participants who were overseas expected to return. They aspired to return with knowledge, skills, and different ways of working, thus improving physiotherapy practice in India and personally benefit from higher status and pay. There was a perception that India valued overseas returnees. The experience and qualifications gained were appreciated and respected especially by educationalists who considered the international perspective, clinical skills, ways of thinking, professional maturity, and confidence were important attributes that returnees possessed. However, gaining formal recognition for overseas master's degrees could be problematic. If course duration was shorter than the Indian standard of 2 years, it was not recognised. This potentially limited employment progression in academic institutions beyond assistant professor.

Participants wanted to time their return so they had sufficient experience to re-enter at a higher level (pay and hierarchical) than that they had left. Returning to the right job with enough autonomy and opportunity to apply new skills and learning was essential for a successful return. Some had achieved this; others had not and subsequently stopped practising as physiotherapists or had re-migrated. Self-employment was considered attractive, but was a long term objective due to the logistics of developing a reputation locally. Factors deterring physiotherapists from returning were the same that facilitated their initial migration. It was not about reluctance to return to India, but

TABLE 5 Narrative evidence underpinning the "taking back" subcategory

Group	Narrative Evidence Examples
Returning	"I am 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 analyse 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) "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." Ashna (overseas returnee, now clinician and educator) "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)
Knowledge transfer	"... basically learnt quite a lot and today I am applying quite lot what I have learnt in every which way "Minda (recently returned to Mumbai following Masters study in the UK) "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)

was about the state of the profession in India, pay and the prospects of transferring their overseas practice into the Indian work context.

3.4.2 | "Knowledge transfer"

There was evidence that individuals had implemented learning gained from their overseas experiences into their current working practice. This ranged from their own clinical practice, within workplace constraints, to sharing their knowledge and perspectives with colleagues through discussions and workplace teaching sessions. Those returning into education environments considered they had influenced the educational progress of the students, their expectations, and how they were equipped to function as newly qualified physiotherapists. The overseas diaspora was keen to share knowledge either through lectures for academic staff or students when they visited India or through setting-up online journals and discussion forums. Most participants considered that to effectively influence the profession and practice in India, the physiotherapist should return.

4 | DISCUSSION

The findings suggest that underlying Indian physiotherapists' global migration is a complex narrative of conflicting social, cultural, political, and economic influences that impact upon an individual's satisfaction with their own physiotherapy practice and professional identity. Working practices associated with a lack of autonomy and respect were important for Indian physiotherapists. Low pay, management, and governance "push" factors articulated in the nursing migration literature[23-25] were also identified factors in this research. The nurse migration literature concludes that whilst access to training opportunities and career progression opportunities are important, of greater importance is income, quality of life, and education for children.

This research suggests professional disjunctures push many physiotherapists to consider migration. Entry level education has advanced and equips graduates to work in semi-autonomous contexts, but many workplaces constrain their potential. They allow physiotherapists to only administer treatments prescribed by doctors and discourage continued professional development. Despite India's need for more physiotherapists,[5] there are insufficient posts for the number of physiotherapy graduates, subjecting many to working for low pay in workplaces that restrict them from

utilising their skills or to develop professionally. The lack of legislative regulation of physiotherapy education and practice has resulted in variable quality of provision in both sectors and confounds the argument for fully autonomous physiotherapy practice. As long as these disjunctures continue to influence physiotherapy in India, and overseas physiotherapy practice is perceived to be different and superior, it is suggested that Indian physiotherapists will continue to seek to study and work overseas.

Brain circulation is one theorised benefit for the donor country of overseas highly skilled migrants, but return migration is an important element,[26] and return migration is a challenge for Indian physiotherapy. Ghosh[27] identified that successful autonomous return depended upon "productive and gainful employment" and the ability to contribute to the economic and social development of the home country. The ability to take new ideas, values, and ambitions back home is described as a "return of innovation" and is considered the most valuable type of return to the home country but difficult to achieve.[28] Iredale et al[29] considered 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, frustration and repeated migration would ensue. Based upon the narrative in this study, only some returnees to India were able to utilise the skills and knowledge they had gained overseas. Successful returnees had moved into carefully selected environments where they were able to manage role expectations and to align them with their professional expectations.

Reports suggest 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, others who have worked internationally for many years 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.[30] Interestingly, returning doctors identified that they had always wanted to return to India but had been held back previously because "they would not have been able to practise medicine the way they had learned abroad."[30,31]

Whilst the factors that push Indian physiotherapist to migrate overseas continue to exist, the return environment will continue to be challenging for their return. The lack of professional regulation and the battle for clinical autonomy are key issues. However the government's new National Health Policy,[32] the drafted Allied and Healthcare Professional's Central Council Bill,[33] and proposed new Physiotherapy curriculum[34] offer Indian physiotherapists an opportunity to work with India's health leadership to shape a professional structure that harnesses the profession's skills and expertise and potential to help India to address its significant healthcare challenges. This research, however, suggests that in implementing policy and legislation, the leadership must incentivise changes in workplace culture ensuring the empowerment of physiotherapists to undertake autonomous practice, fully implementing their existing skills and enabling continued professional development. Standardisation of the quality of practice and education with a greater focus on evidence-based practice and underpinning clinical decision-making is important. Finally, return will be encouraged through appropriate financial remuneration for physiotherapists and the creation of a culture where physiotherapists' contributions are respected and valued.

A key study limitation is the interpretive cross cultural nature of the research. The constructivist approach utilised acknowledges the position of a white UK researcher and their interpretation of the Indian participants' narratives. The researcher's clinical and educational physiotherapy expertise, combined with extensive travel within India visiting education and health institutions, assisted in gaining the perspectives of a range of experts who were grounded in the phenomenon. CGTM trades the scale and breadth of coverage achieved by questionnaire-based studies, for a depth and richness of data. The utilisation of rigorous CGTM[20] for data collection and analysis ensured that the narrative was captured the Indian physiotherapists' perspectives. CGTM is useful in that it facilitates an exploration and understanding of the narrative that could not be anticipated at the start of the study.[20] A strength of the CGTM is that its emergent but systematic nature permitted an in-depth understanding and explanatory theoretical perspective to be developed specifically around the Indian physiotherapy context that was previously poorly understood.

5 | CONCLUSION

Many examples of excellence, innovation, and development of Indian physiotherapy were noted during this study. This ranged from educational institutions striving to develop pedogically to departments embracing contemporary developments and encouraging autonomous practice. Throughout the interviews, there was a narrative that illuminated a vibrant and emergent community striving to develop physiotherapy practice in India. In contrast, the same interviews also portrayed a more negative image of physiotherapy in India; one of varying educational standards, minimal governance to assure quality, differing clinical standards, and restrictive clinical contexts, where hierarchy and the doctor's prescription of rehabilitation dominated. Because of political complexity, the profession struggles 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, whilst striving for professional autonomy. There was a passion for a common objective of an autonomous and respected profession but a lack of coherent leadership or consensus regarding how it should be attained. This more sinister narrative has resulted in a generation of disempowered and disenchanted physiotherapists who migrate overseas to seek a better life and a better profession.

As Indian physiotherapy leaders and Indian health leaders consider the future in light of the proposed government investment in Indian healthcare and associated legislation, it is important and timely that this complex narrative is articulated and understood. The opportunity to reflect upon the messages within the narrative and to identify solutions for the challenges raised by the Indian physiotherapists provides the potential for the issues to be addressed. This narrative suggests that improving workplace satisfaction, through autonomous practice, increased pay and respect are key to reducing the migratory outflow and essential to optimise successful return migration. India cannot afford to lose its talented physiotherapy workforce through one-way overseas migration.

AUTHORS' CONTRIBUTIONS

Kate Grafton conceived and designed the study, undertook all the data collection and data analysis, and wrote the first draft of the manuscript. The work was undertaken as part of a doctorate study. Frances Gordon was the primary supervisor for the doctorate, critically appraised and influenced the study design and data analysis, and critically revised the manuscript drafts.

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CONFLICT OF INTEREST

"The authors declare that they have no competing interests".

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