

Valuing and Recognising the Talents of a Diverse Healthcare Workforce

*Report from the REOH Study:
Researching Equal Opportunities for Overseas-trained Nurses
and Other Healthcare Professionals*

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Preface by Carol Baxter

Professor Carol Baxter is Head of Equalities and Diversity at NHS Employers, which was set up in 2004 to take over responsibility from the Department of Health for much of the workforce agenda, supporting and representing employers in the NHS. Carol has worked as a nurse, midwife, health visitor, and health promotion specialist as well as holding senior positions in the NHS, the Department of Health and the higher education sector.

Since its inception in 1948 the NHS has relied on overseas-trained nurses to bolster its workforce. Even though the NHS is now less reliant on overseas trained professionals to deliver services, international recruitment is still an option for employers trying to fill vacancies in certain geographical areas or in professions/specialties with recognised shortages.

There are arguments for and against nurse migration. Individuals can benefit through a broadening in their professional experience, and their personal and social skills can be enhanced through working in different and challenging environments. Employers benefit because of the broadened labour market. Patients can benefit through receiving more culturally sensitive care.

Nevertheless, there are concerns that the countries from which the nurses are recruited suffer from a knowledge and skills drain which reduces their capacity to provide healthcare to their own populations.

This thorough and well-researched report from the REOH Team highlights a range of issues in the employment of overseas-trained nurses which employers need to address. These cover three broad areas:

- *Patterns of Migration.* What are the motivations for nurse migration? Are there patterns in terms of the countries most sought out? What are the pathways available to nurses to find out about migration opportunities?
- *Entry into the UK.* Is batch recruitment by NHS organisations the best way to fill posts? Does the increasing use of agencies result in unfair treatment of overseas recruits? How should we deal with the trend towards initial placements in Care Homes, where overseas-trained nurses often work as Healthcare Assistants before qualifying for NMC registration?

- *The Workplace Experience:* Once recruited, how are overseas-trained nurses treated? Do they receive appropriate levels of support? Are adaptation and induction processes adequate? Do they have equal access to personal and career development opportunities?

There are guidelines in place to support employers in the recruitment of overseas-trained nurses, most notably from the Department of Health and the Royal College of Nursing. These guidelines cover all of the above areas and include a Code of Practice to ensure an ethical approach to overseas recruitment. However, while many employers are very supportive of their overseas trained staff, this report presents compelling evidence that those guidelines are not yet being translated into practice with sufficient rigour in a number of cases. This evidence includes:

- lack of adherence to the principles underpinning the Code of Practice by some recruitment agencies
- adaptation programmes which do not sufficiently take into account cultural differences between the UK and the country of training / origin
- inadequate levels of local support and mentoring for overseas recruits
- processes around personal development and recruitment which are indirectly discriminatory
- disproportionate levels of bullying and harassment
- career stagnation and under-achievement.

In response to this evidence the report goes on to make six clearly-stated and focussed recommendations. These will require cooperation across a number of agencies to bring into effect.

As part of our work to support employers and promote the NHS as an employer of excellence, NHS Employers provides advice to employers on issues ranging from ethical recruitment and work permit applications to registration and dealing with regulatory bodies. We are committed to improving the working lives of *all* staff in the NHS and are confident that improvements have been made in many of these areas by NHS organisations in recent years. We are equally confident that, working together, we can help to improve employment

practices further to reduce, and ultimately eradicate, discriminatory effects, however indirect and unintentional.

Critical to this is that career and personal development must be fair and open to all, where everyone has the chance to progress and personal success is celebrated.

I have a vision of an NHS which fully and wholeheartedly embraces and welcomes people from all cultures and in which the services it provides meet all of their health needs. This report is a helpful signpost. We need to make sure that we stay on this road and complete the journey.

Carol Baxter

Head of Equalities and Diversity

NHS Employers

Preface by Julia Dutchman-Bailey

I was delighted to be part of the advisory panel for this important piece of work. It has enriched my understanding of the challenges that employers and managers of healthcare settings face today, but it is a powerful piece of research that goes way beyond just healthcare settings.

When I first read the report, I thought - 'not in my patch, my organisation is different' - I went into denial mode, then into defensive mode. However, and importantly, after a period of reflection, I realised that these findings are probably evident, to a greater or lesser extent, in most healthcare organisations including my own. The report provides a mirror for healthcare organisations, a mirror that is not altogether comfortable. Whilst the findings and recommendations may seem to some, 'commonsense', commonsense is often not common!

There are two key areas of reflection that I would like to share with you, firstly relating to deskilling of overseas healthcare staff and secondly the seemingly fair and equitable recruitment process healthcare organisations apply.

When I reflected upon how I organised supervised practice programmes I realised that elements of the well meaning and supportive programme I was delivering was actually deskilling them. The example I will use is that many overseas trained staff arrive in the UK competent in phlebotomy and cannulation skills – many supervised practice programmes, including my own, stop them from undertaking this skill until they have full registration with the Nursing and Midwifery Council. By the time they have gained their PIN number, many of the staff feel, and are, deskilled and are reluctant to undertake this skill. Whilst I am a firm advocate of managing risk and patient safety, a clinical governance process could have been set up to check this skill at an early stage in their programme, allowing the overseas trained nurse to maintain competence and feel that they were making a positive contribution to patient care.

My second illustration is regarding career progression and interviews. Whilst it is routine in most organisations to use robust recruitment processes and a personal specification to select candidates, what is less common are frameworks to ensure candidates have appropriate pre interview coaching and mentoring in order that the candidates have every opportunity to come to the interview on 'a level playing field'. The research provides some thought provoking findings and illustrates the need to consider the impact of cultural differences upon career progression.

This research explores a complex arena and there will be no single or easy solution to improving equal opportunities for internationally recruited healthcare professionals. However, as senior healthcare managers it is essential that we start to reflect upon our own organisation, consider the recommendations outlined in this report and discuss how we can improve the experience and career opportunities for our overseas trained workforce.

Julia Dutchman-Bailey

Nurse Director

Bromley Hospitals NHS Trust

Preface by Beverley Hunt

This study outlines the different ways in which overseas trained nurses and midwives are recruited to work in the UK, particularly in relation to cultural misunderstandings, mismatched expectations and barriers to progression and promotion that are encountered. It makes fairly uncomfortable reading for all who read it, particularly as it triggers questions about deeply rooted prejudice and discrimination that prevails within the health system and the realities and difficulties of unmasking racism as an underlying factor. It also raises further questions about the extent to which misperceptions and misunderstanding of cultural and racial differences can disempower overseas trained nurses and midwives and impact on their interactions with UK trained colleagues and the outcomes of patient care.

What is important is that this practice has been repeated over and over again. In short, over the last 40 years, each time there has been a shortage of nurses and midwives to work in the UK National Health Service and, more recently the Independent Health Sector, the trend has been to recruit them internationally from developing and developed countries alike. This trend has gained momentum more recently with a its focus on recruiting already trained nurses and midwives, rather than training them in the UK which, if done, carries a financial cost for UK health employers and managers. One of the problems of recruiting trained nurses from overseas is that they do not easily fit into the already established work environment. Whilst many of them devise ways to fit in, mostly to their own detriment, they remain an *outsider* in the system with little hope of ever really fitting in. The onus is on them to own the cultural differences that exist within the organisation.

They are recruited as a 'resource' to fill hard-to-fill vacancies but are given, very little, if any, career development, progression and promotion. They are then dispensed with when they are no longer required as a result of financial, policy, or other strategic and contextual changes. Indeed, many of them feel exploited and undervalued. One key question is: what lessons has been learnt from years and years of overseas recruitment of both trainee and trained nurses and midwives about what it takes to work with *others* in a way that sustains each others human respect and professional integrity.

These are some of the issues that have interested me as I became involved as a member of the REOH Advisory Project Board and in my work in leadership development and race and diversity at the King's Fund, London. Some of the struggles I experienced personally and through working with others as 'Black' employees in 'White' organisations are also echoed in some of the experiences of these nurses and midwives.

In this regard, UK health managers, employers and policy advisors need to rethink their strategies for recruiting and retaining nurses and midwives in this competitive market of global migration. Such a rethink cannot and should not focus only on strategies to manage the *policy* or workforce - *human resource* context, but also on those practices that form the norms of behaviour which overlooks the rich potential of this diverse group of overseas trained staff. To do so would be to shift focus away from reducing individuals to a functional commodity as a 'human' resource or as a victim of the process to seeing them in terms of their human potential for growth and development. This means taking action to eliminate the barriers that stop them from applying their collective differences and similarities in pursuit of achieving their personal growth alongside the organisation's goals.

In all of this, one important factor is the willingness to make the choice to adopt, implement and continually assess the impact of practices and policies on managing differences in the workforce between diverse racial and cultural groups. At our Advisory Board meetings we were fortunate to have contributions from a number of people from across a range of organisations, occupations and social, ethnic and racial identities with vested interests in this area of work. We recognise that neither government policy nor legislation can take the place of our willingness to respect each other. We found that our meetings provided a platform for learning and growth, for listening, sharing ideas and valuing our collective differences, all of which has led to the success of this project output.

Over the duration of the project a number of papers have been published by the researchers. A workshop was held at the Open University on the 10th June 2005 and a symposium presentation at the RCN 2006 International Nursing Research Conference. However, the content of these papers and workshops, which has culminated in the outcome of this project, are not intended to provide answers to the problem. They merely outline issues which can be used to trigger a powerful momentum of change in the ways that overseas trained nurses and midwives are recruited and treated to facilitate positive human encounters and aid their retention in the workforce.

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Acknowledgements

The team would like to thank the following for making this project and report possible:

- The Higher Education European Social Fund team at Liverpool John Moores University for part-financing the project.
- Suzanne Comby and Rachel Thomas in the projects team at UniSdirect, University of Surrey for their project management services.
- The Faculty of Social Science at the Open University for their support.
- All of the Advisory Board members for their advice, guidance and encouragement of the project:
 - Howard Catton (Head of Policy Development and Implementation, Royal College of Nursing);
 - Julia Dutchman-Bailey (Formerly of Royal Surrey County Hospital NHS Trust and currently Bromley NHS Trust);
 - Arlie Hochschild (Professor of Sociology at the University of California at Berkeley, USA);
 - Beverley Hunt (Independent Consultant);
 - Sue Jacob (Royal College of Midwives);
 - Verity Lewis (Royal College of Nursing);
 - Mayvis Oddoye (Surrey & Borders Partnership NHS Trust);
 - Janet Veitch (Women's National Commission)
 - Ann Whitehead (University of Sussex).
- Dr Kwadwo Mensah for his cooperation and support in our joint fieldwork in Ghana.
- Finally we would like to thank all of the participants – the overseas nurses, the national and local stakeholders and the participants at the case study sites - without whom this research would not have been possible.

We gratefully acknowledge the financial support of the European Social Fund which made this research possible but the views expressed in the report are entirely those of the authors.

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Executive Summary

The study - Researching equal opportunities for overseas-trained nurses and other healthcare professionals (REOH) - has explored the experiences of overseas-trained nurses and some other health professionals, in the United Kingdom (UK) health services, in both the National Health Service (NHS) and the private sector. The broad focus of the research was on the experiences of employment mobility and career progression of overseas-trained healthcare professionals currently working in the UK and their perceptions of equal or unequal opportunities as compared to locally trained staff.

When the report was commissioned the recruitment of nurses was a priority for the Department of Health. This priority has shifted somewhat during the time of the research to retention of nursing staff, including overseas-trained nurses. This concern with retention means that employers must make the best use of overseas-trained nurses already in post, by identifying in particular how best to accredit their skills, how to help them learn new skills for UK practice and how to promote them to posts within the UK workforce where they can make best use of their often extensive clinical and managerial experiences.

Aims

The specific research aims were:

- To analyse overseas-trained healthcare professionals' experiences of working in the UK;
- To research and analyse their patterns of employment mobility and career progression;
- To illuminate whether and how overseas-trained healthcare professionals' social relations abroad and in the UK might support or influence employment strategies and choices;
- To inform policy debates aimed at supporting the career paths of overseas-trained healthcare professionals in the UK;
- To inform policy development related to international recruitment.

Methods

The research design allowed an in-depth understanding of overseas-trained nurses' opportunities for career development in the UK. Data collection involved individual and in-depth semi-structured interviews with overseas-trained healthcare professionals from different backgrounds across three UK regions; interviews with national and local stakeholders and case studies involving UK healthcare employers in the NHS and independent sectors in three UK regions; and case study fieldwork with one Diaspora community in the UK and country of origin. A total of 93 overseas healthcare professionals, 24 local and 13 national stakeholders were interviewed.

Key Findings

The key findings from the research are that good practice in employing overseas-trained nurses and others requires employers to provide them with good supervision and support. Some of the same issues arise with nurses in training more generally in the UK and issues raised in this report often reflect wider problems in UK nursing and medical practice.

Our main findings are:

- **Overseas -trained nurses' skills and experiences are not recognised**
Overseas-trained nurses' experiences of mentoring and adaptation were shaped by inflexible formal accreditation and assessment systems in the UK which did not adequately recognise their skills and experiences. This lack of recognition of their skills and experiences led to undergrading and consequent deskilling and skills waste.
- **NHS international recruitment has increased from the commercial sector**
In the NHS there has been a recent shift from recruiting directly from countries of origin or intermediary countries, in batches or as individuals, to recruiting overseas-trained nurses from the commercial sector in the UK. This shift increases the costs of migration for overseas-trained nurses and may act as a means of circumventing the largely ineffective and contradictory Department of Health Ethical Recruitment Guidelines.
- **There is increased segmentation and hierarchy of nursing specialist expertise**
The commercialisation of health and social care in the care of older people has been associated with an increased segmentation and hierarchy of nursing specialist expertise, skills and tasks between the NHS and the independent care home sector. In particular, overseas-trained nurses have experienced a devaluing of the experiences and skills that they bring to the health and social care sector.
- **Migrants' motivations are poorly understood**
Healthcare professionals migrate to the UK for a variety of reasons, but these are not understood by British colleagues and managers. This may lead to stereotyping which consequently serves as a barrier to their subsequent career progression.
- **Overseas -trained nurses face multidimensional discrimination in the workplace**
Relationships between overseas-trained nurses and their colleagues and managers are often discriminatory and many lack social and professional support. Our data show

that racial discrimination in the workplace takes a range of guises, including direct discrimination and indirect discrimination embedded in organisational cultures, structures and practices. Discrimination and favouritism in the workplace may take different forms and the relationships between ethnic groups is more complex than White on Black discrimination. Tensions and allegations of discrimination were evident amongst a range of ethnic groups whose interaction is framed by their position in a post-colonial hierarchy of ethnicities within the NHS.

- **Informal systems of support in promotion can inhibit career progression for overseas-trained nurses**

Systems of promotion are not always transparent and can institutionalise disadvantage and create an environment which facilitates discriminatory behaviours. It appears that rather than being based on merit, promotion and particularly promotion into management positions (Grade G and above) involves navigating systems of patronage and sponsorship based on meeting subjective and culturally specific criteria; a process which facilitates racial and ethnic discrimination.

- **Mistakes made by overseas-trained nurses are more likely to be regarded as clinical malpractice**

Overseas-trained nurses are over-represented in cases of clinical malpractice reported to the Nursing and Midwifery Council (NMC). Our data illuminate how this is related to insufficient diversity awareness and a lack of recognition of non-British health care experience and expertise. Some managers' overuse of systems of complaints and grievances is underpinned by a lack of support which can lead to overseas-trained nurses experiencing social and professional isolation in the workforce. These practices based on subjective judgments and social negotiation imply that there is scope for identifying good practice in dealing informally and effectively with the issues before they escalate into formal complaints and legal procedures.

- **Nurses' responses to discrimination can resist and entrench marginalisation in the workplace**

Overseas-trained nurses respond to these difficult environments by resisting, entrenching or re-negotiating and overcoming discriminatory conditions. As a reaction to repeated failure to achieve career progression, overseas-trained nurses and others may become alienated from their workplace and deeply demoralised. These responses have the potential to become self-sustaining and self-fulfilling collective

narratives of racial and ethnic discrimination and exclusion based on an interplay of race, ethnicity and nationality.

- **Overseas-trained nurses have diverse backgrounds and contrasting experiences in the UK**

There are many commonalities in the experiences of overseas-trained nurses, but there are also significant differences. The most notable differences were attributable to nationality, race and ethnicity; location in the UK; and employment sector. Racism and discrimination take different guises and have different effects on and elicit different responses from different ethnic and national groups. Locality played a crucial part in shaping experiences inside and outside the workplace, with a striking contrast between metropolitan and provincial areas in relation to issues of social isolation, forms of discrimination and sources of support. The report found significant differences in the quality of support, exploitation and marginalisation of nurses in the NHS and private care home sectors.

This report allows us to hold up a mirror that enables British nurses, managers and doctors to examine and address current issues and problems in UK nursing practice, health service workforce organisation and education. Over and above all, our findings argue for valuing and recognising the talents of a diverse workforce.

1 Introduction

The study *Researching equal opportunities for overseas-trained nurses and other healthcare professionals* (REOH) has explored the experiences of overseas-trained nurses' and some other health professionals, in the United Kingdom (UK) health services, in both the National Health Service (NHS) and the private sector. The broad focus of the research was on the experiences of employment mobility and career progression of overseas-trained healthcare professionals currently working in the UK and their perceptions of equal or unequal opportunities as compared to locally trained staff. The specific research aims were:

- To analyse overseas-trained healthcare professionals' experiences of working in the UK
- To research and analyse their patterns of employment mobility and career progression
- To illuminate whether and how overseas-trained healthcare professionals' social relations abroad and in the UK might support or influence employment strategies and choices
- To inform policy debates aimed at supporting the career paths of overseas-trained healthcare professionals in the UK
- To inform policy development related to international recruitment

The study was part funded by the European Social Fund and the research partners are the University of Surrey, the Open University and the Royal College of Nursing.

This study was conceived at a moment when the employment of nurses trained overseas had become one of the key strategies to meet nursing shortages in the UK, in a period of NHS expansion. In 2002/3 more than half of the nurses newly registered with the NMC had trained outside the UK (NMC 2005). Government policy, framed by a commitment to ethical recruitment of overseas staff in its Code of Conduct (DoH 2004), emphasises the importance of full protection under UK employment law of all overseas-trained staff, including full information and appropriate support and induction (Mensah et al 2005). This report seeks to strengthen the evidence base for implementation of that policy commitment and at the same time to make recommendations regarding the retention and utilisation of skilled overseas-trained staff in the workforce.

1.1 Global migration of health professionals and UK policy

Fluctuating nurse recruitment has been a feature of British nursing since 1948 and recruitment of overseas-trained and untrained staff has been a recurrent response to recruitment crises since then. This study continues a literature analysing historical patterns of disadvantage

among overseas recruited nurses within the NHS (Iganski et al 2001; Davies 1995; Salvage 1985; Carpenter 1977; 1993) by focusing on the career progression of recent and longer standing recruits while in the UK.

Nurse migration has been widely publicised and debated over the last few years. Many governments, and notably in the USA and UK, have seen recruitment of overseas-trained staff as part of a solution to a critical shortage of nurses. A global shortage of trained nurses, and extreme inequality in their global distribution, threatens the viability of health systems in many low and middle income countries (Kingma 2006:3; Buchan & Calman 2004; Bach 2003; Mensah et al 2005). However, the way health care systems deal with nurse shortages in high income countries can stimulate nurse recruitment and migration, further exacerbate shortages in countries of origin.

This situation has led to a highly competitive market in nurse recruitment which generates unregulated international recruitment practices (Kingma 2006:4; Bach 2003). England has prohibited active recruitment in staff-short developing countries in its ethical code of conduct on recruitment from overseas (Department of Health (DoH) 2004b). However, as Kingma (2006:129) and others (Catton, cited by Mulholland 2004, Mensah et al 2005) point out, the prohibition on active recruitment from countries in the developing world where there is no inter-governmental agreement has had no significant effect on numbers migrating. The NHS has continued to hire health professionals trained overseas while staff shortages continued; however the UK has been expanding training for both nurses and doctors, and a shift in policy is now being signalled. Recent changes in immigration regulations have undermined the employment rights of overseas-trained doctors undertaking further training in the UK (Mackintosh, Raghuram and Henry 2006b) and nurse recruitment is switching from recruitment to retention as larger numbers of UK-trained nurses start to seek jobs. In this context, the extent to which overseas-trained staff have been effectively supported and recognised as valued members of the workforce within the UK health service labour market is, and will remain, an important policy issue.

Some research has been undertaken into overseas-trained nurses' experiences of working in the UK (Allan & Larsen 2003; Winkelmann-Gleed 2006). Recommendations on recruitment and employment of these nurses have been published by the Royal College of Nursing (2005) and Unison Overseas Nurses Newsletter (2006). However, until now, there has been very little research on their career progression while working in the UK.

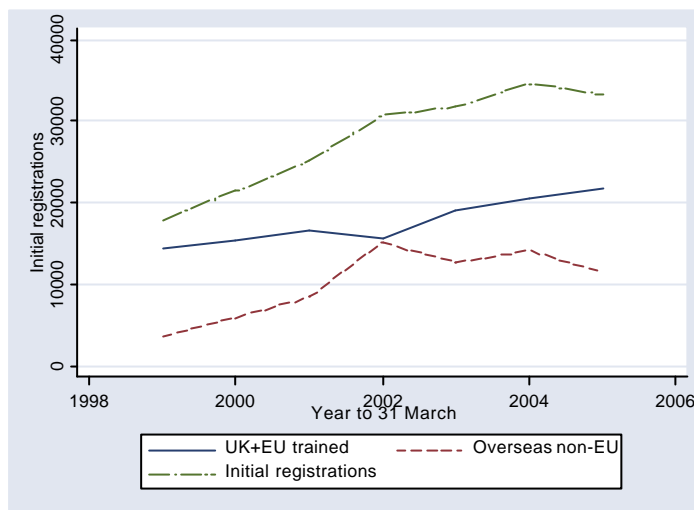
This most recent period of overseas nurse recruitment in the UK was shaped by a different policy context to other periods of recruitment of overseas-trained nurses. First, while there are now attention and resources given to progression of BME staff within the NHS and healthcare services (Stanley 2006; Esmail et al 2005; DoH 2005; NHS Confederation 2005; NHS Employers 2005; DoH 2004; Trades Union Congress (TUC) 1999), there has been little attention given to the employment conditions and progression of overseas-trained nurses. Second, managerial reforms of health and social care have long tended to systematically disadvantage lower paid, largely female staff who care for some of the most disadvantaged in society (Smith & Mackintosh under review). Current changes within the NHS which have led to widely publicised financial deficits at Primary Care Trust (PCT) and acute NHS Trust level and the resulting job losses may well affect recently recruited overseas-trained nurses who are vulnerable as migrant workers to exploitation and lack of knowledge of their employment rights (Winkelmann-Gleed 2006). Third, the segmentation of the health care labour market and the redefinition of some aspects of health care as social care have led to significant numbers of overseas-trained nurses working as care assistants while they wait for placements to undertake their supervised practice courses (Unison Overseas Nurses Forum 2006; Winkelmann-Gleed 2006). Parrish & Pickersgill (2005) estimate the number of these nurses at 39,000.

This policy context, the recent explosion of numbers of overseas-trained nurses registering with the NMC and working in the care sector, and the lack of research into the experiences of career progression of overseas-trained nurses led to the specific research questions addressed in the REOH study.

1.2 Profile of overseas -trained nurses in the UK

The overseas registration statistics on Non-European Union (EU) and EU admissions to the register from the Nursing and Midwifery Council show a sharp increase of registrations from outside the UK and the European Community between 1999 and 2002, followed by a levelling out (Figure 1) (NMC 2005) with the largest numbers from individual countries in 2004 coming from The Philippines, India and South Africa. In 2002 it was estimated that 13% of nurses in the UK were non-UK born (Findlay 2002, in Winkelmann-Gleed 2006:4). This number includes those who came in the 1960s and 1970s; many of whom had or have gained British citizenship. In addition, it is estimated that around 30,000 non-British nurses are working in the National Health Service (NHS), and have no citizenship rights as they rely on work permits (Winkelmann-Gleed 2006:4), as well as the 39,000 overseas-trained nurses estimated to be waiting for adaptation courses.

Figure 1: initial registrations of nurses and midwives on the UK register, by year: totals, UK and EU and overseas non-EU, 1999-2005



Source NMC (2005)

It is difficult to track from published data where overseas-trained nurses are employed. However from the Royal College of Nursing (RCN) Labour Force Survey, Ball & Pike (2005) have identified the following differences between overseas-trained nurses and UK trained nurses (these figures are of course limited as they pertain only to those UK and overseas-trained nurses who are RCN members):

- More overseas-trained nurses are employed in independent care homes/hospitals and bank and agency work often in older people's nursing
- 61% of those trained overseas are employed on D grade as compared to 14% of all UK-trained nurses. More are employed full-time, despite the fact that equal proportions have dependent children
- More overseas trained nurses work shifts on an internal rotation format and 44% work 11 hour shifts compared to 27% of UK trained nurses.
- Fewer have a nursing diploma but a larger number have a degree.

The issues raised by these data have likewise framed the research on career progression undertaken by the REOH study.

1.3 Report overview

In section 2, we present the research method, sample and analysis; and provide an overview of the participants who took part in this study. For the purposes of this report we have structured the findings from the analysis in the following sections. Section 3 explores why overseas-trained nurses leave their countries of origin in order to come to the UK. It then

discusses the importance of these motivations to strategies and methods of migration and the impact on early workplace experiences and, particularly, on how overseas-trained nurses interpret their experiences in the UK.

Section 4 discusses overseas-trained nurses' experiences of mentoring and adaptation which were shaped by the nature of nursing work and the delivery of nursing care in the UK and by the formal accreditation and assessment systems used in the UK to recognise skills gained overseas. The nature of nursing work and the accreditation systems led, we argue, to the undergrading of overseas-trained nurses in the workforce and experiences of deskilling and skills waste. Section 5 explores interpersonal relationships in the workplace and provides a critical reflection on the dynamic nature of overseas-trained nurses' relationships with their colleagues and managers. These findings illuminate overseas-trained nurses' experiences of discriminatory processes in the workplace and the role of social support.

In section 6 we explore overseas-trained nurses' experiences of career progression and promotion in the UK. We argue that when entering management, systems of promotion are not always significantly transparent. These systems and practices can institutionalise disadvantage and create an environment which facilitates discriminatory behaviour. Section 7 highlights concerns over complaints and grievances and how they are related to formal and informal procedures and support systems. In section 8 we direct attention to overseas-nurses' various responses to the experiences and procedures they are confronted with, and we explore how some may resist, entrench or re-negotiate and overcome discriminatory conditions. Section 9 concludes by summarising key points from the study and in section 10 we suggest policy recommendations.

2 Research design and methodology

The rationale for the research design was to allow an in-depth understanding of overseas-trained nurses' opportunities for career development in the UK given their individual circumstances, local workplace issues and available social support systems. Data were sought to illuminate dynamics involving three key dimensions:

- a) An in-depth examination of overseas-trained nurses' experiences with and views on opportunities and barriers for career progression and how their professional skills and experiences were used in the UK.
- b) A contextual understanding of overseas-trained nurses' situations in local workplaces and how these might vary according to local policies and practices.
- c) The informal networks and social support systems that overseas-trained nurses may have access to outside the workplace and how migratory processes and decisions are connected to the migrant's country of origin.

For the purpose of data collection, these dimensions were operationalised in the following way:

- a) Individual and in-depth semi-structured interviews with overseas-trained nurses with different backgrounds and in different circumstances across the UK.
- b) Interviews with national and local stakeholders and case studies involving UK healthcare employers in the NHS and independent sectors in different regions of the UK.
- c) Case study fieldwork in one Diaspora community in the UK and country of origin, tracing migratory networks and intentions.

In accordance with qualitative and interpretive research methodology, the study prioritised variation and in-depth exploration (Patton 2002). This facilitated the illumination of complex experiential and interpersonal processes that could contribute to develop theory and suggest viable policy recommendations to support equal opportunities policies and the implementation of diversity management in the UK healthcare sector. Hence, this approach differs from but supplements quantitative methodologies which seek to demonstrate statistically significant and representative distribution of already known variables and processes. In contrast, this study needs to be assessed on its ability to critically illuminate new and previously unexplored dimensions and dynamics.

The study was conducted in Northern England, Southeast England, London, Wales and Ghana, and involved individual in-depth interviews with 93 overseas-trained healthcare professionals: mainly qualified nurses, but also some midwives, doctors, physiotherapists, and other professional groups. The study included national stakeholder interviews, case studies of workplaces in the NHS, voluntary and independent sectors and a case study among Ghanaian healthcare professionals and students in London, South East England and Ghana.

Due to the focus in our data, and for the purpose of simplicity of language, in this report we will refer to the informants generally as “overseas-trained nurses”, unless issues of particular concern to other specific professional groups are being addressed. The multi-site approach aimed to capture overall trends while paying attention to regionally specific concerns and, in particular, to individual overseas-trained nurses’ experiences of career progression, the impact of the local work environment as well as the importance of social networks and connections to the country of origin.

2.1 Regions, interviewees and case studies

Selection of regions: The regional variation within the sample was determined on the basis of evidence from the RCN which indicated substantial regional populations of overseas-trained nurses from which to sample. We also wished to pursue wide variation in terms of urban-rural locations and with varying degrees of ethnic diversity in the local community.

The study was based on previous and concurrent research activities which had already established contacts in certain regions and population groups. The researchers at the University of Surrey, in collaboration with the Royal College of Nursing, had in 2002/3 conducted a study involving focus group interviews with overseas-trained nurses in Northern England, Southeast England, London and Wales (Allan and Larsen 2003). The researchers from the Open University had long-established contacts with healthcare professionals and researchers in Ghana as well as in the Ghanaian Diaspora community and its associations in and around London.

Although each of these regions undeniably have specific characteristics, the focus of the research was to employ an in-depth explorative approach to illuminate basic structures and dynamics that may prove theoretically significant and of explanatory value when applied to similar or related conditions and situations.

Selecting interview informants: A total of 93 overseas-trained healthcare professionals were included in the study and took part in an in-depth individual interview (see participant profile

in section 2.3). When selecting participants for individual interviews we sought to include both individuals who had lived for some time in the UK and those who had arrived more recently. The issue of time was considered of crucial importance due to the study's focus on career progression. Therefore, four parallel approaches were used to select overseas-trained nurses for the study (see Table 1 in section 2.3).

Firstly, to include participants who had worked in the UK for a number of years and to capitalise on the personal relationship to the individual researchers, we approached participants from the previous focus group study (Allan and Larsen 2003). These participants were contacted by telephone by the researcher, based on information held in the sample database from the previous study. In all eighteen of the original 67 research participants were included in the current study.

Secondly, to supplement the interview sample with more recently arrived overseas-trained nurses, the RCN sent out information letters to overseas-trained nurses who had registered within the last two years and were living in Northern England, London and Wales. The letter described the study and invited the nurses to contact the research team by telephone. This strategy was supplemented by a call for research participants advertised in the RCN Bulletin. After having contacted the research team the participant was sent a letter with the full information about the research and an interview time was arranged. Eleven were recruited in this way.

The third overall sampling strategy involved case study visits at healthcare workplaces in NHS Trusts as well as independent healthcare providers in Northern England, Southeast England and Wales (see below). These case studies involved individual interviews with overseas-trained nurses and local stakeholders. The researchers spent two to four days in each workplace, approaching potential interviewees directly on the wards or in the care home. These interviews required the R&D permission from the workplace and generally took place *in situ* in an empty room during working hours. They were flexibly arranged in order not to interfere with the work routine. In some cases, the R&D management had distributed the study information sheets in advance; in other cases the researcher explained the research purpose and procedure to unprepared staff and, if they were interested in taking part, a convenient time was arranged for an interview. Forty one were recruited to the study in this way.

Ghanaian healthcare professionals for interview were located through a combination of networking and snowballing strategies. This was based on utilising contacts from previous

research and accessing the Diaspora communities through associations and prominent individuals. The approach included both Ghanaian healthcare professionals working in the UK and Ghana and was supplemented with students of nursing and medicine in Ghana based in three teaching hospitals in Accra, Kumasi and Agogo (see Appendix 1). This strategy included nineteen participants for the study, describing their personal views and experiences. In addition two focus groups in Ghana with a total of twenty nursing students provided insights into their views on migration, but as these data differ substantially from the individual interviews they are not included in the tables below (Table 1-17).

Workplace case studies: A total of six healthcare workplaces were selected from across the regions: four NHS Trusts (London, Northern England, South Wales and North-mid Wales) and two independent sector employers (South Wales and Southeast England). Contacts to these employers were established based on networking and snowballing techniques, utilising the researchers' existing contacts in clinical practice. While the sampling strategy in this sense was partly opportunistic it was not exclusively so, as we aimed to capture employers of each sector in different regions and emphasis was placed on including a variety of NHS Trusts, where issues of career progression and the implementation of diversity management are most pertinent (as career progression opportunities are less widely available in the independent sector). As mentioned above, this approach involved interviews with local stakeholders as well as overseas-trained nurses employed in the respective workplaces.

Local stakeholders: The study included twenty four local stakeholders, interviewed as part of the workplace case studies and including senior NHS Trust managers, independent sector managers, clinical ward managers, HR personnel, clinical placement facilitators with special responsibility for overseas-trained nurses, overseas-trained nurses' mentors and student nurses. Three of the local stakeholders were employed in the independent sector and the rest in the NHS. Three were male and with the exception of one Black British, one Filipino, one African-Caribbean and one Irish they were all White British.

National stakeholders: Thirteen national stakeholders were interviewed from key organisations. They were all White except for three previously overseas recruited nurse/midwives (Filipino, Indian and African-Caribbean) and only two were male. The stakeholders were actively involved in either employing, regulating, overseeing or supporting nurses in the UK and included representatives from: the Nursing and Midwifery Council; Unison; the Royal College of Nursing; the Royal College of Midwives; the EU accreditation committee (allied health professionals); social services with experience recruiting overseas-trained social workers; a Strategic Health Authority with responsibility for workforce issues;

a self employed language and communication consultant working with NHS Trusts in the delivery of educational courses for language and communication; and an advisor to refugee nurses.

2.2 Profile of overseas -trained interviewees

This section provides an overview of the 93 overseas-trained interviewees who took part in the study. As shown in Table 1 the Ghanaian case study provided a fifth of the informants and the workplace case studies almost half, while the rest were approached from the previous study (Allan and Larsen 2003) or the RCN database. Just under half of the participants in the Ghanaian case study were interviewed in Ghana while the others were interviewed in and around London (Table 2). The significant majority, 63% of the interviewees were currently working in the NHS (Table 3) – although many of these had previously been working in care homes.

Table 1: Recruited to study through

Workplace case studies	41 (45%)
Ghanaian case study	19 (20%)
IRN study	18 (19%)
RCN database	11 (12%)
Unknown/not listed	4 (4%)

Table 2: Locality of informant

Wales	28 (30%)
London	23 (25%)
Northern England	20 (22%)
South East England	14 (15%)
Ghana	8 (9%)

Table 3: Current employer

NHS	59 (63%)
Care/nursing home	13 (14%)
Independent	11 (12%)
Ghana Health Service	6 (6%)
Student in Ghana	2 (2%)
Unknown	1 (1%)
NHS/Private	1 (1%)

Table 4: Date of arrival in the UK

1968-1969	2 (2%)
1970-1979	4 (4%)
1980-1989	6 (6%)
1990-1999	7 (8%)
2000	8 (9%)
2001	15 (16%)
2002	17 (18%)
2003	14 (15%)
2004	8 (9%)
Born in UK	1 (1%)
Unknown/not listed	11 (12%)

Table 5: Age

21-25	2 (2%)
26-35	35 (38%)
36-45	27 (29%)
46-55	21 (22%)
56-60	7 (8%)
61+	1 (1%)

Table 6: Gender

Female	66 (71%)
Male	27 (29%)

The personal profile of informants shows that the largest age group was the 26-35 years olds (38%) and that only 9% were above 56 years of age (Table 5). Just under a third of the informants were male (Table 6), providing a statistical over representation compared to the population of overseas-trained nurses in the UK and allowing our study to explore issues of gender. The inclusion of the Ghanaian case study is reflected in the ethnic composition of

informants with a majority (53%) being Black African, while Filipinos (23%) are the second largest group, Asians are represented by 11% of the informants and 10% are White (Table 7).

Table 7: Ethnicity

Asian (Pakistani)	1 (1%)
Asian (Sri Lankan)	1 (1%)
Black African	40 (43%)
Black British/African	1 (1%)
Black Caribbean	1 (1%)
Filipino	25 (27%)
Indian	9 (10%)
Indo-Guyanese	1 (1%)
Mixed Race	2 (2%)
White Other	11(12%)
Unknown	1 (1%)

Tables 8 and 9 present the informants' place of birth and place of training, respectively (see Appendix 3 for full details). The lack of total match between listed countries and numbers represent the fact that some informants were trained in a different country than they were born in. Our sample reflects the inclusion of the Ghanaian case study but captures broader tendencies in UK nurse recruitment by including a significant proportion of Filipino nurses, as well as between five and nine nurses trained in India, Nigeria and South Africa. Three interviewees were trained in Zimbabwe and the remaining countries are represented by only one or two informants

Our sample does not reflect an increase in nurses from former east European countries, and this limits our ability to explore the specific concerns and experiences for these nurses. Equally, our sampling method (see 2.2) did not especially target overseas-trained nurses who are refugees in the UK (see Winkelmann-Gleed 2006).

Table 8: Place of birth

High Income	11
Australia & New Zealand	3
Western Europe	6
USA	1
UK (UK/Sudanese national)	1
Eastern Europe and Russia	1
Sub Saharan Africa	42
Of which	
Ghana	24
South Africa	7
Nigeria	5
South America	2
Asia	37
Of which	
India	9
Philippines	26

Table 9: Place of training

High Income	10
Australia & New Zealand	3
Western Europe	5
UK	2
Eastern Europe and Russia	1
Sub Saharan Africa	43
Of which	
Ghana	23
South Africa	8
Nigeria	5
South America	2
Asia	37
Of which	
India	9
Philippines	26

Tables 10 and 11 show that the largest proportion of our informants were married and had children. Tables 12 to 14 indicate that our informants had varied degrees of commitment to a life in the UK.

Table 10: Marital status

Divorced	8
Engaged	2
Married	45
Partner	6
Separated	2
Single	24
Widowed	1
Unknown/not listed	5

Table 13: Home ownership in UK

Yes	38
No	55

Table 11: Children

No children	36
One child	9
Two children	15
Three children	11
Four children	5
Taking care of nephews	1
Unspecified no. children	6
Unknown/not listed	10

Table 14: Home/land ownership in country of origin

Yes	68
No	17
No (but family does)	7
Unknown/not listed	1

Table 12: Family in UK

Yes	51
No	42

Table 15: Year of Registration

1968-1969	1
1970-1979	11
1980-1989	22
1990-1999	32
2000	1
Unknown	26

Table 16: Professional Qualification Overseas

AHP; MSc	1 (1%)
Bsc Physio	1 (1%)
Barefoot Doctor	1 (1%)
Medical Doctor	7 (8%)
Midwife	1 (1%)
Nurse assistant, RN, RM	1 (1%)
Physiotherapist	1 (1%)
RN Community, Psychiatric	1 (1%)
RN Midwifery, BSc, MSc	1 (1%)
RN	20 (22%)
RN; BSc	25 (27%)
RN BSc MSc	2 (2%)
RN RM	9 (10%)
RN, RMN	3 (3%)
Social Pedagogue	1 (1%)
Unknown/not listed	18 (19%)

2.3 The interview process

Interviews were semi-structured following an interview guide approach (Patton 2002), and were audio-recorded. Individual interviews with overseas-trained nurses took place either in the participant's home or workplace, an office in the local RCN office (Central London, Leeds and Cardiff) or the local branch of the Open University. The interviews generally lasted around one and a half hours. (See Appendix 1 for details.)

2.4 Data management and analysis

In accordance with the interpretive and dialogical approach, analysis was an integral part of data collection. This was then further developed in a cumulative process involving reflexive practices and negotiations in the research team. (See Appendix 2 for details.)

3 Motivations to migrate

The section explores why overseas-trained nurses leave their countries of origin in order to come to the UK. It then discusses the importance of these motivations to strategies and methods of migration, on early workplace experiences and particularly on how they interpret their experiences in the UK.

3.1 Migration motivations

The informants stated reasons for migration are clustered around three interrelated issues:

1. Material advancement
2. Professional space
3. Personal development and other personal issues

These three issues tend to be closely interrelated and can be seen as responses to shifts in the global labour market and socio-economic conditions in the home and host countries (see also Larsen et al. 2005).

Material advancement

For many nurses the primary motivation for migration was the desire for material advancement particularly increases in remuneration and improved quality of life for themselves and their immediate and/or extended families. This can be regarded as *doing* nursing or medicine in the UK as a means to achieve other material objectives as opposed to *being* a nurse or doctor in the UK as an end in itself.

Material advancement was the primary motivation for the majority of Filipino and Ghanaian nurses and was very important for informants from other developing countries (Indian sub-continent and Africa). Between the different nationalities and between social groups within these nationalities there were significant differences in the extent of obligations to people and places in source countries and consequently differing perceptions of the meaning of material advancement. This was evident in differing motivations for entry to the nursing profession particularly the extent to which it had been part of a strategic plan to facilitate migration. Many Filipinos felt strong obligations to provide substantial material support to the extended family which acted as an economic unit through financing the education of siblings and supporting parents in addition to their own children. Within the Filipino informants there were significant differences in the extent and effects of obligations to families which appeared closely related to the informants' class background. Equally, some informants described how

they had changed their approach to supporting their families in the home country, especially if they had started their own nuclear family in the UK and expected to continue living here.

For many Filipinos being able to support the parental family through migration was a primary motivation for entering the nursing profession. However, whilst the Ghanaians and other Africans also had obligations to the parental family these did not appear to be as demanding and informants did not suggest that meeting these obligations was their primary reason for migration. In addition to providing some support for the parental household the Africans emphasised improving the quality of life for their immediate family. The Ghanaians focused on developing assets back in Ghana in particular building houses (all except one of the Ghanaian informants were building houses in Ghana) and to a lesser extent business investments. These long term investments were a possible response to inadequate remuneration for healthcare professionals and also to the lack of access to credit in Ghana. The extent of these investments reflected the fact that most intended to work in the UK for an extended period of time.

Professional space

The other main motivation for migration was the desire to seek professional space to have a more fulfilling or more successful medical or nursing career. This can be summarised as migration to the UK for the purpose of *being* a good nurse or doctor rather than *doing* nursing or medicine as a means to facilitate migration. There are three closely interrelated aspects of professional space for these informants:

1. access to training and education
2. access to improved resources, modern equipment and healthcare practice
3. professional respect, autonomy and working under conditions of good governance within the healthcare system

The desire for professional space and career development was presented by all the doctors interviewed in the UK and in Ghana as the overwhelming reason for migration and it shaped their subsequent experiences in the UK. Ghanaian doctors' main motivation for migration was access to post-graduate medical education in the UK in order to have a more fulfilling career and to specialise. They were obliged to migrate overseas as the Ghanaian post graduate medical training system was regarded as unpredictable, inflexible, restricted and access was deemed arbitrary. They also argued that other aspects of healthcare governance were arbitrary and unpredictable and led to doctors having a limited amount of control over their career trajectories which acted to drive medics away from Ghana. This was part of a process of disenchantment and alienation that begins in medical school as a response to poor and

arbitrary governance whereby every negative experience is seen as another reason to leave the country. These factors, taken with the lack of resources in the healthcare system come together and inhibit the “professional space” to be a good doctor and lead to migration for career progression.

Recently qualified Ghanaian nurses and nursing students suggested that similar grievances with healthcare governance particularly high handed, arbitrary decision making, provided a significant incentive for them to leave Ghana. Ironically the dispensatory, inegalitarian and arbitrary management of some of the schemes designed to encourage healthcare professionals to stay in Ghana had actually provided both a further impetus to leave and critically reasons for not returning to the Ghanaian healthcare system. The examples of Bonding, the Additional Duty Hours Allowance and access to cars and accommodation are discussed at length in Mensah et al (2005).

In the UK, nurses’ discussion of professional development varied between nationalities and social backgrounds. However there were some clear differences by country of origin with nurses from the Indian sub-continent talking at greater length and in more detail than the other groups about training and education as their primary motivation for migration. In addition to better salaries many African nurses, particularly Nigerians (this could be related to the gender of the Nigerian informants four male and one female) and to a lesser extent South Africans, emphasised developing their skills, knowledge and careers through access to resources which would enable them to be more effective nurses.

In the [named hospital] even though it was a big hospital we couldn’t practice a lot of the stuff that we were taught because of the lack of equipment, most of the things we improvised. So when the opportunity came that some people were recruiting I said ok let me go for this and see if I can get the opportunity to work with the proper equipment, work in a different place, with a different culture, so I made up my mind to have a change

Female, 43 years old, Nigerian, Black African, D grade, employer: NHS, arrived in UK: 2004 - AJ048.

However it is important to note that this notion of “improvisation” is also regarded by most African nurses as one of their key strengths and points of differentiation from UK trained nurses (see Allan under review).

A striking relationship between migration and career development in nursing came from Spanish nurses. Due to a lack of jobs for newly qualified nurses in Spain many were obliged to travel to the UK to gain experience in order to start a career in Spain.

Many informants mentioned both issues of material advancement and professional space as motivations for migration. However some also linked their material wellbeing, professional space and governance in countries of origin emphasising the relationship between the management of healthcare systems and the general economic and political climate.

A Nigerian nurse stated:

Due to the political system, the education system has been destroyed; the health system has been destroyed. For example, the university college hospitals in my area were ranked amongst the top 100 hospitals in the world. The government has destroyed that, they did not make it improve.

Male, 42 years old, Nigerian, Black African, D grade, employer: Nursing Home, arrived in UK: 2003 - AJ042

Whilst a Ghanaian nurse emphasised the interrelationships between lack of resources, poor management and demoralisation:

The money is not good, the facilities are very poor. Opportunities for them to move up are not there. Some of the matrons have been there or years and they don't do anything it's like a vicious circle there is a lot of frustration.

Female, 40 years old, Dual UK/Ghanaian, Black African, G grade, employer: NHS, arrived in UK: 1989 - DL055

Whilst the impact of governance on standards of living and professional space were discussed by many informants none of the informants, including Zimbabweans, mentioned political persecution as a reason for migration (note that no refugees were included in this study). However many Africans discussed how political instability led to fluctuating economic conditions which became a factor encouraging them to migrate, in particular Zimbabweans and Nigerians emphasised how “the economic situation” or “economic depression” pushed people to migrate.

Personal issues and personal development

The third significant motivation for migration relates to personal and familial issues. Nurses from the old commonwealth and some young Ghanaian doctors discussed migration as a means of experiencing life in other countries almost as a form of tourism, or “working holiday” (see also, Larsen et al. 2005). Other informants discussed migration in order to rejoin family members including partners and parents who had previously migrated. One informant migrated in order to express their sexuality. Some nurses also outlined how migration was a means of facilitating major life changes.

3.2 Why the UK?

This section outlines why the overseas-trained healthcare professionals selected the UK as a destination and how this relates to their life and career plans.

The African informants were all from ex-colonies and, with a few exceptions, tended to migrate directly from countries of origin to the UK. This is connected to the fluency in the English language of highly educated people in most ex-colonies. These migration pathways utilise long term post-colonial professional and personal linkages. The professional linkages include similarities in medical and nursing curricula, connections between educational institutions, colleges and personal. Other personal linkages are built on the existing migration pathways of skilled and unskilled migration from Anglophone Africa to the UK particularly the presence of large African Diaspora communities in London and other localities. The relative proximity of the UK in terms of direct and cheap airfares, cheap telecommunications and the availability of professional media such as Nursing Times were also significant as were the related activities of agencies discussed below.

Filipinos and South Asians knew about a broader range of possible destinations and selected them on the basis of ease of registration and ease of movement including the role of agencies in making their migration more straightforward. Filipinos tended to be more transnationally mobile than other nationalities and many had been to a range of countries using an established pattern of stepped migration from the Philippines to its closest high income neighbour Singapore or to the Middle East, and then to the UK. The ultimate aim was often to migrate to work in the USA.

This migration pathway resembles a continuum which was, on the one hand, becoming increasingly costly and bureaucratic, and on the other hand, becoming more attractive with relatively improving remuneration, working and social conditions in the UK and USA. This is particularly salient in the context of material advancement for those in relative poverty being a primary motivation for migration. Thus Singapore was an ideal first location not requiring visas and automatically accepting Filipino qualifications; however, the Filipino nurses argued that Singapore and the Gulf states openly discriminated against foreigners in the workplace and did not allow them to buy property or bring families with them. They were treated as “guest workers” and deprived of basic citizen rights. This can be contrasted with the UK where discrimination is less overt and restrictions on family members were less severe. Many also intended to move on to other destinations particularly the USA which was seen as the ultimate (in both senses) destination which was both more expensive to get to and more difficult to get employment but had better salaries and working conditions. Furthermore, the relationship between the USA and the Philippines has elements of post-coloniality making the USA particularly attractive to the Filipinos trained in an American influenced nursing system.

(Choy, 2003) However it appears that the UK retains a significant advantage over the USA as a destination for some Filipino nurses as it appears more family friendly.

3.3 Recruitment

Issues of entry and existential condition in the UK

The situation for overseas-trained nurses in the UK is fundamentally shaped by the particular way in which they enter the country and secure employment in the healthcare sector.

The Ghanaian nurses and doctors in the UK all migrated to the UK as individuals and then found employment usually directly and occasionally through agencies. However they and the nurses in Ghana all emphasised how the migration of nurses had recently become increasingly commercialised with recruitment agencies actively recruiting newly qualified and experienced nurses from Ghana to work overseas primarily in the UK. Nurses in Ghana also pointed to how the internet and the availability of UK nursing literature such as the Nursing Times made it easy to apply directly for jobs in the UK.

Other nationalities outlined a range ways of getting to the UK including:

1. The overseas-trained nurse is actively recruited overseas (country of origin or intermediate country) by an agency recruiting several nurses at one time (in “batches”).
2. The overseas-trained nurse initiates the migration from overseas and uses an agency to arrange employment in the UK.
3. The overseas-trained nurse initiates the migration from overseas and arranges employment in the UK through direct contact with the employer.
4. The overseas-trained nurse is already in the UK (as a tourist/visitor, a student or a refugee) and arranges employment from here.

These differences in individual recruitment and migration circumstances determine whether the overseas-trained nurse migrates and arrives in the UK as part of a group or not, and, therefore, whether the individual has an immediate peer support network available or not.

Batch recruitment and social networks

Around the turn of the millennium the recruitment of batches of overseas-trained nurses particularly from the Philippines became an increasingly important means of staffing many NHS Trusts. It appears that this form of recruitment had both positive and negative implications for the nurses involved. When arranged by the NHS, using a large and regulated recruitment agency it is generally the case that setting up the employment contract is free of

charge on the part of the overseas-trained nurse, and that information and support are provided in advance of, during and after the migration. Thus in theory batch recruitment should reduce the costs of migration for nurses, however, as discussed below this has not always been the case.

In many cases batch recruitment has facilitated the establishment of strong social networks which have played an important role in easing overseas-trained nurses' adjustment to life in the UK and its healthcare system. This is likely to be particularly important for those migrating to areas with small BME and particularly Filipino populations. The types of social support included advice and help in finding accommodation and dealing with landlords and advice on immigration issues. In one case these networks also pooled resources to assist nurses return in cases of emergency at home.

However, whilst these networks seem to mitigate social isolation and cultural shock for new overseas-trained nurses there is little evidence of the social networks facilitated by batch recruitment producing mutual aid for career advancement. Indeed there is a strong perception amongst some employers that batch recruitment has actually inhibited career progression as members of the tightly knit group avoid conspicuous success in order to maintain group solidarity.

A Director of Nursing argued that without intervention from senior management Filipinos recruited to her trust as a batch

Were quite content to sit in the nurses home on a D-Grade indefinitely and send the money home...the majority of them are too comfortable with being comfortable. There seems to be a comfort level that individuals seem not to like to shine above. There seems to be a sort of "this is where we are" sort of line...they live together and eat together and there is very much a sort... I'm trying to think of a word that avoids me having to say a herd mentality...For obvious reasons, I mean, here you are, in this weird place in the middle of London it is not the easiest place in the world...your colleagues are pleased you are there, but different. The culture is wildly different...so of course they are going to be like that. And because they have the numbers it was easy for them to do that.

Female, white, local stakeholder, Director of Nursing - LJ005

Agency recruitment

Agency recruitment can be seen as reducing the cost of migration by dealing with bureaucracy on behalf of nurse migrants. Furthermore some agencies recruiting batches of nurses for trusts offered inducements such as payment of visas, work permits and return flights. However as discussed below there were some allegations that these inducements were withheld.

Many nurses reported complaints about three key malpractices by agencies:

Firstly; charging and often increasing placement fees for migrant nurses. This is reported by informants as a widespread practice amongst Philippines based agencies recruiting for the NHS and for care homes and amongst agencies based in Ghana. This is in addition to receiving fees from Trusts and other employers and is contrary to the Department of Health Ethical Recruitment Guidelines which state that overseas healthcare professionals should not be charged registration fees by agencies.

Secondly many informants reported being misled about the nature and status of the work they would be undertaking, the grade they would be working at and their remuneration package.

Thirdly and most important in terms of their experiences in the workplace many reported being misled or pressurised into taking work in the care-home sector often as healthcare assistants after being promised work as nurses in hospitals. As discussed below informants in care homes and those working in the NHS reported significant differences in early UK job experiences whilst there appeared relatively fewer differences in early UK job experiences in the NHS between those directly recruited, apply themselves or going through agencies. Thus it appears that the most significant implication for overseas-trained nurses of the commercialisation of healthcare recruitment is the increased likelihood of being sent to a care home if recruited through an agency.

The implications of working in the care home sector are discussed at length in section four.

Individual recruitment

The overseas-trained nurse who seeks employment directly from overseas (see “Issues of entry” above) avoids the problems with the agency’s exploitation and high fees, but risks finding similar problems with terms of employment in care homes.

Finally, the overseas-trained nurse who seeks employment from the UK (no. 4) will have a better chance of assessing the quality of the employment opportunity through a personal visit and face-to-face job interview, and by already living in the UK and usually having a social network here, be less insecure and uncertain about the general situation in the country. This situation may, however, be more complicated if the person urgently needs a permanent job to be allowed continued stay in the UK (to secure a work visa), if the person is a refugee and struggles with difficulties of trauma and/or lack of access to documentation of the professional status, or if the person does not have official permission to stay in the UK and is

an “illegal immigrant”. As described in the method section (2) the latter two situations are, however, not represented in our data.

The degree of social vulnerability or group loyalty represented by these different situations of entry shapes the overseas-trained nurses’ experiences in the UK, as it equally shapes their capabilities for responding or objecting to the conditions they are offered (see sections 4 and 5). Nurses who arrive alone in a foreign and unfamiliar environment and start working in a care home for the elderly in a town or village in the countryside, are in a quite different social situation than those who arrive in a group of other nurses from their country to live in the staff accommodation of a large NHS trust.

Shift in healthcare recruitment: the burden on migrants

There is increasing evidence that some NHS Trusts have ceased batch recruitment from overseas and are increasingly relying on recruitment of overseas-trained staff from the private sector. This shift in recruitment patterns greatly reduces the costs for Trusts of employing overseas-trained nurses in the following ways.

1. The costs of adaptation, induction, mentoring, accommodation, travel, legal and agency fees are offset to the private sector. However as discussed below it is far more likely that these increased costs are actually being borne by overseas-trained nurse due to exploitation and malpractices by agencies and care homes.
2. Recruitment of overseas-trained staff from the UK care home sector allows Trusts to “cherry pick” the best staff from care homes thereby reducing uncertainty over the quality and adaptability of staff.

As this method of recruitment increases the costs of migration for nurses and/or their families, they are obliged to stay for longer in the UK in order to pay off the debts incurred through migration prior to trying to achieve their material aspirations. We speculate that this process may well contribute to the recent increase in the number of overseas-trained nurses working as healthcare assistants in care homes to 39,000 (Parrish & Pickersgill 2005) whilst waiting for adaptation. This is discussed further in section four.

Recruiting from the UK care home sector could also be a way of avoiding the prohibitions on direct recruitment from developing countries experiencing chronic shortages of staff as defined by the Department of Health Ethical Recruitment Guidelines. However there is little evidence that they have been effective in reducing migration from developing countries experiencing chronic shortages of staff. Furthermore inhibiting migration from specific countries militates against equality by creating two categories of migrant healthcare

professionals, those using formal and those pushed into informal unregulated migration systems (Mensah et al 2005; Mackintosh et al 2006). Thus the two elements of the Ethical Recruitment Guidelines are contradictory as they dictate differing methods of migration but oblige equal treatment upon arrival in the UK.¹ As we outline the methods of migration have a significant impact on experiences in the UK labour market.

3.4 Implications

Understanding why healthcare professionals migrate to the UK frames the subsequent discussion in this report of overseas-trained nurses' experiences in several ways:

1. Firstly, understanding healthcare professionals' reasons for migration and their aspirations allow us to contextualise their subsequent experiences in the UK labour market.
2. Secondly, it can illustrate how informants' professional and material aspirations change whilst working in the UK.
3. Thirdly, it provides a baseline for exploring the variations in experience related to nationality within a diverse workforce.
4. Fourthly, it contributes to debates on devising policies to appropriately manage the migration of healthcare professionals from developing countries (see Mensah et al. 2005; Mackintosh et al. 2006a; Mackintosh et al. 2006b).

4 The deskilling of overseas-trained nurses in the UK workforce

In this section we discuss overseas-trained nurses' experiences of mentoring and adaptation which were shaped by the nature of nursing work and the delivery of nursing care in the UK and by the formal accreditation and assessment systems used in the UK to recognise skills gained overseas. The nature of nursing work and the accreditation systems led, we argue, to the undergrading of overseas-trained nurses in the workforce and experiences of deskilling and skills waste.

4.1 Adaptation and mentoring

The NHS has established mentor preparation and update courses and a well-publicised value system which sees learning as key to nursing (DH 2001; DH 2004; DH 2005). However, in care homes overseas-trained nurses reported not being adequately supervised by trained nurses during their placements for adaptation but working with HCAs to do care work and, seemingly, learn British nursing. Working in this fashion means that overseas-trained nurses felt they were not properly and safely introduced to UK nursing practices because they worked unsupported by UK nurses. A Nigerian trained nurse summed up the frustrations of many who undertook their adaptation in the care home sector:

So that's where I consider the problem started in recruiting nurses from overseas countries. Adaptation means how they can be adjusted to the present nursing procedure of the country they are working. And they have to be able for them to learn the culture. Nursing home is not an ideal place (KNOCK ON THE TABLE) for a qualified nurse to start adaptation...during the adaptation time I am expecting, when we started the programme, that I have been a lecture by a competent nursing staff, a competent lecturer, it is not okay, when we start the clinical experience, there is no lecturer, we are being trained as BBC London. You know the name of BBC? British Bottom Care

Male, 42 years old, Nigerian, Black African, E grade, employer: NHS, arrived in UK: 2001 - CJ032

As a result of poor adaptation experiences, the move to the NHS after adaptation in a care home can be difficult if the overseas-trained nurse registered for her/his personal identification number for the NMC (PIN) without any other experience of British nursing. As one overseas-trained nurse said: "you're a nurse and you're left without support."

Our data suggest that working with HCAs and undertaking caring work is not an adequate adaptation placement for trained nurses who need to learn British nursing practices. This situation arose because of the reasons underpinning overseas recruitment; namely, the falling recruitment of home students to nurse training, the shortage of UK trained nurses in the workforce and the targets set by the NHS Plan to increase the number of qualified nurses in the workforce. We argue elsewhere (Smith & Mackintosh under review) that overseas-trained

nurses' recruitment to care homes and the NHS is shaped by the need for carers rather than qualified nurses as this quote from an overseas-trained nurse shows:

That is right, instead of being there as a student adaptation you were there as a spare hand for them.

Female, 31 years old, Filipino, D grade, employer: NHS, arrived in UK: 2001 - AJ050

Stakeholders viewed overseas recruitment as a necessity rather than an opportunity and, as this quote suggests, were ambivalent towards overseas recruitment. This NHS Trust manager argues that s/he would prefer to recruit "home nurses" (i.e. nurses trained in the UK) but is unable to and is therefore forced to recruit overseas:

It's to make sure we've got an adequate workforce. We struggle to do that from within the UK so we have to look at alternative options. It's a bit of a dilemma; on the one hand we do truly value overseas recruitment so we want to make them feel part of the Trust. At the same time, a bit of me would like to be able to say we wouldn't have to do that. It's not that we don't value them, but I would like to think that planning and recruitment and education was robust enough in the UK, then we could train enough nurses within the UK to work within the UK. Unfortunately we're not in that position, so we need qualified nurses to provide high quality care and we recognise nurses from overseas have those skills and can deliver that for us. If we didn't think that, we wouldn't do it. From a management point of view we'd be saying it's too risky to have overseas recruitment as they're not as good as our nurses. That's not [the case] because they have to get familiar with our working practices and how things work in the UK, they are registered nurses within their own country.

White, NHS Trust manager - LH169

Overseas-trained nurses felt that there has not been sufficient monitoring by the NMC of adaptation placements for overseas-trained nurses nor of mentoring systems in these placements. Extreme examples from national stakeholder interviews include placements which are not accredited and where overseas-trained nurses are stuck after placement with no PIN and no prospects of moving to the NHS. This situation is made worse by the lack of adaptation places for overseas-trained nurses because no trained mentors are available (NMC 2006). Currently, 39,000 overseas-trained nurses are waiting for adaptation courses while working in the British care sector (Parrish & Pickersgill 2005). Of course, these problems were one of the drivers for the introduction of the new Overseas Nurses Programme [ONP (NMC 2006)] and the NMC hope that, with audit by institutions of higher education, these issues will diminish in the future. However the number of ONP places audited by higher education institutions will be insufficient for the numbers of overseas-trained nurses awaiting registration with the NMC which will leave a significant backlog of nurses awaiting ONP places.

Our data suggest that UK healthcare managers, both in the care homes and the NHS, have not sufficiently prepared for meeting the different learning needs of overseas-trained nurses.

None of the mentors, clinical or Trust managers or care home managers we interviewed had considered that overseas-trained nurses might have different learning styles and needs compared to British nurses. As one Trust manager said, when describing the interview process for overseas-trained nurses applying for adaptation posts from care homes in the UK, she “*had no idea how we’d assess them [their skills] or anything*”. Approaches to mentoring overseas-trained nurses varied from (a) treating overseas-trained nurses the same as newly qualified nurses:

We basically treat them as newly qualified members of staff with no experience until we find out what their experience is
White, British, mentor - LH170

To (b) concerns about standards of training overseas and whether the adaptation courses are meeting the needs of the overseas-trained nurses and the needs of the NHS for competent nurses:

Then there are concerns in regards the basic [training in home country]. How the adaptation programme would need to bridge some of the gaps between what you recognize as an educational study in their programme and what was in ours. X did bring back concerns with regards to people [who] may be registered nurses in some countries and what that means is different to other countries. Our adaptation programmes are supposed to be tailored towards people and it’s not totally consistent.
White, Trust manager - LH169

Others treated them as trained nurses:

You are dealing with competent nurses and that’s that
White, British, mentor - LH175

At times, mentoring a more experienced overseas-trained nurse could be difficult for the UK trained mentor as this nurse described:

The only difficulty I found was that the nurse I mentored had much more experience than I did. And she was only having to be mentored and trained because she was coming over to Britain and practising here. And I just felt ...not out of my depth but she had years and years more experience than me and yet I was having to train her almost and that was difficult for me.
White, British, mentor - LJ003

Overseas-trained nurses report a lack of continuity in the amount of time they spend working with the mentor to support their learning, and not learning from mentors unless the overseas-trained nurse is able, or learns how to ask for help.

Well there’s sometimes where they just delegate the jobs to us that we didn’t know how to do it but my mentor actually doing the job for me. You were not always working with your mentor, you’re working with other staff sometimes; they don’t care how we feel and they just ask us “do you know how to do it?” like that, so they don’t care.

Female, 26 years old, Filipino, D grade, employer: NHS, arrived in UK: 2002 - AJ051

The attitudes of the mentor revealed in the previous quote are also reflected in the observations of overseas-trained nurses on their learning experiences during adaptation as this Filipino nurse explained:

Interviewer: As a mentor you need a completely different set of skills?

Definitely, a different set of skills. What I'm saying, maybe not the preparation and all the...the language barrier and things like that because I used to go on...the mentors, the English mentors that mentored us, mentored the Filipinos...I think it's not prepared enough. They're prepared for students rather than they're prepared for the overseas nurses, but I think that also, they're being given the false safety. Saying that these people are already qualified and only need very little and then they find out that there's still a lot that giving report and things like that and they're not being understood.

Female, 49 years old, South African, Black African, D grade, employer: Nursing home, arrived in UK: 2002 - BJ001

During the adaptation period, the links between the academic work and expected learning style (which focused on reflection and adult learning) and how this learning style was expected to be transferred to practice were not made explicit to overseas-trained nurses by their mentors. In the following quote from a mentor about an overseas-trained nurse, she comments on the nurse's learning style, the failure to produce the "work" (written assignments) rather than her practical skills:

Interviewer: What do you like about your involvement with them and what do you find challenging?

I find challenging some students who just don't have the... they need a push. At the moment we don't know how hard we have to push them in terms of producing the work. We're doing all the teaching, but she's not producing the work. I said to her "this is the beginning, you're a month and a half into it. You've got 6 months to do it, if you don't get this work done, it's going to be so backlogged that you won't get through" She still hasn't produced the written work. When we're doing assistance and teaching her, she's managing to do it. It's just that she's not giving us the work so we can say "yes she can do it". I said to her "if we don't sign you off, you can't do it".

White, British, mentor - LH157

The mentor was happy that the overseas-trained nurse could do the practical work 'she's managing to do it' but was frustrated that the overseas-trained nurse did not appear to be "learning" in the way the mentor expected. The mentor did not address this difficulty with the nurse concerned apart from threatening her as she describes in the quote "if we don't sign you off, you can't do it". If this mentor had been supported to mentor in a more constructive way, she could have addressed differences in learning styles. The following quote shows that overseas-trained nurses were aware that a different learning style was expected in the UK:

Because this ward is very busy as well, the teaching here is not spoon feed as in the Philippines. But it's ok because I realise that the UK and the Philippines are two different countries. So they have to go on with their own ways of teaching people.

Female, 49 years old, South African, Black African, D grade, employer: Nursing home, arrived in UK: 2002 - BJ001

After constantly being questioned and supervised, some overseas-trained nurses began to question their own skills. Reports of bullying and discrimination were common and overseas-trained nurses developed strategies to ensure they survived these negative experiences in order to get their PIN. One overseas-trained nurse described this experience as remaining silent and not complaining. At its worst, being an overseas-trained adaptation student could mean being bullied, feeling the lowest in the hierarchy and not being paid adequately for the work s/he was expected to do as this quote reveals:

You are being questioned and after doing something, instead of a person criticizing you in an obeying manner, she criticizes you in a destructive manner. Female, 49 years old, South African, Black African, D grade, employer: Nursing home, arrived in UK: 2002 - BJ001

The following quote is from a Filipino nurse who had experienced bullying many years previously and described the effect this had on her:

Interviewer: Do you think now that is tackled any better within the Trust?

Yes, I mean the bullying you see, I was scared and nervous I suppose because you have that feeling of paranoia and you become, I started questioning myself. I started questioning my competencies because people make you feel like that, make you feel incapable, make you feel incompetent, you know you become paranoid, you felt isolated and I felt like that. When I talk to the overseas nurses when they come to me, I recognise all these issues and when they come to me there is issues, maybe because of appearances they don't recognise them. Another thing I have from that experience is about looking at their behaviour too, so when they come to me, you re-analyse the problem and then looking at their behaviour because I recognise that in myself. If I was more assertive and knowing what I need to know I wouldn't have been in that situation. So it's about preparing myself for that job but nobody supported me before, nobody guided me, nobody directed me, I didn't have any mentor.

British, Filipino, mentor - LH176

These attitudes towards adaptation and mentoring of overseas-trained nurses and the acceptance that adaptation in care homes is an adequate experience for adapting to British nursing reveals negative attitudes towards otherness which are based on culturally biased judgments about others or an ethnocentrism and a lack of awareness of how to manage diversity in the workforce. These ethnocentric attitudes led to difficult relationships between mentors and overseas-trained nurses, and a reluctance by UK staff to address what they perceived as culturally sensitive issues. An example of this reluctance is revealed in the following quote from a mentor:

It's the same with some of them speaking on 'phone. That's another issue because whatever's being said, they don't always understand what's being said to them. Incidents have happened where a 'phone call has been taken and I would say, "Who's that?" [They would reply] "Oh I don't know". They'd put the telephone down. Well of course, you're thinking "what's happened? Who was that?" was it important?

Interviewer: How have you addressed that?

Well, there's nothing you can do. You just have to hope the person rings back

White, British, mentor - LH173

The example demonstrates a lack of genuine care, and a lack of support and guidance for the overseas-trained nurse who remained incompetent in the eyes of her colleagues and her own self-perception.

These attitudes to overseas-trained nurses and their poor experiences of mentoring and adaptation were also shaped by the nature of nursing work in the UK which is divided into highly skilled technical work and lower status caring work (Allan under review). This is particularly so in elderly care and in care homes (Smith & Mackintosh under review) which is reinforced by an occupational structure segmented into a rigid hierarchy. This restricts the performance of skills and competencies that the individual brings to the role over and above those required (Melia 1987; O'Brien under review).

4.2 Health care practice/nature of work

Two features of British health care organisation and delivery affected overseas-trained nurses. The first was their employment in care homes for the elderly and working with health care assistants in these care homes. The second was the divided and segmented nature of British nursing work.

While many overseas-trained nurses had worked in community hospitals, care of the elderly, as it is organised in the UK, is unknown in their home countries. Until recently, in countries such as the Philippines and many countries in Africa, care of the elderly is provided by the family, although some South African overseas-trained nurses commented that due to the AIDS epidemic, such homes might become a necessity in the future. Overseas-trained nurses said that they had very little idea of what a care home was before they arrived in the UK. As one overseas-trained nurse from South Africa said:

I thought a care home was a mini hospital but realised it was an old age home. When we came initially it was strange. I had to work as a carer rather than a nurse. It was a bit of waste of time

Female, 56 years old, South African, Black African, D grade, employer: care home, arrived in UK: 2001 - AH015

Overseas-trained nurses were also affected by the lack of respect shown by HCAs towards overseas-trained nurses and the lack of management support (see also, section 5). As one overseas-trained nurse said “*you’re against the group*” as an outsider and it is very difficult to exert authority in that situation. In addition, if overseas-trained nurses’ adaptation courses were undertaken within the care home sector, they, as “students”, felt lower in the hierarchy than the HCAs:

Actually it wasn't too bad because as I said things are different, so it was ok for me to be a student again because I was learning different things. So what I know is that I really had to learn what goes on here. Although sometimes when you talk to the relatives, they have questions and they don't listen to what you are saying, they still question other staff.

Female, 36 years old, Filipino, D grade, employer: NHS, arrived in UK: 2004 - AH023

When they did obtain their PIN, it remained difficult for them to establish a new identity as a registered British nurse with HCAs who had until recently been disrespectful towards them because of their outsider and student status.

One successful overseas-trained nurse from South Africa who had remained in the care home sector, said she'd learnt quickly to be firm with HCAs to ensure good care was delivered:

They know that when I'm on duty, I'll expect no ill-treatment. I just become firm and do the right thing. But that supervision, they don't like it. The first question from them would be "I know my job". I'm supposed to supervise care assistants. But that supervision when you say "why are you doing it like this?" they don't like it.

Female, 67 years old, South African, Black African, D grade, employer: care home, arrived in UK: 1999 - AH017

These difficulties in exerting authority over HCAs were often exacerbated by the lack of managerial support. In the worst cases, this could lead to complaints to the NMC and the overseas-trained nurse being sacked over what are, seemingly, differences in cultural expressions of nursing care and in expectations of the overseas-trained nurse and the manager over the registered nurse's role in managing HCAs and delivering care which is congruent with British nursing values (see also section 7).

These poor experiences with adaptation were also shaped by the recruitment of overseas-trained nurses to the care home sector where care work is not valued as "proper" nursing work either by British or overseas-trained nurses (Allan under review). Some overseas-trained nurses described UK nursing (even in NHS hospital wards) as *'hard work'* because it involves basic care which they found less stimulating and boring than more technical tasks and they were not used to seeing basic care as a nursing task. As one overseas-trained nurse said *"it is nursing home nursing even in hospitals"* compared to the Philippines where the family does the "unskilled" work. Some Filipino nurses described UK nurses as "laid back" and not so strict with competencies and procedures while African nurses described British nurses as more bureaucratic. African nurses tended to see UK nursing as less skilled and more risk averse and they feel they become deskilled and used to not using their initiative as these nurses described: *"just bleep and a specialist will come"* and *"you unlearn everything you learnt in Africa"*. However, in contrast, some African overseas-trained nurses said they have become aware of managing risk and learnt to document care as a consequence. Attitudes

towards UK nursing held by overseas-trained nurses are discussed at greater length in Allan (under review).

4.3 Skills recognition and accreditation

In 4.1 and 4.2, we have described the processes and systems of adaptation and mentoring which overseas-trained nurses have experienced both in the NHS and the care home sector; and how the nature and delivery of British nursing work, which is historically segmented and divided, affects overseas-trained nurses who are used to different systems of nursing and expect to be treated with respect as trained nurses. These experiences were both shaped by and helped shape the recognition of overseas-trained nurses' skills and how their skills were accredited.

Overseas-trained nurses expressed confusion over the accreditation of their training and experiences, and also surprise that their skills gained overseas were not recognised. As this Zimbabwean nurse said:

Interviewer: What were your expectations about coming over here?

I thought I would work as soon as I come here. After the adaptation, I thought the adaptation was just a formality. I thought I'd be accepted onto the UK register and then I would be working in a place where I would be accepted because of my experience. And because of my experience I thought I'd go straight into a higher grade.
Female, 38 years old, Zimbabwean, Black African, E grade, employer: NHS, arrived in UK: 2001 - CH001

As this quote suggests, overseas trained nurses' skills and competencies gained overseas, were not recognised and valued by their employers and colleagues in the UK. In addition, the NMC has failed to provide a flexible model for assessment in the ONP which will start to regulate learning environments which have hitherto been unregulated and exploitative of overseas-trained nurses (Allan & Larsen 2003). In addition, our data suggest that instead of being seen as trained nurses with skills to offer the workforce, they are seen as learners whose sole learning need is to adapt to the British nursing system.

We argue that their learning is approached as a one-way process of learning how the British system works rather than a potential exchange of expertise and ideas to enhance practice. This is clearly stated in the following quote from a member of the NMC:

What we're saying is that these are people who are nurses, they have a lot of skills. The competency part is about confirming that they conform to our standards.

We don't want a queue of people from outside coming to complain about standards and failure to protect the public. But we recognise that many of these applicants are skilled and can make a positive contribution to the service. We're delighted to welcome them if they conform to our requirements.

Stakeholder from the Nursing and Midwifery Council (NMC) – NH152

We argue elsewhere that this situation is discriminatory (Larsen 2006b; Henry 2006a, b) and is shaped by empirical differences between international systems of nursing practice and ethnocentric attitudes towards difference in the UK workforce (Allan et al 2004). It is also shaped by a discourse of “risk” and litigation in UK health policy and practice (Allan under review; Richman & Mercer 2004; Watson 2001) which seeks conformity in practice. We argue in section 6 that there are sponsored systems of promotion in nursing as well as markets of recruitment and employment which mean that overseas-trained nurses are restricted in their career progression. This is aggravated by a resistance to recognising overseas-trained nurses’ qualifications, skills and experiences. We argue that overseas nurses are also systematically discriminated against because of the values underpinning accreditation, that is, a value which prefers similarities in practice rather than difference. Our position is supported by evidence in the literature (Masterson 2002; Wickett & McCutcheon 2002; Hancock 2002; Iredale 2004). These authors argue, not only that the process of assessing professional nursing qualifications globally is unnecessarily difficult and time consuming, but that there are problematic issues concerning qualification assessment of nurses in a global market which have yet to be addressed by national and international bodies. Both Hancock and Masterson argue that assessment for registration in the UK of overseas-trained nurses could take place in the clinical environment but point out that this process may be contaminated by the ethnicity and gender bias of the assessor. Iredale (2004) argues that mutual recognition schemes are the least open to gender and ethnicity bias. Overall, Raghuram & Kofman (2004) argue that the post-arrival processes of accreditation and recognition lead to deskilling and skills waste because of complex processes of gender and ethnicity discrimination.

While our data suggest that overseas-trained nurses experience deskilling and skills waste, Masterson (2002:59) argues that it is unreasonable and inappropriate to expect nursing practice to be the same the world over. There are significant differences in standards of practice within and between different health care providers in individual countries. Masterson (2002:59) states that ‘it might be more appropriate to ask each practitioner to prepare a portfolio of evidence against competencies expected for registration rather than evidence of registration in the qualifying country’. In addition she argues that a core competency which overseas-trained nurses need to demonstrate in their portfolio might be the ability to be flexible and transfer skills they already possess to different cultures and contexts. Even if portfolios were adopted as a system of accreditation, Masterson (2002) argues that it is difficult to estimate with any certainty how many years and how many hours per week nurses, whatever their year of training, are likely to have worked and therefore how this experience may be expected to be recognised and valued. It is equally difficult to estimate the

relationship between years of experience, educational qualifications and continuing professional education which an overseas-trained nurse might reasonably expect to have assessed.

To further complicate this issue, current systems of accrediting learning in nursing, e.g.: acquired prior learning (APL), acquired prior experiential learning (APEL), acquired prior certified learning (APCL), are fairly complex and there is no standard acceptance within the NHS about any prior training and its portability between hospitals or trusts or the independent sector.

I think quite often we just don't understand. It's quite frustrating dealing with the NMC from Australia. I think they did my application within 9 months, but it took them another 3 months just to give me a PIN number. So I couldn't leave Australia for those 3 months. Things like that were quite frustrating. And not knowing enough about, I know a lot of paediatric nurses would come over here and not been able to register in Paeds. A friend of mine's a midwife who's not working as a midwife, because she didn't register something correctly.

Female, 31 years old, Australian, White other, F grade, employer: NHS, arrived in UK: 2002 - CH005

There is an obvious tension in different stakeholders' positions. Overseas-trained nurses felt devalued and deskilled while their managers felt their skills did not always match British standards. This tension is reflected in the following quote from an interview with a spokesperson from the NMC:

There have been concerns raised about their skills levels and competencies. We're starting to see that coming through our registered practice systems, where we now have the power to look at individuals' competencies. On the newly registered nurses, there have been instances, quite small in number, but a high proportion among overseas nurses. We're pleased to see that happening [reporting] but obviously it raises an issue for us to address quite urgently.

Stakeholder from the Nursing and Midwifery Council (NMC) – NH152

The lack of appropriate mentoring and adaptation, the segmented nature of nursing work and the differences in delivery of nursing care worldwide and the lack of flexibility in accreditation and recognition of skills led, we argue, to the undergrading of overseas-trained nurses in the workforce.

4.4 Undergrading at grades D and E

It is clear from our data that the overseas-trained nurses we interviewed were experienced nurses overseas before migrating to work in the UK. All those interviewed who gave their year of registration in their home country had registered before 2001, with half registering between 1990 and 2000 (see Table 15 above). This indicates that they had a wide range of post-registration experience and continuing professional development. Of the total, 21% had dual registration in their home country, with ten overseas-trained nurses registered as

midwives in their home country (see Table 16 above). However, none were registered as midwives in the UK, whereas the three overseas-trained RMNs were registered RMNs in the UK. 41% of the sample had a BSc or MSc.

We would expect these overseas-trained nurses' qualifications and experiences to qualify them for senior grades given that the majority were experienced, had post registration experience in a speciality or a dual registration and were also working full time when these attributes are associated with higher grades in nursing (Allan 2006). Instead, the majority in our sample, arriving after 1999, were employed as D grades in the NHS (see Table 17).

Table 17 Nurses: grade by date of arrival (only nurses, n = 70)

Grade	Date of arrival		
	Before 1990	1990-1999	2000-2004
D		1	40
E	2	3	10
F and above	8	2	4
Total	10	6	54

This finding is similar to Ball and Pike (2005) who found that 61% of overseas-trained nurses (RCN members) are employed as D grades in the independent and care home sector rather than the NHS. Our data are also similar to O'Brien's sample of overseas-trained nurses working in the NHS (O'Brien, under review). It appears that from evidence from multiple sources that overseas-trained nurses are not being employed effectively, that is, their skills are being wasted through under-grading and inflexible accreditation systems.

We have compared current grade with ethnicity for overseas-trained nurses working in the NHS and in the care home sector (Table 18). Within the NHS there was a tendency for white overseas-trained nurses to be employed on higher grades compared to other groups of overseas-trained nurses. The only group who compared favourably with white overseas-trained nurses were the Ghanaian sample, who arrived before 1989, and were employed as midwives at F and G grades.

Table 18 Nurses: ethnicity by grade (NHS only, n = 54)

Ethnicity	Grade	
	D or E	F and above
Black African: Ghanaian	1	8
Black African: other	5	2
Filipino	23	
White	5	4
Other	5	1
Total	39	15

Of those working in the care home sector, the majority of whom were Black African and employed as D grades. There were only two Filipino and no White overseas-trained nurses in the care home sector in our sample. We have argued that the migration pathway of Black Africans tended to be to the care homes rather than the NHS while the Filipino and White overseas-trained nurses tended to be recruited directly to the NHS (section 3). This appears to be because of the recruitment restrictions imposed by the Department of Health on public services while the care home sector remains unregulated.

It is clear that overseas-trained nurses are undergraded in relation to their year of registration, experience, educational qualifications as well as working patterns.

4.5 Deskillling

Overseas-trained nurses describe this period of adaptation and early employment as a registered D grade staff nurses as a period of deskillling before they are allowed to retrain in the British system to perform skills they have previously performed overseas. This situation led to feelings of frustration as these three Filipino nurses discuss:

You can't catheterise without the course.

Interviewer: Even the female patients?

Yes. Because previously if you're ICU, you're all equipped to do all these things because you're in critical. But if nobody's around, nobody's around to help you in case of emergency. So we are all trained there back home, but because you are legally not allowed to do so, so you expected to do things that you are doing before.

That you can't do now.

You can't do now, because you'll go insane.

Interviewer: How did that make you feel?

Frustration. Because your skills will be gone if we're not doing it. This is where I started before.

Group interview: 1 male, 2 females, all aged between 35 - 37, Filipinos, D grades, NHS, all arrived in UK: 2003 - BH004-006

This has been described elsewhere in the literature as brain waste and deskillling which is more common for professional women migrants compared to male migrant workers (Raghuram & Kofman 2004). It is clear from the managers' interviews that very little thought had been given to overseas-trained nurses' promotion based on their extensive skills and experience gained overseas:

Interviewer: I just wondered whether you can see them being employed immediately on an E grade? Would any of them have the experience?

That's an interesting question. I'll be honest with you. I haven't even thought of that one... I think the issue of the grade I hadn't considered that

White, NHS Trust manager - LH166

Overseas-trained nurses felt that their previous experience and skills were not the principle reason for their recruitment, resulting in them being "passed" off as more junior members of

staff to fit into UK nurses' expectations of them. As one Filipino overseas-trained nurse said when she explained why she had not mentioned her managerial experience:

Just embarrassed about it. In my CV I put staff nurse as they required a staff nurse. ...Most of my time at work had been as a clinical instructor. Not managerial.

Interviewer: So you had to present a different profile here?

Yes. That's why I didn't tell them.

Interviewer: When you go for an E grade would you tell them?

Yes. It's not fair but there is a difficulty for British nurses having more qualified overseas nurses working with them.

Female, 37 years old, Filipino, D grade, employer: NHS, arrived in UK: 2000 - BH007

This perception among overseas-trained nurses that skills gained overseas were not required in the roles in the NHS and may indeed prove "difficult" for less experienced British nurses led some of them to downgrade their experiences and skills so as not to appear arrogant and to allow them to get on better with UK colleagues (the overseas nurses felt) who placed overseas-trained nurses at the bottom of ward hierarchy and did not expect much from them (see also section 5). As this Filipino nurse said:

Interviewer: Do you think they realise how much experience you have?

They do, maybe that's why they don't like us and avoid us. When I was in ICU they told me "oh you're a senior nurse". I was very careful in my work, like every time I do things I was very careful. They might look and say something bad. They might criticise. I have to do carefully. Not perfect, but I've learnt to be humble for them. It's like they are the superiors

Female, 36 years old, Filipino, D grade, employer: NHS, arrived in UK: 2003 - BH001

We argue that treating overseas-trained as newly qualified nurses through the lack of recognition of previous experience (APL, APEL, APCL as well as CPD) led to deskilling and skills waste (as suggested by Raghuram & Kofman 2004; O'Brien under review) and arises because of the nature of British nursing work and the avoidance of risk. O'Brien (under review) has argued that the overseas-trained nurse is recruited to a lower status position in the nursing hierarchy where the personal care rather than technical skills are required. This is not made plain to overseas-trained nurses before they arrive in the UK. Allan (under review) argues that overseas-trained nurses have simply taken the place of students and less qualified nurses in performing personal care work. The legal framework within which UK nurses worked, which has arisen partly because of the delegation of medical tasks to nurses at the same time as the emergence of a discourse of "risk" and litigation (Allan under review; Richman & Mercer 2004; Watson 2001) has constrained how managers recognise and value overseas-trained nurses' skills. They are not recognised because they are not British and therefore not "safe" until accredited against British standards. Deskilling and skills waste arises because of an expectation that overseas-trained nurses will adopt British nursing practices which are accredited as the standard and valued as safer and, as a result, their skills learnt overseas which are different to British practices, are ignored. In our data, overseas-

trained nurses felt that little effort is made to accredit overseas' skills against British standards.

5 Interpersonal relationships, discrimination and support

The nature of overseas-trained nurses' relationships with their colleagues and managers were crucial to their experiences of working in British healthcare and this section provides critical reflection on this dynamic. In particular, we present findings on the nature of overseas-trained nurses' experiences of discriminatory processes in the workplace and the role of social support.

5.1 Relationships with colleagues: issues of discrimination

When overseas-trained nurses talked about their relationships with colleagues and managers both positive and negative experiences emerged. Before moving on to detail the positive aspects of support we will look more closely at the different ways in which overseas-trained nurses described their experiences of being discriminated against, illuminating two types of discrimination: overt and indirect discrimination.

Overt discrimination appeared in the forms of blatant racism, xenophobia and apparent deliberate strategies to exclude or harm the overseas-trained nurse. During interviews, overseas-trained nurses described discrimination as it was expressed through "little things" on a day-to-day basis - a process examined by Larsen (2006b) as the micro-sociology of discrimination. For example, some were excluded when jobs were allocated in a care home and the overseas-trained nurse consistently was given the jobs to be performed in solitude, while their British colleagues decided to work in pairs together. Or it could be when the overseas-trained nurse was not invited to join for lunch breaks or other social events.

These forms of discrimination were not always or exclusively based on race, with White British staff discriminating against a Black overseas-trained nurse. The social divisions and discriminatory attitudes could be expressed along other lines as well. For example some Ghanaian nurses working in London reported that they were victims of ethnic discrimination perpetrated by African-Caribbean nurses; and a Dutch nurse working in Northern England described how she felt she had been treated better by the local British nurses than a British nurse from Southern England would have been.

In this way, regional locality within the UK can play a significant role in shaping the type of discrimination that may occur. This is perhaps most obviously the case in London where many healthcare workplaces are highly multi-ethnic, and White British nurses may be a minority. As one NHS trust manager commented:

I think you can't underestimate human nature. It is a fact that an existing group of staff do not always welcome with open arms new groups of staff with open arms, for

different reasons. I think if you are working in a central London trust it is a fact of life that you are going to have a very mixed group of staff, very, very mixed. Mixed from backgrounds, mixed from language, all sorts of things, and that brings its own problems. And you do have to recognise that that is and will be the case.

Female, white, local stakeholder, Director of Nursing - LJ005

Commenting on managers' preference to promote those who are perceived to be "similar" (see section 6), a Ukrainian nurse suggested that discriminatory processes based on favouring the "insider" is unavoidable, and can be constructed along any lines – nationality, gender, ethnicity, race, hobby:

That's a basic human psychology of getting back in a group, because as a unit we like to be together in groups. It makes you feel comfortable within that group. I think probably she or he [a ward manager] might find a more loyalty within a group of people from the home country. I think on the English principle, I think the principle which is in every nation, is that if you scratch my back I'll scratch your back. It's probably loyalty combined with the principle of choosing these groups of individuals. I think choosing these groups of individuals based on sex, based on colour of skin, of nationality. Do you like bungy jumping? Let's form a group loyal friends because we might go bungy jumping. That's OK. I'll tell you if we carry out next week, because we are a group of bungy jumpers. That's all right.

Male, 31 years old, Ukrainian, White other, E grade, employer: NHS, arrived in UK: 1999 - CJ036

Within nursing, discrimination is historically connected to multi-layered dimensions of disadvantage related to gender, class and nursing speciality (Allan under review, Smith and Mackintosh, under review). Some overseas-trained nurses felt that discriminatory attitudes could be provoked when they took a more senior role than the British workers. This observation appears to support a recurrent theme in our findings, namely a link between British discriminatory attitudes and an apparent prevailing perception that overseas-trained workers should work at lower grades, not taking senior and managerial responsibilities (see section 4.5). Overseas-trained nurses frequently described difficulties in asserting their authority over HCAs, a fact that may reflect discriminatory attitudes. It may also suggest that HCAs feel their status and authority in the care home threatened by the overseas-trained nurse who is in the precarious situation of being new to British nursing practices in the care home and having to take a superior role in respect to the HCAs. Overseas-trained nurses talked about the difficulty of having to control senior HCAs who in many cases have worked in the care home for numerous years. These difficulties may be amplified by the expectations some overseas-trained nurses have of working with HCAs based on experiences in their countries of origin, where untrained care staff are expected to promptly follow the nurse's orders. For example, some overseas-trained nurses may find it inappropriate and disrespectful if a HCA challenges the nurse's clinical decision and practice.

Although White overseas-trained nurses tended not to describe such attitudes as discrimination or racism they appeared to experience similar reactions, as this specialist nurse from New Zealand described:

I think nurses on the ward also found me difficult, because I come from abroad, where I'm treated as a specialist nurse, whereas here I felt like I was treated like: "we need her to do something, let's get her to do it", rather than using me for my knowledge and skills and asking me for advice. They just wanted me to do the task. And I'm going "no, I'm not going to do it". And I think they all looked at me and thought "who does she think she is?".

Interviewer: Was that related to being from overseas?

I think a lot of it was to do with that. I hadn't come up in this system, I came from a different country and here I'm telling them what to do, and I don't think they liked that at all. I think they would have been a bit more open to it if it had been from another English nurse.

Female, 30 years old, New Zealand, White other, I grade, employer: NHS, arrived in UK: 2001 - CJ031

Not surprisingly, overt discrimination and social isolation gave rise to feelings of being marginalised and not liked, which could be especially hard to bear if the overseas-trained nurse was not part of a "batch", but the only overseas-trained nurse in a small care home and separated from the family. Nurses who found themselves in such situations described how they felt miserable and were homesick. Some explained that they would have travelled back home if had not been for the financial restraints and often huge debt they had incurred in order to migrate (i.e. those who had paid an agency). Exclusion could also appear when the professional authority of the overseas-trained nurse was ignored or overheard, for example when the care home manager put a healthcare assistant in charge instead of the overseas-trained nurse.

Interviewees described how colleagues could express critical and negative attention through minor but persistent day-to-day things such as questioning their clinical practices and judgements. Some overseas-trained nurses felt systematically disrespected and stated that racist stereotypes or notions of "economic migrants" were used to make them appear inferior (see also, Allan et al. 2004; Larsen et al. 2005). An Indian nurse explained how she was questioned by British colleagues:

I was also asked on numerous occasions "why you are here?", "why do you work here?", "how long do you want to stay?", "why should you stay when your family is not here?", they say that, you know, sometimes they say "we are not happy because you come here and take all the money, take all the benefits and making us lose our benefits". So what, I am also paying all the taxes!

Female, 54 years old, Indian, D grade, employer: private hospital, arrived in UK: 2000 - AJ041

5.2 Integration, culture and indirect discrimination

Our data also demonstrate indirect discrimination, which was different from the above as it was not necessarily driven by the intention to treat less favourably the person being discriminated against. Instead it was operationalised by the power relations embedded in social structures, practices and cultures. As such it could be evident in practices such as not recognising individuals' particular qualities or needs and in attempts to persuade or socially pressurise overseas-trained nurses to conform to dominant values and practices. As this form of discrimination relates to differences in social and cultural norms of interaction, it was not described as a difficulty by overseas-trained nurses who broadly shared contemporary Western or Anglo Saxon culture (see also discussion of "cultural proximity" below).

In the case studies where the workforce was predominantly local and White British (Wales and Northern England), overseas-trained nurses described how this form of discrimination is expressed when British staff, perhaps without any conscious ill-intentions, seek to encourage or "gently pressure" overseas-trained nurses to conform to British cultural and social norms. For example, British colleagues may invite the overseas-trained nurse to come out to the pub after work or they conduct "small-talk" during the lunch break, talking about for example private relationships. Overseas-trained nurses might not feel culturally and socially familiar and comfortable with this type of behaviour, and if they are not able or willing to socialise in this way, it is likely that they will be excluded from the social network and informal support of their British colleagues. Evidently, the dimension of time is crucial here, as nurses have described how they with time learned to feel more at ease and confident in such situations (see also discussion of "fitting in" in section 8).

Regional variation influences these processes, as, for example, the multi-ethnic composition of the healthcare workforce in London provides for different dynamics of social power as well as different levels of awareness of inter-cultural communication styles. A Black British manager with extensive experience of supporting overseas-trained nurses in a large NHS trust in Northern England illustrated the situation for overseas-trained nurses in an overwhelmingly White British work environment:

British nurses will talk about their social life, they will talk about what is in their homes, what they are doing, they give a lot of information about themselves, how many children they have, that sort of thing... the groups of nurses may go out for a visit to a restaurant etc ... all of this helps people get to know each other and the gelling of the team because that is the way that things are done here. ... a lot of British nurses, their way of learning more about each other and work together as a team is about talking about themselves... Some overseas-trained nurses find that really alarming, they come to work, they do the job to the best of their ability, and that is it. They don't really talk about their personal lives, and find that really intrusive ... This is about talking, and the more you will speak to people the more you

will understand what the culture of that ward is, so for some people [overseas-trained nurses] it is difficult, even though they know what they should be doing it is difficult for them.

Female, 46 years old, Black British, manager - LJ002

The overt and indirect forms of discrimination may coexist or merge into each other. This could arise from situations of misunderstandings when confronted with British cultural norms for interaction and communication. This South African woman described how she had experienced being misunderstood:

*In my culture, the Zulu culture, if you avoid eye contact that is a way of showing respect, and giving both hands, that is being friendly. ... [in the UK] you've got to beg them [colleagues] to do things for you. "Can you **please** take the blood pressure!" If you don't, you are being rude. ... But that is how they misconstrue things here. ...In Britain there is something with the tone in which they speak, a high tone. So if you speak deep they think you are being rude or aggressive.*

Female, 39 years old, South African, mixed race, D grade, employer: NHS, arrived in UK: 2003 - AJ043

In such situations overseas-trained nurses described how their British colleagues often misinterpreted the cultural difficulties of communication as a reflection of the overseas-trained nurse's unsocial intentions. Lack of mutual cultural understanding could in this way lead to ill feelings and an unsupportive work situation for the overseas-trained nurse.

Over time, and if the overseas-trained nurse did not seek social integration on the culturally and socially specific terms that dominated in the workplace, overt discriminatory forms might develop in social dynamics of "scapegoating" the social outsider, who is not seen as "one of us" by the dominant group (cf. Girard 1986). This can have direct consequences such as inhibiting career progression.

5.3 The importance of informal support at work

The social dynamics of discrimination, as outlined above, whether they are of the overt or the indirect type, are significant because they determine the status of the overseas-trained nurse as either an insider or an outsider to the social network of their work colleagues. This affects job satisfaction and general well-being for overseas-trained nurses, but, of special interest to this study, it also affects the overseas-trained nurse's access to career development and promotion (Larsen, 2006a).

The crucial importance of informal support structures such as social networks among colleagues and systems of patronage and "sponsored promotion", as illuminated in section 6, are also consistently reported in studies of career progression; the latest was a report from the

Health Foundation examining BME staffs lack of access to leadership positions in the NHS (Esmail, Kalra & Able 2005). Our data strongly echo this evidence.

*Some overseas nurses who don't like to join in [with the British colleagues] do feel isolated because everybody else is chatting about what they did last night and what they are going to do tomorrow night, meanwhile you're just there and when jobs and other things that....study days or things relevant to the work comes up, **that person may be passed over because that person isn't in that little group.***

Female, 46 years old, Black British, manager - LJ002 (emphasis added)

5.4 The ambiguous role of support: conforming or comforting

Support relevant to overseas-trained nurses in the UK can take different forms and come from a variety of sources. It is important to stress that *support is a relational phenomenon*, whose quality and usefulness is simultaneously dependent on the party giving and the party receiving it. While the support offered needs to be relevant and of a good quality, it is of no use if the person needing it is not in a position to take or make active use of it.

Support therefore also depends on perspective, and, for example, the social pressure to conform to British norms that we earlier described as indirect discrimination can in some instances be experienced as valuable support. Overseas-trained nurses who are willing to adapt their behaviour and appearance (and self-perception) can make very good use of this type of social pressure as support to become more socially agreeable and “fit in” to prevailing expectations in the UK. Previous research on the Ghanaian Diaspora identified one such institutionalised example. Associations made use of the Windsor Fellowship, which offered individuals the opportunity to be mentored to build “cultural capital” deemed necessary in order for their skills to be recognised and to facilitate social mobility in the UK (Henry & Mohan 2003: 618).

Support could, however, also be directly connected to the batch recruitment style, as it provided the overseas-trained nurse with a peer group of others in similar circumstances who could give good practical advice and moral support. In many cases batch recruitment has facilitated the establishment of strong social networks which have played an important role in easing overseas-trained nurses' adjustment to life in the UK and the healthcare system. This appears to have been particularly important for Filipino nurses, who were the prime target for NHS-driven batch recruitment and who did not already have an established Diaspora community in the UK despite previous recruitment drives in the 1970s. Only one network run by Filipino nurses recruited in the 1970s supported newly arrived Filipino nurses in this way. This network was started by an overseas-recruited nurse who experienced discrimination and used her negative experiences to found a network to provide support for others (see quote above LH176). The types of social support provided in these networks included advice and

help in finding accommodation and dealing with landlords and advice on immigration issues. In one case these networks also pooled resources to assist nurses returning in cases of emergency at home.

However, whilst these batch recruitment networks seemed to mitigate social isolation and cultural shock for new overseas-trained nurses, there is little evidence of the social networks producing mutual aid for career advancement. Note that the Filipino network described above is different from batch recruitment networks being established by Filipinos who came to the UK decades ago. Indeed, there is a strong perception amongst some employers that batch recruitment (see section 3.3 above) has actually inhibited career progression, as members of the tightly knit group have avoided conspicuous success in order to maintain group solidarity (see also the discussion of “collective responses” in section 8). The batch recruitment network developed a strong group-mentality and a feeling of social dependency, which might have led individuals to fear to “stick out” by seeking career advancement. Managers have emphasised the need in such situations to set up formal programmes to systematically encourage individuals to go for promotion, and that individual overseas-trained nurses who went on to achieve promotion provided “role models” to facilitate a breakthrough.

The important role of social support was equally pointed out by overseas-trained nurses who described that they felt lonely, isolated and homesick, and how it was a great relief for them to bring their spouse and children to live with them in the UK. A Zimbabwean nurse described the reasons behind the decision to let her family join her in the UK sooner than originally planned:

I couldn't, I couldn't settle without them [her children], I couldn't manage. I got upset at work. I couldn't settle, so we arranged that they come earlier. ...

Interviewer: Did you make that decision before you left?

No, during the course of the 8 months. It was a continuous exchange of phones and whatever. “What are we doing, what do we do now?” and all that. We just decided it's too much, let's just do one thing at a time. If we have to go back, we go back together.

Interviewer: Because you didn't want to live apart?

Yes. It was the most traumatic experience I have ever encountered. I don't know, maybe it was because of the change in culture or whatever. You know, in my career I used to leave my home, but it wasn't as traumatic as I experienced this time.

Interviewer: What was it that was traumatic?

Mainly the distance, culture shock when I got here. Things were a bit different, the experiences in the nursing home where I did the adaptation and the nursing home I went to. Waiting for our PINs and then starting as nurses. It was tough.

Female, 48 years old, Zimbabwean, Black African, D grade, employer: NHS, arrived in UK: 2000 - BJ008

In the workplace support from colleagues and clinical managers has been crucial in fighting expressions of overt discrimination. Our data reveal examples both of good practice where

colleagues and managers immediately support the overseas-trained nurse and emphasise the zero-tolerance approach to discrimination, see also section 8. In other situations colleagues and/or clinical managers avoided confrontation, and the overseas-trained nurse was left with a feeling that racist discrimination might be regrettable, but should be accepted. Similar issues arose when overseas-trained nurses' had confrontations with colleagues who expressed discriminatory attitudes. In these situations clinical managers reacted differently by either directly confronting or quietly accepting the discrimination and bullying. An overseas-trained nurse who had become manager of a care home provided a perspective into socio-psychological processes that might drive such behaviour, by pointing out that it at times can be very lonely to be manager, and that "weak managers" may be afraid to challenge their staff and instead seek to please them, thereby becoming complicit in scapegoating the overseas-trained nurse. Similarly, a senior NHS trust manager pointed out that the ward sisters are the key to securing good collegial practice.

Professional and trades union organisations, such as the RCN and Unison, play an important role in providing support and advice for overseas-trained nurses, not least in legal matters concerning complaints over clinical practice or conflicts with the employer. Similar to the example provided above, overseas-trained nurses have pointed to the importance of having this support. Given the difficult situation that some overseas-trained nurses find themselves in they will, however, at times chose not to formally act against what they experience as unfair treatment (for reasons described above), and the RCN and Unison are in such cases not able to do other than giving advice. A case in point is that no individual in the Ghanaian case study had made use of either of these organisations to fight legal workplace issues. Overseas-trained nurses may most times choose not to formally complaint in order not to be seen as a "troublemaker" (see discussion of grievances in section 7).

Finally, we wish to reflect on what our findings can say about diversity management at the level of overseas-trained nurses' experiences and their social relationships. In our data there is widespread evidence that current practice in the NHS and the independent sector has not adopted and implemented clear practices that celebrate and make positive use of the diversity of staff although this was the theme for the NHS Employers Conference in 2005. On the contrary, overseas-trained nurses overwhelmingly felt either directly or indirectly pressurised to conform to dominant social norms in order to be accepted and recognised as a valuable member of the team. This was not least the case in respect to career progression. In overseas-trained nurses' experiences "fitting in" and complying with established cultural norms and clinical practices is what works best when overseas-trained nurses go for job interviews and

seek promotion. This suggests that there is substantial work to be done “on the ground” in order for the ideology and vision of diversity management to make a real impact in practice.

5.5 Collective responses to discrimination

Previous sections have explored how individuals respond to the UK work environment and particularly discrimination. One of the aims of the Ghanaian case study was to highlight the role of Diaspora support networks in addressing economic and social exclusion. Through exploring the role of informal networks and institutions based on identity and profession the following conclusions are drawn:

- 1 Support networks are a vital part of the process of migration for nurses and doctors
- 2 These networks play an important role in providing welfare and social adaptation to the UK
- 3 Until very recently these networks appear to have played a very limited role in career advancement

The transnational recruitment of healthcare professionals has become increasingly commercialised, however, for many overseas-trained nurses, social networks continue to ease migration to the UK. Many initially found accommodation with relatives and friends, particularly class mates whilst looking for work in the UK which considerably reduced the costs of migration. These networks and various associations also provide considerable social support for migrants. For example the Association of Ghanaian Nurses (GNA) has focused on providing social support and welfare such as support in times of personal crisis particularly bereavement and support for institutions in Ghana. This to a certain extent mirrors some of the functions of associational life in the Ghanaian Diaspora, such as hometown associations and other Ghanaian associations in the UK (Henry and Mohan 2003).

However whilst these support systems assisted many nurses in the process of migration, there appears to be little evidence of recently arrived overseas-trained nurses using these social networks to help adapt to the UK healthcare system or to facilitate career progression through building their social or cultural skills through systems of mutual aid. The exception appears to be an International Overseas Nurses’ Network which ran courses on writing curriculum vitae for overseas-trained nurses as well as other courses targeted at career development. This network was set up by an overseas-trained nurse and funded by her NHS Trust for all overseas-trained nurses. However, until recently the majority of these associations and networks have not provided support through developing the skills, knowledge and attributes necessary for career progression and there appears to have been little pressure on them to do

this from their membership. It appears that collective responses to discrimination have been constrained by a number of interrelated and often paradoxical factors.

Some informants claimed that within some networks of Ghanaian nurses there is an element of collective denial about discriminatory practices. The reasons for this reluctance to seek help from within Ghanaian nursing networks could also be related to embarrassment in the context of the power and status relationships within the network. In addition to wishing to avoid embarrassment many regard these networks as social gatherings where they can relax and forget about their unhappiness at work.

However, whilst there is an element of denial, negative experiences are shared within these networks. Paradoxically, the ways that these experiences are shared may reduce their usefulness for developing solutions as they took the form of letting off steam. This was often categorised by informants as moaning or “veranda culture” rather than producing any constructive outcomes. The lack of constructive collective responses may also indicate a collective lack of capacity to address the challenges of the UK healthcare labour market.

The role of collective action in career development is currently changing and recently there has been a substantial increase in collective self-help. The GNA with the support of the Confederation of Black and Minority Ethnic Nurses and Midwives (CBEN)² have run workshops on building key career development skills identified by their members. The areas addressed by these programmes are closely related to issues identified above particularly building the ability to demonstrate ones abilities through performing in an appropriate manner in interviews and on application forms. A few nurses were also receiving informal and ad-hoc mentoring from more successful nurses such as help with applying for jobs. Furthermore Black overseas-trained nurses are now beginning to share experiences and develop common solutions to their marginalisation in the workplace. This involves sharing experiences with nurses who have been in the UK for much longer, some of whom have overcome marginalisation and have had successful careers and become prominent advocates from within the Black communities. Whilst this clearly addresses some of the marginalisation caused by structural and cultural factors we have found little evidence of overseas nurses collectively challenging the racial and ethnic discrimination that they allege is widespread.

5.6 Who is a stranger? Ethnic hierarchies and inter-ethnic relationships in the NHS

Relationships were analysed between different Black minority ethnic (BME) groups in the NHS and tensions explored between these different groups including discriminatory

behaviour and differential career progression related to insider and outsider status of different ethnicities.

Previously we have explored the ways that both BME and White overseas staff are marginalised structurally and have highlighted how structures, practices and cultures in the NHS provide the space for discriminatory behaviour. In a multi-ethnic hierarchy, such as the NHS, discriminatory practices are not only inflicted on BME overseas staff by White staff. Our data contain many references to tensions between various BME groups and includes allegations of discriminatory practices inflicted by members of one BME group against others. These tensions were particularly apparent in the often contradictory and paradoxical relationships between African and African Caribbean nurses.

Some Ghanaian nurses characterised African Caribbean nurses as aggressive and claimed that they discriminated against them whereas others expressed solidarity with African Caribbeans who they regarded as being sisters or “one people”.

I think I have a very good relationship with the (Jamaicans) on my ward. I think we see ourselves as one people.

Male, 31 years old, Ghanaian, Black African, D grade, employer: independent, arrived in UK: 2001 - DL039

Some nurses suggested that when they first arrived in the UK they received a form of mentoring from Caribbean nurses who taught them how to adapt to the NHS by being more assertive, as discussed below this is also closely related to issues of “cultural proximity”. One nurse recounted her relationships with African Caribbean nurses in her first post:

Sometimes the way they say things, they come across as aggressive, but they don't mean to be. We speak (quietly)...I found it challenging, but they helped me talk more as I was very quiet. So I always say I am glad I worked there first as they made me stronger.

Female, 40 years old, Dual UK/Ghanaian, Black African, G grade, employer: NHS, arrived in UK: 1989 - DL055

This often contradictory discourse appears to be a way of articulating the ways that Ghanaian nurses are obliged to change the way that they relate to colleagues in the workplace. However many of the Ghanaian nurses and midwives interviewed, but by no means all, alleged that African Caribbean colleagues and managers colluded to promote each others interests often at the expense of African nurses:

You know, there is that confliction between the Afro-Caribbean and the Africans, there is no way you know, there's no way that an Afro-Caribbean will let an African get near her in position and that is a fact, especially in the NHS...if they are in a position to put you at bay they will you know and you the African and the African that is born here and bred here is will be they will be they will accept that, yes they will accept that. So if you see Africans that have been, that are in a higher position, it's because they, most of them are born and bred here and they were educated here so

those are not so different, not so much of a threat to the Afro-Caribbean's. But when we that were born and bred in Ghana and in Africa we then come here and then try to take up positions there is that conflict and they try to keep us out. I'm not sorry to say it, it's a fact, our sisters, Afro-Caribbean sisters will do whatever they can in their power to put us at bay and they resist us so much.

Female, 47 years old, Dual UK/Ghanaian, Black African, GP, employer: NHS, arrived in UK: 2001 - DL024

Other nurses made similar statements although less overt and as such it serves as a reminder that when conceptualising racism in a multi-ethnic hierarchy such as the NHS one should be aware that White Europeans are not the only people marginalising other ethnic groups. As this quote indicates, allegations of discrimination by African Caribbeans and the relative position of Africans and African Caribbeans are linked to a belief that African Caribbeans have adapted more effectively to the UK than African nurses³. This in turn is closely related to issues of cultural proximity and definitions of “who is a stranger?” and how this relates to the construction of professional ethnic hierarchies in the NHS. An African Caribbean informant captures the essence of this hierarchy:

People say that there is a pecking order in the NHS to get positions. So it's White first, White British first, then White Australian, White South African. When you run out of all of that and you have only got Black left after all the Whites its Asians. After the Asians you come down to Black and if you have to differentiate its Black Caribbean then Black African... It's a pecking order.

Local NHS stakeholder – DL025

The same manager went on to link the position in the hierarchy to cultural skills and acceptability of different cultures:

I think that a lot of the Black Africans feel that in the pecking order the Caribbean will come first and I think that is probably true. I think that is true because Black Caribbeans understand British culture and how it works because a lot of us have come from British colonies. We have learned how to deal with and what to say and how to say it and I think because of that we have a little bit of advantage and they have a strong accent and we have much more of a British accent. The general friction appears to be because they perceive the Caribbeans as having more opportunities than them and I think it is probably true...I think it is cultural differences and because we have been around the British longer and we therefore understand how to play the game much more than they do...There are differences in the ways we react to things. Because Black Caribbeans tend to be much more, they are not as verbal, they are not as, its like Nigerians are very forceful strong people but the Caribbeans are much more quieter, diplomatic. All the African nations are very different though. The Nigerians are very forceful, The Ghanaians are very sweet, they are very nice and quiet so often the Ghanaians will not get anywhere because they won't push themselves

Local NHS stakeholder – DL025

The insights offered by this informant are important on several levels. Firstly it highlights the importance of cultural skills and proximity to the dominant cultures in navigating the workplace and in the different ways people interpret experiences in the workplace. Thus African Caribbeans are likely to understand processes in the workplace more quickly than

Africans. This also informs an analysis which explains the different reactions to perceived discrimination in terms of levels of cultural understanding particularly whether incidents are labelled as racial and the appropriate responses to them (see section 8).

Secondly the informant also discusses the issue of *strangeness*. Previous sections have highlighted the importance of the construction of categories of insider and outsider. In London and other urban areas, the historical presence of African Caribbean communities and particularly nurses, and histories of cultural exchange, makes African Caribbeans more acceptable to the dominant communities in terms of culture and language. This is evident from another quote from the same source:

The British White population (are) on the side of the Caribbeans more. I think that people want to work with who they are comfortable with and I think that the British are not as comfortable with Black Africans as they are with Black Caribbeans. So they prefer to go with those they feel more comfortable with and who they understand. Whereas I think that they feel that they don't understand the Black Africans.

Local NHS stakeholder – DL025

This point was repeated by a Ghanaian midwife who accounted for improved mobility for African Caribbeans:

The West Indians have done a little bit better where I presume probably they are more inclined towards the White side than probably think of themselves as Africans. But even then I haven't seen that many that have gone that high.

Female, 56 years old, Dual UK/Ghanaian, Black African, G grade, employer: NHS, arrived in UK: 1975 - DL002

She also points out that this success is limited and relative to Africans rather than the wider population.

Critically, informant DL025 also points to the postcolonial power relationships that underpin the construction of the hierarchy which frames the workplace interactions of African and African Caribbean nurses and midwives. These hierarchies are a legacy of colonialism and are underpinned by the cultural power of dominant ethnicities to decide who is a stranger i.e. an outsider.

Notwithstanding the ethnic or racial background of the perpetrators of discriminatory practices, their behaviours are regarded as racist as the outcome is racial marginalisation. Hence it is the systems of marginalisation and their practices that should be the main area of concern rather than being obscured by similarities in skin colour between victims and perpetrators. However these tensions and conflicts should also be contextualised as operating at the bottom of an ethnic hierarchy and should not obscure analysis of which groups really benefit from these processes.

6 Career progression and systems of sponsored promotion

In this section we explore overseas nurses' experiences of systems of promotion in the UK and argue that, particularly in the case of entering management, systems of promotion are not transparent. These systems and practices can institutionalise disadvantage and create an environment which facilitates discriminatory behaviour. As discussed below, this type of discrimination can involve an interplay of factors including race, ethnicity, nationality, country of training and a more generalised sense of otherness.

6.1 Becoming established

It is not surprising given the data describing overseas-trained nurses' adaptation and mentoring and the deskilling and skills-waste they experience (see section 4) that there is also confusion with the processes and systems which govern career progression. Overseas-trained nurses felt there was a lack of information which may in itself be evidence of institutional racism and discrimination. For example, one overseas-trained nurse expressed a wish "*Not be thrown in at the deep end*". Initially this sense of being thrown in at the deep end may be increased by the necessary stages of settling down in the UK in terms of: undertaking the adaptation course, registering with the NMC, finding accommodation combined with, in some cases in the care homes, poor contractual arrangements. To manage this confusion many overseas-trained nurses used Diaspora networks and support churches (see section 5). One NHS Trust had funded an initiative run by an overseas-trained nurse to support other overseas-trained nurses recruited to the Trust to manage this early period.

One strategy to manage the confusion and gain knowledge of how careers work in the NHS is for overseas-trained nurses to move from one NHS Trust to another to get promotion and recognition of their skills. Another strategy is to use agency work in other care homes or the NHS as a way of understanding how the system works (see section 6.4).

Care homes offer little in the way of career opportunities for the majority of overseas-trained nurses we interviewed; they generally experienced the work as professionally unchallenging. Furthermore, there appeared to be fewer grades to be promoted through to managerial positions once the overseas-trained nurse had proved themselves. However for a minority, either for financial reasons or because they found a particular home which suited them, care homes offered better pay. Indeed, one overseas-trained nurse who was manager of a care home said care homes offered better career opportunities and access to managerial positions (above the F grade) for nurses from British Black and minority ethnic groups as well as

overseas-trained nurses from BME backgrounds. Hence there are a few exceptions from the general picture.

Generally, the NHS was seen as more secure in terms of work conditions and contractual arrangements and many overseas-trained nurses had plans to develop their career in the NHS once they had obtained their PIN, often in the care home sector. They also recognised that there were opportunities to specialise in the NHS rather than care homes and, particularly for nurses trained in the Philippines who are educated to Bachelor degree level, nursing in care homes was perceived as basic care rather than nursing and therefore boring and unfulfilling. In this way, work in the NHS was generally seen by overseas-trained nurses to be more professionally fulfilling and stimulating. However, negotiating an exit from care homes to the NHS could be difficult. There is one example of a manager withholding a reference to stop or delay an overseas-trained nurse leaving for the NHS while another overseas-trained nurse related that his manager reported him to the NMC after he handed in his notice to move to the NHS. Overseas-trained nurses in care homes spoke of not wanting to be seen as wishing to move on and a fear of moving on openly because managers may resent this and overseas-trained nurses may experience backlash and less access to training opportunities while remaining in a care home.

Many overseas-trained nurses choose nursing as a career which offers choice and opportunities to support family members, although this is more frequently described by nurses from the Philippines or older African nurses who plan to only stay in the UK for a relatively short period. However overseas-trained nurses from the Philippines said their choice to train as a nurse is influenced by family decisions (both their birth families in their original choice of career and their marital families in terms of their responsibilities for their partners and children) and opportunities for travel and earning power rather than the “vocational” model prevalent in UK discourses.

Clearly, managers have a key role in disseminating information about career opportunities and promotion systems as well as providing formal and informal support to facilitate promotion. Many overseas-trained nurses commented that they lacked insider knowledge and the style of promotion in the UK was different; there was both an espoused system of competitive promotion with a need to be pushy and self-advertising and a system of sponsored promotion. Overseas-trained nurses identified a clear need for transparency in managing promotion and career progression and for ward managers to be supportive of overseas-trained nurses’ career aspirations. One overseas-trained nurse described her successful career so far in the UK as a matter of “*being in the right place at the right time*”

rather than being planned or encouraged in any systematic way. They also lacked support structures within the workplace to support their promotion (see section 5).

It appears that when it comes to promotion, managers prefer British trained nurses and overseas-trained nurses who have adapted to the British way of nursing. Thus overseas-trained nurses need to *demonstrate* an aptitude and performance which matches the British system of nursing and is therefore valued as a basis for promotion. Many informants felt that managers expect UK experience before they apply for promotion. As discussed in section 4.2, this is difficult if adaptation experiences are completed in the care home sector and overseas-trained nurses undertake care work rather than being exposed to British hospital nursing.

Many informants stated that they need a period of stabilisation and settlement perhaps in low stress work before applying for promotion even where they have experience overseas which would seem to suit them for more senior positions. They say they need a solid foundation before applying for promotion and also to avoid risking losing the PIN if they are placed in jobs with high stress and potentially less secure positions. This is particularly important given the current context of job redundancies in the NHS.

6.2 Promotion

It appears that rather than being based on merit, promotion and particularly promotion into management (grade G and above) involves navigating systems of patronage and sponsorship based on meeting subjective and culturally specific criteria, a process which facilitates racial and ethnic discrimination and entrenches marginalisation based on structural factors. Many of the informants experienced difficulties adapting to career advancement in the NHS. Some such as Ghanaians and Filipinos who were accustomed to different systems of promotion initially found it difficult to adapt to a system of promotion which at least on the surface is based on competition and merit. For example in Ghana nurses are promoted automatically after every five years of service. Whilst interviews are part of this process they are regarded as a formality as promotion is automatic rather than competitive. In the Philippines, overseas-trained nurses described a system of promotion based on one's superior approaching the nurse rather than a competitive system. It is worth noting that almost all the nurses and nursing students interviewed in Ghana had detailed knowledge of how to find work in the UK. However, none had any understanding of career structures or the process of promotion in the NHS.

Early negative experiences of the UK system of promotion tended to be attributed to socio-cultural differences and particularly communication skills rather than clinical skills. Many

experienced difficulties in performing in interviews and particularly found it difficult to use buzzwords and professional discourses to demonstrate their nursing skills. A Ghanaian midwife expressed the difficulties some Africans experience in relation to communication skills and cultural differences when contrasting her career stagnation with the success of a White colleague:

She got it (promotion) because the questions they asked and everything, it's her natural language, that's her natural expression...for the African you have to prod...because that is the way we do things, you know. So the panel who are not used to the Africans, their way of life, or mannerisms, they say that we are thick, we cannot perform. But we can perform, we've got it all here, but sometimes it's the expression to make the panel understand us or to impress them.

Female, 47 years old, Dual UK/Ghanaian, Black African, G grade, employers: NHS, arrived in UK: 1979 - DL024

The way that the informants were marginalised by these discourses indicates the discriminatory power of culture and language in nursing.

However this process of exclusion based on structural factors was further entrenched and institutionalised by a perceived lack of support from managers in addressing their specific needs as overseas trained staff. This was articulated by another midwife:

They tell us to sell ourselves, but then what are we saying to sell ourselves? What should we say to sell ourselves? (It) is our downfall because we don't know what to say and this is a time that we need help. How do you sell yourself...? We need somebody to tell us that this is how the panel want it and then we will say it because we've got it there. But it's not forthcoming.

Female, 47 years old, Dual UK/Ghanaian, Black African, G grade, employers: NHS, arrived in UK: 1979 - DL024

Moreover most informants had experienced practices and structures which they labelled as discriminatory on the basis of race or ethnicity including: access to training, quality of training and opportunities to gain experience of management through "acting up". A manager commented candidly:

Usually if you say that you are underdeveloped they will send you on a billion courses, not because they are particularly interested in helping you to get anywhere but because it seen to do something.

Local NHS stakeholder – DL025

The midwife outlined how whilst she had received some support thorough being sent to libraries and given articles on interview success there was a fundamental need to explain how to use this information:

It's not information I do not have, it's how to structure the information...how to make it sensible to me, and to understand it and to be able to deliver it in the acceptable way. That is all we need... But that is what we don't get, but that is why, especially the African group of midwives and nurses, we don't move forward.

Female, 47 years old, Dual UK/Ghanaian, Black African, G grade, employers: NHS, arrived in UK: 1979 - DL024

This marginalisation was further reinforced by what appears to be a system of sponsored promotion and patronage which takes the form of discrimination in the quality of support given to candidates in the promotion process particularly in interview preparation and feedback, whereby chosen candidates were pre-selected and coached whilst others were ignored or received inadequate or misleading support. One nurse stated:

You hear the manager or some senior member of staff call a colleague who is also going for the interview, they go to office for a long time, and they come back they are doing this (and) that ... (but) nobody even asks me... "have you prepared or is somebody helping you prepare for the interview?" No-one, no senior member of staff ever called me or asked me.

Female, 47 years old, Dual UK/Benin, Black African, F grade, employer: NHS, arrived in UK: 1988 - DL001

Similarly one midwife stated "they would call people to their offices and show them, tell them everything" whilst another claimed:

What was happening at the time was that they would help other people because I witnessed so many other things in that they would call some people.

Female, 57 years old, Dual UK/Ghanaian, Black African, F grade, employer: NHS, arrived in UK: 1977 - DL026

Whilst some informants were given some support, often after repeated requests, many claimed that this support was inferior to the support given to more favoured candidates. One midwife noted these differences:

Just before the interview I asked (the manager) if I could come for coaching, she said "no, no I may be on the panel so I won't be able to help you" so the day before the interview all she could do was just help me with how to use the projector...but the manager called my colleague to her office and rang personnel, got her an application, helped her to apply for a G grade.

Female, 56 years old, Dual UK/Ghanaian, Black African, F grade, employer: NHS, arrived in UK: 1969 - DL003

In addition to inadequate interview preparation some informants also argued that the support they received was actually counterproductive as it was misleadingly positive:

I didn't get that kind of help. I would go to them and then... present myself and ask them what they think about the issues that were going to be interviewed on and then I tell them how I think it is. I tell them my version and they tell me it is alright. So I go away thinking that what I know is alright and is enough to go through the interview. So I go to the interview I get asked the questions and I tell them what I know and then it's like I make a fool of myself.

Female, 57 years old, Dual UK/Ghanaian, Black African, F grade, employer: NHS, arrived in UK: 1977 - DL026

Overseas-trained nurses realise that they have to rely on a manager to support promotion (see Henry 2005). They talk about the politics of promotion and skills for promotion which are needed and one overseas-trained nurse used a colloquial saying from the Philippines to describe how important informal networks are for gaining promotion:

Standing around the rice cooker to get some rice to eat.

Male, 48 years old, Filipino, D grade, employer: NHS, arrived in UK: 2000 - BJ002

Another factor which overseas-trained nurses felt influenced their access to sponsored promotion was their unrecognised overseas experience and not being a local (see also, section 4). An overseas-trained nurse from New Zealand who had had a successful promotion to F grade, described how being an outsider would affect further chances of promotion:

Interviewer: Would there be opportunities for you to apply?

Not at the moment I would have thought. I don't think I'd be asked to. It would be really difficult to because of the way the unit is. There are others who've been F grades longer than me, so perhaps they're more entitled to it...I don't feel I belong here. It's okay as long as I don't speak

Female, 49 years old, New Zealand, White other, F grade, employer: NHS, arrived in UK: 1997 - CH002

Overseas-trained nurses recognise that junior members of the ward team are supported in this way and achieve promotion before them despite their previous experience and greater expertise and skills. An Australian overseas-trained nurse described how she had challenged her failed application for promotion in the light of junior local staff being promoted before her:

I think being an overseas nurse was a bit of a hindrance. Initially [on applying for F grade] I wasn't offered it. It was given to 3 other people with a lot less experience. So I resigned. I wasn't willing to stay. They said they didn't want to lose employees so they made another position for me.

Interviewer: How did that make you feel?

Pretty rotten! Rotten and angry. Given that I had the experience. They knew I could do the job. I don't know what the problem was

Female, 31 years old, Australia, White other, F grade, employer: NHS, arrived in UK: 2002 - CH005

This evidence could be dismissed as sour grapes from unsuccessful applicants, however, a remarkably similar description of the process of interview preparation was outlined by a manager:

So if I was on the interview panel I would, I might say to the person applying for the job. If I'm on the panel I won't help her to prep[are] but I will send her to my colleague, another manager. The other manager will sit with her and say "Look interview structure, usually you have to do a presentation", they will go through the presentation and say "well what do you think about the presentation? What do you think you need to put in?" and you tell them what needs to go in and they might suggest what about this and what about that. They won't tell you what to put in but they will make suggestions. They will also say you will need to act confidently. They might even do a practice interview with you. So they prepare somebody. If a manager is preparing you, you know you stand a very good chance... [but] they need to interview two or three people for it to be fair or seem to be fair

Local NHS stakeholder – DL025

Although this group of informants implied that their experiences were shared by most African, and to a lesser extent Black, nurses and midwives it should be noted that these

processes were most commonly reported in the context of promotion to grade G and above. As such they were mostly related by the midwives and experienced nurses in our sample seeking to move into managerial positions who had been in the UK for some time. A manager outlined that the system of promotion becomes less transparent and more patronage based at managerial levels:

Generally speaking when you get to G grade, if a manager tells you to apply for a G grade you will get it. Because often you will see if they are good so you will go and say to them “there is a G grade coming up apply for it”.

Local NHS stakeholder – DL025

She went on to emphasise that this form of promotion only affected managerial positions and suggested that this does not recur at lower levels:

It’s [only] once you get to management level. In one sense they start to headhunt who’s good at the job. You can tell who is good and who will do a good job generally.

Local NHS stakeholder – DL025

In this context promotion into management thus involves systems of patronage based on meeting subjective and culturally specific criteria and creates the space, legitimates or turns a blind eye to practices and creates a culture in which racial and ethnic discrimination can flourish (Henry 2006a).

Sponsored promotion presents several other specific difficulties for overseas-trained nurses.

1. It is difficult to gain sponsorship if not a local and not aware of a system of patronage which is masked in a veneer of meritocracy.
2. Nurses are excluded if their social and communication skills are not accepted by UK nurses, HCAs and managers.
3. Overseas-trained nurses are recognised by UK staff as “fitting in” and approached for promotion, yet “fitting in” is itself a difficult skill and process. The key skills identified by overseas-trained nurses as essential to obtaining promotion are assertiveness and communication skills.
4. Overseas-trained nurses may not recognise the British system of patronage and think promotion is same as country of origin which can be incremental and time related. This can lead to withdrawal and apathy

6.3 Communication skills

The need for the presentation of self in established mainstream ways is key to being successful in obtaining promotion. Included in this is the role of communication and being seen to “fit in” and the need of being recognised for promotion is not underestimated by overseas-trained nurses. This is clearly described by this Filipino nurse:

Interviewer: What do you see as a barrier to getting promotion in the UK?

Probably one is communication. Sometimes they don't understand or I don't understand them. But lately, probably adjusting and I'm already adjusted. And one thing is discrimination. I can see that the sisters, we work very hard and they like us. One of us actually is promoted already.

Interviewer: She's an E grade?

Yes. And another one is applying, as there's a post now, 2 E's. I didn't apply, but another Filipino nurse did. They're asking why I haven't applied.

Interviewer: Do you think there is discrimination then?

Of course they prefer the White ones probably, as number one is their confidence. Communication wise they don't have any problem, more communication and confidence

Female, 37 years old, Filipino, D grade, employer: NHS, arrived in UK: 2000 - BH007

Other barriers to promotion mentioned by overseas-trained nurses were the potential effects that Agenda for Change may have on the entrenched system of sponsored promotion. It may make it more difficult for outsiders like overseas-trained nurses because it relies on the clinical manager deciding on the promotion to a higher band. One ON described this as “kissing arse” for promotion. Another barrier was a perceived quota of grades available in any ward:

Interviewer: Do you think there are any barriers to promotion within the Trust?

In an area, you are experienced or other, there's no available British position for a grade E, then you will not be promoted. If you want to be promoted, you have to look for any other ward without a grade E.

Female, 36 years old, Filipino, D grade, employer: NHS, arrived in UK: 2003 - BH001

Or as a key national stakeholder expressed it, midwives who get promotion quickest will be:

Those that bullshit the best

National stakeholder – DL

Another overseas-trained nurse from the Philippines described how she felt there were quotas of positions at different grades and “no free space prevents progression of qualified staff”. She argued there was a need for these informal processes to be transparent.

Managers may block promotion within the NHS and not just in the move between the care sector and the NHS. As referred to above, one overseas-trained nurse cites his manager threatening a poor reference when he wished to transfer to another NHS post at E grade (see further discussion of how these points relate to complaints and mistakes in section 7). Even more threatening to personal security than these examples is Alexis at al's argument (under review) that there are cultures of fear which operate within the NHS and care home sector around managers' threats to overseas -trained nurses' employment status as migrant workers. These threats may involve a confiscation of passports and, in two cases in our sample, an Indian and an African nurse ended up homeless and unemployed through the actions of their

care home employers. They were saved from homelessness in one case through a Church network offering free accommodation and emotional support and, in the other, through the actions of an independent charity hospital who employed the nurse as a care assistant and gave her free accommodation.

6.4 Finding ways to overcome or get around barriers

During the interviews some overseas-trained nurses described how they had been able to find various ways to overcome the obstacles they faced in terms of career progression.

One such example was a Nigerian nurse who had been placed by the recruitment agency in a nursing home for the elderly, but was determined to use and further develop his extensive psychiatric experience by obtaining employment in an NHS psychiatric ward. At his first job interview he was rejected, as he was unfamiliar with the clinical vocabulary and practices he was questioned about (as the adaptation in the care home had not prepared him for using his specialist skills in the UK – see section 4). But he wrote down the questions asked by the interview panel and afterwards used the library and internet to seek further knowledge. After a number of unsuccessful interviews, but useful information gathering, he had gained sufficient knowledge to then understand and correctly answer the questions he was asked during the job interview, and he was offered the job he sought.

Other ways of developing competence and overcoming the insufficient adaptation in a care home was to take agency jobs as a nurse in the NHS. This allowed exposure to British nursing in NHS wards and thereby provided an informal opportunity for the overseas-trained nurses to develop knowledge, skills and familiarity with the practices and vocabulary relevant to various specialist areas. This involved either a learn-as-you-go-along approach or dependency on colleagues who were willing to introduce the agency nurse to the practices. As this nurse explained:

Interviewer: Have you applied for any jobs?

No, I'm still looking.

Interviewer: So you haven't...?

Because I got a bit mixed up with agency, since I've been going to different... you know it's an eye opener as well, I've been considering and reconsidering which area is best for me. Because it's like I go to this unit that's developing another interest so it's like I'm still going round to decide which department I would like.

Interviewer: So by doing agency work you also can kind of scope the area and learn different things and get a better idea?

Yes, and seeing which department I would fit best in [to].

Female, 37 years old, Zambian, Black African, D grade, employer: nursing home, arrived in UK: 2003 - BJ003

Apart from doing agency work to find an attractive specialist practice ward, it also allowed the overseas-trained nurse to find a work environment with a good atmosphere and friendly colleagues. This was particularly important to a Zimbabwean nurse who felt strongly affected by discrimination in the previous and present workplace, as this exchange illustrates:

Interviewer: Where do you see yourself in 1 year?

I get the feeling I want to change from this ward, but come to think of it, I've got areas where now I've had exposure of the trust, areas through the agency we use on the trust. I've got some areas which I think may be I could try this. Like I said, trying to, getting used to different people again.

Interviewer: You said that you do only agency work in different hospitals?

Yes, we have our agency in [named NHS hospital]. You can pick up a shift in any area. I think I've picked up all areas apart from ITU.

Interviewer: You don't want to do agency within your own work environment?

No, if I'm doing agency I always want to do it at different hospitals. Just as an exposure to different hospitals as well.

Interviewer: By doing this you get some better ideas of how they work differently in different places?

I've been doing it for a while now, I think I know all of them.

Interviewer: That might help you to think about where you would like...

Where I want to go.

...

Interviewer: By doing agency work does that allow you sufficient idea of how they do things differently in different areas?

Yes, it does.

Interviewer: So that maybe gives you opportunities and confidence in, you know, how things are done in different areas?

Exactly, you know how things are done, you know how support workers are, how staff nurses are in different areas. You cannot sit and compare and say if you go to such and such a ward it will be done like this. We know why people do things this way because they want an advantage over such and such issue. But for someone who's coming straight from wherever, trying to adapt to stay in the UK, I tell you, it's not easy, it's tough.

Female, 48 years old, Zimbabwean, Black African, D grade, employer: NHS, arrived in UK: 2000 - BJ008

Other nurses talked about how they tried to find their way out of dead-end jobs where there were no opportunities for career progression. This could be the case in a small private or independent workplace where there were not many senior posts available, or where there did not seem to be a likelihood that any of the senior posts would be vacated in the foreseeable future. In such situations some nurses sought positions that might not in themselves be a promotion, but would place them in a new work environment with better career prospects. Such horizontal career moves could also involve considerations about the general living and attitudes as they might relate to specific regions in the UK. For example, some preferred London due to its multi-cultural character and the urban lifestyle, others avoided it for reasons to do either with high costs of living or a preference for living in a less densely populated area. Particularly doctors mentioned that areas outside London were more attractive as there was less competition for training places.

A similar approach is that of “acclimatisation” when the overseas-trained nurse chose to stay in a less demanding work role for a while in order to allow time to get accustomed to the different way of living and working in the UK. As we have seen, lots of new impressions, practices and requests are placed on the newly arrived nurse, and our data suggest that two to three years are typically required for the nurse in order to feel more secure and develop the energy and confidence to seek career progression. The length of time required for this was strongly associated with the degree of familiarity or unfamiliarity the overseas-trained nurse experienced with regard to general life, language and nursing practice in the UK. One NHS manager pointed out that nurses from Australia or New Zealand would generally “hit the ground running”. While this supports our finding that cultural familiarity and “fitting in” was important, also nurses from Australia and New Zealand described difficulties with being accepted and recognised by British colleagues, as discussed in section 5.

7 Complaints and grievances: social power and visibility

In this section we address the issue of complaints over clinical malpractice raised against overseas-trained nurses as well as the complaints or grievances that overseas-trained nurses may or may not raise over either being complained about or their experiences of discrimination in day-to-day social interaction (see section 5) or, more specifically, in respect to promotion (see section 6). Although these may be seen as diverse issues, our findings suggest that they are similar in the sense that they all concern the problem of identifying and formally articulating a happening as a specific type of socially meaningful event, i.e. a case of “clinical malpractice” or “discrimination”. This is not a simple and straightforward process, but involves a subjective judgement and a complex social process of presenting and making the case for the formal and legal accusation, which it is then becoming. This makes evident issues of social power and the practical limitation of formal complaints procedures in dealing effectively with injustice. In this section we illuminate this complexity and demonstrate the crucial points of social negotiation, which, our data suggest, open up possibilities for identifying good practice in dealing informally and effectively with the issues before they escalate into formal complaints and legal procedures.

7.1 Complaints and mistakes

Our data provide findings on complaints about clinical mistakes (including interpersonal aspects of nursing practice) which raise particular concerns. Its importance is underlined by the statistical over-representation of overseas-trained nurses involved in reports of malpractice, as reported by the representative interviewed from the Nursing and Midwifery Council (see section 4). This fact may partly reflect poor quality of the adaptation process (discussed in section 4), but interviews with overseas-trained nurses suggest that also other issues are involved. Most notably, these have to do with insufficient diversity awareness and a lack of recognition of non-British healthcare practices, problems with overseas-trained nurses’ status and authority in respect to colleagues (particularly HCAs), and insufficient support from clinical managers (Sisters and care home managers). After discussing how mistakes are identified or socially constructed we go on to explore social and institutional processes of how complaints are raised and formalised in the workplace and eventually formally reported to the NMC.

Across-case analysis of the data in our sample identified 17 overseas-trained nurses who described personal experiences of having complaints raised against them, and another five spoke about complaints raised against overseas-trained colleagues. Notably, all those who described experiences with complaints over their clinical practice were non-White, suggesting racial discrimination as a potential aspect of the problem.¹ Importantly, managers described

complaints as based on perceived “poor” interpersonal and communication skills as well as perceived mistakes based on clinical differences in practice. Very few managers analysed why the latter were labelled as mistakes and from overseas-trained nurses’ accounts, little leeway was given to exploring how communication difficulties arose; instead blame was apportioned to the overseas-trained nurse.

As discussed in section 4 there is a tendency for British healthcare staff and managers to perceive current British nursing practice as the only correct nursing practice, reflecting an ethnocentric outlook and lacking diversity awareness. Our findings demonstrate how this perception is materialised in a tendency to misperceive overseas-acquired nursing practice as a “clinical mistake”. A Ghanaian nurse gave an example:

... a student [overseas-trained nurse doing adaptation] forget to put stockings on a resident, it becomes a very big issue whether the student is really capable of being a nurse and I am like... “in Africa we don’t put on stockings, it’s a cultural thing”, so people should understand this has nothing to do with nursing skills and that is what I mean, that is an example, because I remember that very well and it was even a gentleman from Mauritius, and it was later when I talked, I like to understand why people behave, so I remember when I was talking with him “why do you keep forgetting to put on Mrs x’s stockings when you are helping to dress her?” and he said “do you know what, in my country men do not dress women, so even as a nurse in my country I wouldn’t nurse a woman, I would nurse a male and then we don’t wear these stockings, so I don’t even know how I have been taught by other carers and student nurses [inaudible/strong accent]”. But the way it was handled!

Interviewer: How was it handled?

They made him feel that he wasn’t adequate, he wasn’t competent to be a nurse, that is what I didn’t like, and it wasn’t a nursing issue, it was to do with culture and not knowing.

Female, 48 years old, Ghanaian, Black African, Home manager, employer: nursing home, arrived in UK: 2000 - BJ009

While poor adaptation and lack of appreciation of different cultural values and healthcare practices may present their own challenges, other aspects become visible as we un-pick the complaints procedure. Raising a formal complaint of malpractice is not a straightforward response to an objective identification of a clinical mistake, but involves a multi-layered and complex social process of assessment and negotiation. It is our suggestion that a very significant reason for the over-reporting of overseas-trained nurses is to be found in the nature of this process, and the relative lack of power and status overseas-trained staff experience as employees in the British healthcare sector.

The process starts with the allegation of a clinical mistake. The majority of narratives about complaints in our data came from care homes where typically HCAs would complain about overseas-trained nurses to the manager in situations where the overseas-trained nurse had different expectations of practice and experiences to HCAs and had been unable to exert

her/his authority over HCAs. The following quote describes a situation where an overseas-trained nurse and another overseas colleague had had a complaint made about them to the care home manager by the HCAs on the night shift. She had resolved this situation by joining the Royal College of Nursing (RCN) and the manager had backed down and withdrawn the threatened report of malpractice to the NMC:

Precisely because we didn't understand the systems and ways of British nursing and we should fit in. We had no orientation because we had no waiting for our PINs. So we had to get on and we didn't know. Yes, it was a shock. Not knowing, and they said no it's the first time as even on the interview we were not told anything. We've never worked in a nursing home so we don't know what's happening there, but we needed to be orientated, so there was no proper orientation. Until things had to happen, then they started to feel bad. But they told stories, the health care assistants saying things that you had never done and there was a lot. The RCN I was obliged to join at the end then, I did get help from them.
Female, 56 years old, South African, Black African, D grade, employer: care home, arrived in UK: 2001 - AH015

This quote is typical as it reports difficulties in the interpersonal relationship with colleagues, based on being an “outsider” both in terms of being foreign, of a different ethnicity and having trained overseas. However, it was also atypical as the nurse was able to resist the complaint through assertiveness and support from the union. A Filipino nurse working in the NHS described how complaints can be related to the way overseas-trained nurses are seen by British colleagues as an outsider group to be talked or gossiped about:

... the British nurses are sometimes on night shift, but whenever they are on night shift there are no complaints, but when the Filipino nurses are on there is always one complaint that will come up.

Interviewer: Why is that?

Because we mind ourselves Filipinos, maybe they just need somebody to talk about, they are bored. They are bored, the atmosphere is boring, there is nothing to talk about except for other people.

Male, 34 years old, Filipino, E grade, employer: NHS, arrived in UK: 2002 - BJ007

Perhaps more importantly, it was his experience that observations of mistakes would only be formalised by being put into writing if it was a non-British nurse who was involved:

Interviewer: ... have you observed any difference in terms of that way of bad communication towards you and other overseas nurses compared to British nurses?

They won't put it in writing if it's the British.

Interviewer: Why is that?

God knows.

Interviewer: So that's quite a blunt difference?

Yes.

Male, 34 years old, Filipino, E grade, employer: NHS, arrived in UK: 2002 - BJ007

As discussed in section 5 overseas-trained nurses at times found particular problems interacting with more junior colleagues, in the care homes typically HCAs, who could appear unwilling to accept the senior authority of the overseas-trained nurse. Similar difficulties

could arise in the NHS between a British enrolled nurse and an overseas-trained degree nurse, as this Filipino nurse explained:

... I was working with this nurse and she made things worse, matters worse for me, she's an enrolled nurse and I don't know if you can appreciate the enrolled nurse phenomena here with Filipino nurses, that they don't want to be below the Filipino nurses, kind of thing. Anyway, an incident that happened in the nursing home where one resident had to be brought to the hospital, and overnight I did not see the need for her to be brought to the hospital and eventually in the morning they found out the problem and accused me of neglecting the resident. It's a rampant situation you don't know right away what's happened, but this enrolled nurse dug into to it in great detail, encouraged the relatives to file a complaint just to get rid of me because we weren't getting on well.

Male, 29 years old, Filipino, E grade, employer: NHS, arrived in UK: 1999 - BJ005

When working in care homes overseas-trained nurses described how they felt that HCAs went “behind their back” and undermined their authority by reporting directly to the care home manager or another (typically British) nurse. A South African nurse described how this situation was so unpleasant that it almost made her go back only a few months after she had arrived in the UK:

... I started in January, in May I nearly packed my bags and went back home.

Interviewer: And why was that?

It was terrible. People...you know, like I'm saying, we've got different cultures, speak differently so people didn't understand me, so the carers used to, every day they used to go and report me to the managers office. You know every time when I come on duty I'm supposed to go to the office first. It was sad this and... argh!... and then I said “this is too much!”. But I decided to settle everything on my own because I could feel that this was just going on and on and on, so I just called all the carers and said to them “I think we have to come to a compromise here, we should understand each other, we should tolerate each other. I'm from a different culture, from a different country. So I think if you know the thing like I want a person a do, if I do something to you, say it to me at that time, don't go behind my back and tell somebody else that “[interviewee's name] has done this, [interviewee's name] has said this”. I don't like that thing”, so I told them. Everything is smooth now [LAUGHTER]

Interviewer: So that helped?

Yeah

Interviewer: Helped clear the air?

Yeah it did, I was never called to the office again [LAUGHTER]

Interviewer: Did they all come to you then if they had an issue?

Yeah, they started understanding me because... I don't know, I've got a very stern face. When you first see me you say “oh, I don't think I can approach” and yet when you start talking to me it's then that you notice, “oh, it's just her face, there nothing wrong with her” [LAUGHTER] “she's a barking dog without teeth!”

Female, 49 years old, South African, Black African, D grade, employer: nursing home, arrived in UK: 2002 - BJ001

However, overseas-trained nurses are not always able or allowed to resolve conflicts by addressing them head-on, and assertively re-negotiating the practices of social interaction. In such situations the clinical manager plays a key role in determining how the conflict is resolved. The ways that complaints and mistakes are resolved by clinical and trust or care

home managers can be a litmus test of their true attitude to overseas-trained staff. It is easy to pay lip service to equal opportunities when there are no problems. However, the Ghanaian case study revealed a perception that when overseas-trained staff needed support from managers in complaints procedures they were often further discriminated against. Other informants also reported that this was often, although not always, the case. The Filipino nurse quoted earlier described how the Sisters, instead of critically investigating complaints raised against overseas-trained nurses, tended to participate in this formalising of mistakes – making them visible and “an issue”:

... what I'm concerned about is when they bring it up to the Sisters and the Sisters don't stop them from... they don't want them...they don't say "that can't be right, I will talk to the person concerned" whoever, they would go to the point of writing a memo or writing other communication which shouldn't happen because its just stirring things up.

Male, 34 years old, Filipino, E grade, employer: NHS, arrived in UK: 2002 - BJ007

In addition to receiving *more* complaints than White and UK-trained staff, the overseas-trained staff believed that complaints against them and mistakes they made were *perceived* and *treated* differently. The differences in the management of mistakes and complaints against Black and White staff highlight what could be termed the racialisation of the mistakes and complaints procedures. This racialisation took three key forms:

1. Minor mistakes involving overseas-trained staff are over-reported whereas these minor mistakes performed by British nurses and midwives tended to go unnoticed.
2. Some Ghanaian informants argued that mistakes made by Black staff were treated far more harshly by clinical and trust managers than those made by White staff. They argued that when White staff made mistakes they were usually resolved in a blame free manner whereas when Black staff made mistakes they were punished.
3. Clinical mistakes tended to be blamed on or referred to “inferior” foreign training, reflecting xenophobic notions and an ethnocentric idealisation of British training and practice.

The next step in raising a complaint after the identification and informing the manager is to formally report it as an issue of malpractice to the NMC. When it reaches this stage, it proves that the social negotiation and attempts at resolving the problem at the level of the workplace have failed – or they have not even been attempted. As the earlier quote illustrated, it is at this stage that the overseas-trained nurse can make good use of legal support and advice from a professional or trades union body (RCN or Unison). It appears that the authorities at times are able to identify when complaints are raised due to interpersonal issues, as this Nigerian nurse described:

There was a time they [employers in care home] sent a letter to the health authority, unfounded allegations. The reply came and they said “these are internal things, not professional”.

Male, 50 years old, Nigerian, Black African, F grade, employer: NHS, arrived in UK: 1996 - CJ003

Some nurses, who during employment in care homes had experienced complaints raised against them over alleged clinical mistakes, described how they sought to get out of the situation by negotiating with the manager to secure a positive reference and seek employment elsewhere. This may have been before a formal complaint of malpractice was raised with the NMC. Without the positive reference overseas-trained nurses feared that it might be impossible to find a new job and they would have to leave the UK when the work visa expired – or stay in the country illegally, being even more vulnerable to exploitation as any legal rights would vanish.

7.2 Grievances

Although the interviewed overseas-trained nurses frequently reported having experienced discrimination or unfair treatment (as discussed above with regards to reports of clinical malpractice and promotion), in our data there are only six examples of actual confrontation and challenge through official channels. This is important, as senior healthcare managers emphasised that these formal complaint and grievances procedures safeguard against maltreatment, discrimination and unfair practices in the organisation.

Our data offer suggestions as to why these formal structures are seldom used by overseas-trained nurses. In the rare situations where they were used, it was characteristic that the overseas-trained nurses were self-confident and drew on support from their private lives in the form of strong religious belief or a British partner who encouraged the need to insist on citizen legal rights. It was also characteristic that they were directly supported by the professional (RCN) or trades union organisation (Unison), as mentioned above. Three overseas-trained nurses had gone through a full complaints and grievances process: A Filipino nurse successfully complained over unfair treatment and, as a result, was moved to another Ward, but with no compensation. A mixed race Australian (CH005) complained that investigation of her conduct was harassment, and having won her case the investigation was stopped. An Irish nurse (LP178) took out grievances over not having been promoted; she won the case and was promoted as a result. Three other overseas-trained nurses described that they had been reported for malpractice by their care homes employers, but that the employer had not taken further action as the RCN had intervened on their behalf.

During the interviews a further two nurses explained that they were planning to complain to the RCN over their employers. A Zimbabwean nurse (CP001) felt that the manager had bypassed her for promotion and that the manager instead was recruiting from a hospital where she had worked previously (highlighting the issues of favouritism, discussed in section 8). A Filipino nurse (CJ039) had experienced being assaulted by a patient and felt that his colleagues and managers had not provided sufficient support and assistance for him, so he was considering taking forward grievances and a request for compensation.

More usually, however, overseas-trained nurses described how they felt powerless when confronted with unfair treatment and discrimination, as they didn't know their rights or felt unable to exercise them. This Nigerian nurse described the experience at the time of doing adaptation in a care home:

It was painful. The adaptation was a painful time for me.

Interviewer: What made you stay?

I didn't know my rights at that time. If I know my rights no one could treat me like that. I don't know my rights, I don't know anybody.

Interviewer: So you felt isolated at that time?

Yes. I felt like there was nowhere for me to go. It is true! ...[describing the routine of the care home].

Interviewer: None of that had been made clear to you at the adaptation?

No, I wasn't told anything. There was a time where you sit and think "why did I leave my country?"

Interviewer: Did you contact the agency at that time to talk to them about it?

Who am I! If you make a complaint, you are extending your adaptation period.

Interviewer: That was the feeling you had?

That was the feeling. I didn't know my rights [so] I couldn't have said so [make a complaint].

Male, 42 years old, Nigerian, Black African, E grade, employer: NHS, arrived in UK: 2001 - CJ032

Aside from the problems of the lack of knowledge and social isolation, the legal and professional rights of overseas-trained nurses, particularly when newly arrived, are undermined by the power imbalance between themselves, managers and UK staff due to the inherent threat of removal of residency rights. Therefore, having no formal status of "leave to remain", overseas-trained nurses generally chose not to confront the employer by challenging a complaint over clinical mistakes or raising grievances over their treatment. In this situation overseas-trained nurses generally sought to "keep their heads down" or, as quickly as possible, to get away from such exploitative and destructive employment and social situations.

However, even with residency rights or citizenship and apparently robust formal grievance procedures there are a range of reasons why overseas-trained nurses avoided using these procedures. Our data illuminate how the effectiveness of grievance procedures was

undermined by the degree of autonomy exercised by line managers and the nature of the power relationships that operate on the wards, as informants did not want to be labelled as troublemakers or further damage their working relationships with colleagues and managers (see also, Henry 2006a). One Ghanaian midwife explained:

We are afraid to make noise. That is what a lot of the Black and ethnic minority staff are going through because they will be victimised... you will be victimised in such a way that nothing will move on for you. You will be noted as a trouble-maker and because of that people would rather suffer in silence [and] get their daily bread... we are not only looking after ourselves and our immediate dependents, we also have an extended family and we need to view that, who needs an enemy at your job place.

Female, 47 years old, Dual UK/Ghanaian, Black African, GP, employer: NHS, arrived in UK: 2001 - DL024

Similarly, a manager in a NHS trust summarised her experience from working with supporting overseas-nurses:

... the majority of staff don't like to complain, because they feel that it would jeopardise their standing on that ward and their job. So a lot of staff, although there can be a lot of memories about harassment, bullying, racism, they don't like to come out and stand up and complain about it. I think that most people would prefer to either find another ward to work on in the trust or, as I said, they just leave the trust. But I have only known a very few that have actually left the trust, but I know of some nurses who have gone to other wards.

Female, 46 years old, Black British, manager - LJ002

This response to avoiding using formal procedures to confront malpractice is vindicated to a certain extent when one considers that at least two of the six nurses who used these official channels subsequently reported being victimised as a result of using the grievance procedures. Overseas-trained nurses feared that direct confrontation through formal grievance procedures would only add further negative attention to their person, and, in any case, not be seen to promote their future career prospects in the organisation.

This finding is significant, as it challenges the perception that formal or legal procedures for equal opportunities, anti-discrimination and fair treatment can protect individual workers effectively. Our data suggest that it is only in rare and extreme cases that overseas-trained staff will make use of such procedures, and that informal practices are far more effective in protecting against and responding to instances of injustice. The clinical managers, that is, in the NHS, the ward managers (Sisters) and in the private care home sector, the home managers (or matrons), are key to these procedures, as they are in positions to deal with the issues before they become either silenced or escalate into a formal complaint. In the next section we will look more closely at the different ways in which individual nurses respond to the challenges they face.

8 Responses to discrimination: resisting and entrenching marginalisation

This section highlights the importance of individual agency in determining the outcomes of racial discrimination. We explore how some nurses' responses to perceived discrimination entrench the marginalisation and exclusion of those affected whilst others act as forms of resistance and enable career progression. The type of response will depend both on the type of discrimination they are confronted with, their individual employment circumstances and their personal biographies and current social situations.

Subject to social marginalisation by colleagues, overseas-trained nurses applied strategies of either "sticking it out" or more assertively "seeking greener pastures" elsewhere. The former is related to the uncertainty they mention regarding their status in the country and the lack of information and knowledge about rights and opportunities. This strategy may seem the only viable option to the overseas-trained nurse who is socially isolated and has found no alternative ways of getting sufficient advice and support (see below). Others described how they had fought to get out of their situations either aided by others or, in more unique cases, through impressive individual struggles and strategies.

8.1 Disengagement

For many nurses and midwives the discriminatory processes outlined above have led to career stagnation whereby they remained on the same grade for years whilst regularly applying for promotion and consistently failing without being given adequate explanation and without receiving any meaningful support from their clinical managers (see section 6). One midwife outlined her frustrations:

While I was (acting up) I went for an interview for the proper job. I didn't get it. The following year I went, I didn't get it. The following year I went, I didn't get it and then the fourth time I was I was doing this, I was in charge of the unit department, and I went the fourth time and I didn't get it. So I got frozen...I felt that I wasn't getting any help. I was working but I wasn't getting any help, I got so frustrated... I'm so hurt and I'm so painful you know I'm grieving. It's like I'm good, I'm doing my work well, I'm good at what I do, but it seems I'm marking time I'm not moving forward.

Female, 47 years old, Dual UK/Ghanaian, Black African, GP, employer: NHS, arrived in UK: 2001 - DL024

Many of the Ghanaian nurses and midwives contrasted their stagnation and lack of career progression with a perception that in promotion managers favoured White or African Caribbean nurses over Africans and that consequently these ethnic groups are promoted far more quickly. Thus many nurses and midwives experienced long periods of career stagnation and under-achievement caused by what they believed to be endemic racial or ethnic

discrimination and reinforced by a perception of a lack of support or interest from managers. As a reaction to repeated failure to progress many informants become alienated from their workplace and managers and many became deeply demoralised (see also, Henry 2005, 2006a, b, c; Larsen 2005a, b). To shield themselves from what they saw as a humiliating process, they disengaged from career progression and adopted what appears to be an increasingly instrumental attitude to their professional life. This is evident in the following comment from a grade F midwife:

I'm really fed up and I've just (click of finger) [LAUGHTER] don't want to know anymore, I think I will just be where I am, just get my money to pay mortgage and that's the attitude, which is bad but at the end of the day I don't know probably I feel I can't get anywhere anymore. There was a time I just felt so de-motivated I just couldn't be bothered, honestly. I just didn't even want to go on any course or anything because I felt I can't get any further so why should I bother.

Female, 56 years old, Dual UK/Ghanaian, Black African, F grade, employer: NHS, arrived in UK: 1969 - DL003

She continued:

I don't think my face fits so I won't even bother because when you go for interviews and you don't get it its really depressing, it demoralises you and me in particular, it takes months to overcome it.

Female, 56 years old, Dual UK/Ghanaian, Black African, F grade, employer: NHS, arrived in UK: 1969 - DL003

In this process of demoralisation and alienation the traumas and frustration engendered by past and ongoing discrimination have become internalised by the victims who now seek to avoid exposing themselves to further humiliation. One midwife stated:

I'm used for everything but yet without having to go up or anybody taking an interest in my welfare to see to my development so I just feel for four years, for four years I didn't even want to hear the word interview, each time I heard interview I panicked.

Female, 47 years old, Dual UK/Ghanaian, Black African, GP, employer: NHS, arrived in UK: 2001 - DL024

This disengagement from career progression and career development included stopping applying for jobs and promotion, not updating their skills and avoiding responsibility. Thus after years of perceived discrimination and exploitation many nurses and midwives simply give up on career progression. This is evident in the following quotes:

Even they said I was nearly there in the first one and the second time and the third time I didn't get I thought god, this is ... so I've now given up ... I find interviews really stressful [LAUGHTER] I just don't want to know. (I've) tried for all these years, you know, since this grading and I've applied for G grades so many times but I don't get it so I've given up

Female, 56 years old, Dual UK/Ghanaian, Black African, F grade, employer: NHS, arrived in UK: 1969 - DL003

I've just lost interest ... I just work and come home...(when) I was young, very enthusiastic and, you know, always there. I didn't get anywhere so now... I just feel that I don't want to stress myself that's the attitude to be honest.

Female, 47 years old, Dual UK/Benin, Black African, F grade, employer: NHS, arrived in UK: 1988 - DL001

A manager outlined how many Black minority ethnic staff disengaged from promotion:

They won't apply for senior posts because they think there is no point even though there are a huge amount of Black African and Afro-Caribbean midwives. If you look pan London, there is one Black head of midwifery. You get areas like...where nearly every single midwife is Black and the head of midwifery is White. In...99% of midwives are Black! The head of midwifery is Asian. You rarely see an Asian midwife ... You see that a lot so the Black girls don't bother, they just earn the money and go home.

Local NHS Stakeholder - DL025

It is important to note that these responses should not be regarded as static. Many informants talked about moving on from periods of stagnation and disengagement to assertiveness. For example a Ghanaian midwifery manager stated:

People haven't been bold enough to go forward for a post because they have felt "what's the point, they won't give it to me anyway" so they don't go. And certainly before I became a sister I was like that. I wouldn't go for a sisters post I thought "why should I waste my time?" that was my attitude. Because I have learnt from past experience and I think that people are still doing that.

Female, 56 years old, Ghanaian, Black African, Matron, employer: NHS, arrived in UK: 1968 - DL021

8.2 Narratives of discrimination

The Ghanaian case study indicates that these responses have the potential to become self-sustaining and self-fulfilling collective narratives of racial and ethnic discrimination and exclusion based on an interplay of race, ethnicity and nationality (Henry 2006a, b). They are based on a perception that, as ethnic and racial discrimination are endemic in the NHS, career stagnation and other forms of discrimination are largely a result of Africans being at the bottom of a racial and ethnic hierarchy within the NHS. Critically, these narratives have material effects as they affect behaviour and responses to a range of situations and relationships in the workplace. They can become a lens through which all experiences in the workplace, especially negative ones, are interpreted. This operates as a form of racism that exists within the mind of the victim and affects attitudes, behaviour and ultimately social structures. Furthermore it can become self-sustaining, and when taken in conjunction with the process of alienation, demoralisation and disengagement the narrative can be self-fulfilling. In institutions where career progression lacks transparency and where Black and especially African staff routinely underachieve, the most obvious explanation for negative experiences is systematic racial and/or ethnic discrimination. In this process negative experiences are automatically racialised by the victims – i.e. they are perceived as racial or ethnic discrimination, as racism can become a lens through which people interpret events in the workplace.

The power of this narrative to shape responses to negative experiences has several further implications.

1. Most obviously by focusing almost exclusively on discrimination it can lead to overlooking alternative non-discriminatory explanations, such as poor or under-resourced management or indeed a lack of skills or other deficiencies on the part of the nurse.
2. By automatically ascribing a racial or ethnic motivation to a wide range of discriminatory behaviour it also obscures other non-racial motivations for discriminatory practices, such as favouritism.

These racialising narratives are a reflection of the powerlessness of certain sections of nursing, who lack the confidence and cultural skills to challenge racialised explanations. They also indicate of a lack of appropriate support networks and inadequate institutional support in developing the cultural awareness and confidence of staff. In the context of poor and partial support from managers the adoption of these narratives to explain all negative experiences can become part of a process of collective denial on the part of managers and staff whereby other serious underlying problems related to clinical performance or interpersonal skills are not addressed by managers or staff. It is easier for managers to do nothing, and in this environment it is easier for nurses to blame race rather than examine their own skills and competences, particularly if their experience tells them that they will receive only limited and partial support in addressing these issues.

The interpretations of shared negative experiences as discrimination can become self-sustaining particularly in the context of very little evidence supporting alternative explanations. It can then feed back into forms of alienation and demoralization. It appears that a significant group of African nurses and midwives share this interpretation of their situation in the workplace. Due to the history of perceived racism they expect to be met with racism, become alienated and demoralized, therefore do not apply for posts and their marginalization as a group and individuals is entrenched as the narrative becomes increasingly self-fulfilling

8.3 Deracialising discourses

Above we have discussed how responses to structures and practices of discrimination can intensify the effects of discrimination. However, many informants have also indicated coping strategies and ways of resisting discrimination which illustrate the importance of individual agency and responses to discrimination and racism in determining outcomes.

Most of the African and African Caribbean nurses and midwives who have been promoted into managerial positions emphasised the importance of not labelling every negative experience and incident as racially motivated discrimination. Our data also showed evidence of how a deracialising discourse can be used actively by nurses as they plan their career and set themselves up for promotion or job interviews. A Nigerian nurse gave a vivid explanation of how it challenges and rejects the notion of self as a victim:

If you come into [a] room yourself, nobody can discriminate against you. That is one thing I realised. So I don't count on it. ...Because you'd be depressed. Because whatever they do, even if it is not discrimination, you would think "oh God, that again!". You understand, kind of misinterpretation of peoples' actions, and you would just be rejected every time.

Male, 50 years old, Nigerian, Black African, F grade, employer: NHS, arrived in UK: 1996 - CJ003

In this sense the deracialising discourse is in direct opposition to the narratives of discrimination, as described above. The nurse quoted was aware of the entrenching effects of the narrative and actively avoided it by saying to himself that “*nobody can discriminate against you*” – as discrimination, in this sense, is in the mind. This does not mean to deny the social reality of discrimination, but it specially targets the harmful and entrenching effect that the narratives of discrimination may have by making the person feel victimised and disengage from having career ambitions.

However the process we call “deracialisation” is complex and covers a wide range of responses. It can take various forms including perceptions that racism does not affect them or that racism can be resisted through ignoring it or humour. The approach that we will focus on involves when nurses assess negative situations and determine firstly whether they are discriminatory and secondly the extent to which discrimination is racially or ethnically motivated. This involves an appreciation that there are layers of discrimination in the workplace and that not all are racial. One successful African Caribbean manager stated:

I'm diplomatic. When I see my other Black colleagues now below me. Those who I think will listen to me I say to them look learn to play the game. Don't bring everything down to race. Even if you think it is because of race don't say it. Find another way to say it. Don't bring everything down to the race card. Don't take offence all the time because you're Black. Even if you feel that's what it is play the game otherwise you won't go anywhere.

Local NHS Stakeholder - DL025

These deracialising approaches are a form of assertiveness which involves challenging behaviour and practices of colleagues and managers. As such they require several basic prerequisites. Firstly they require confidence and an enabling environment to challenge negative experiences. Critically, they require cultural skills including the ability to understand local, organisational and professional cultures and discourses in order to differentiate between

different forms of discrimination and to determine the extent to which racism or other factors best explain behaviour and practices. This is expressed in the comments of a Ghanaian district nurse:

I don't dwell on negatives. I don't look at myself because I'm Black they have done this. If anything should happen I'll find out why they're doing it most of the time they'll tell you. If I can change it or make it better I will.

Female, 40 years old, Dual UK/Ghanaian, Black African, G grade, employer: NHS, arrived in UK: 1989 - DL055

Different ethnic groups will have varying abilities to do this related to their cultural proximity to the dominant cultures in nursing and their length of time in the UK. For example this will be easier for overseas-trained nurses who broadly share contemporary Western or Anglo Saxon culture (that is, overseas-trained nurses from e.g. Australia or New Zealand). Equally, the Ghanaian case study and interviews with African-Caribbeans suggested that African-Caribbeans are in an advantageous position in comparison with Africans as they are perceived to be culturally closer and more familiar with the dominant British norms, values and behaviours.

8.4 Playing the game

Indirect discrimination is also responded to in different ways. Some struggle to “adapt” or “fit in” by trying to learn to change their behaviour and appearance to conform to what they perceive are the prevailing cultural norms (Larsen 2006a). For example, overseas-trained nurses described how they have learned to go out to the pub or the restaurant when the colleagues have a “night out”. In other cases cultural assimilation can involve aspects such as “how you dress, how you speak or how you set your hair”. These changes in many cases significantly impact on notions of self, and while the individual may choose to do this in response to social pressure, it is relevant to observe that for others the change of lifestyle that this involves was presented as part of the original motivation for emigrating to the UK (see section 3, and also Larsen et al. 2005).

This way of seeking to adjust to British expectations, or “playing the game”, as some Ghanaians and African-Caribbeans described it, is one way for the overseas-trained nurse to respond in order to seek and achieve acceptance among their work colleagues. This type of cultural assimilation may not necessarily mean that the person is trying to “become British” but can involve an attempt at adjusting to the social requirement in the British culture of sharing private information (as mentioned above). This can involve presenting openly your own personal and culturally specific character. As one manager explained:

People have to give a little bit, we try and say [to the overseas-trained nurse] “try to give a little something” so that people understand you and you understand others as well.

Female, 46 years old, Black British, manager - LJ002

Another manager made similar points:

(The area served by the hospital) is a huge Black area. Nearly all the staff are Black. Of all the staff there are very few English girls I would say 3 or 4. But whenever any opportunities came up they would still get it. Even when there were other Black people, even when there was a Black head of midwifery the White girls always had greater opportunities than we had. I suspect it's because you had to be seen to “fit in”. Now that I'm in management the other Black people in management we all know that ok you have to play the game don't be too Black. Don't be too Black until you get to the top. When you get to the top you can twist your hair off you can be Black when you get to the top but until you get there you know you have to play the game.

Local NHS Stakeholder - DL025

The value of this advice appeared to be confirmed by some successful overseas-trained nurses we interviewed. They expressed strong self-confidence and described how, through joking and skilful social interaction, they were capable of turning around potentially threatening social situations. For example, when criticised for speaking aggressively the nurse can say “well, I speak in a rich voice, that's how I am” or when British colleagues sit in a small group together during the lunch break the overseas-trained nurse can squeeze in between them, jokingly commenting “we need to divide you up a bit”. However, while this advice and social strategy might be good and effective, it crucially depends on the confidence and social skills of the individual overseas-trained nurse. And, as we have described, many overseas-trained nurses arriving in a new and unfamiliar country, socially isolated, homesick and under great pressure financially and due to work-related requirements, will be very far from capable of meeting this challenge.

The responses discussed above should not be regarded as mutually exclusive or polar opposites. Many informants talked about moving on from periods of stagnation and disengagement to assertiveness. Others seemed to be simultaneously relatively successful, assertive and able to “play the game” yet they were also alienated for example an African Caribbean manager stated:

You just had to work harder, have more qualifications, do more and at the end of the day you think “is it really worth it?” It's not really worth it for the stress. You might as well earn your money and go home. For me, to go any further along, I just can't be bothered. I'm just going to enjoy life. It's not worth it.

Local NHS Stakeholder - DL025

8.5 Social re-negotiation and confrontation

In our data we have come across examples of how overseas-trained nurses have assertively challenged a range of barriers and forms of discrimination that faced them in the UK. It is

important to remember that by their choice to leave their country of origin and seek a better future elsewhere they have already demonstrated that they have initiative and ambition. This basic fact is often lost to the prevailing stereotype of overseas-trained nurses in Britain as migrants who are weak in resources and “in need” (see also, Larsen et al. 2005).

A very direct way to re-negotiate an unacceptable and discriminatory social situation is to confront it directly, as, for example, discussed in section 7 when the South African nurse called for a meeting to address the way the HCAs were complaining to the care home manager behind her back. In that case she managed to radically change the way HCAs behaved towards her, and our data confirm the impression that direct confrontation generally is effective in instituting change. But some other successful nurses had chosen a more indirect strategy. A Ghanaian nurse who had become the manager of a care home described how she let abuse “wash over” her, and that she gave the same advice to her overseas-trained nurse friends:

... you know what I will tell them to do... to be strong and just let it wash [over them] and to prove that “yes, we are competent”, if they prove that then... but it’s a shame, its not easy because not everybody is like me.

Interviewer: Its takes a lot of courage to confront?

But it helps, I didn’t do it for myself, but for the new staff, I did that, I confronted it, I confronted what was happening and after I had done that the way they related to those new staff members changed, but they couldn’t confront, so that’s why they came to me so if we could have people in top positions helping that would also help.

Female, 48 years old, Ghanaian, Black African, Home manager, employer: nursing home, arrived in UK: 2000 - BJ009

Based on her experience as a manager she pointed out the key role of the manager in providing support for the overseas-trained nurse in such situations. When she described her own strategy of letting it “wash over” shortly after she started working in a care home in the UK it became clear that the success of this approach had also been supported by the firm intervention of the manager:

... I went in and I wanted to help a carer with the resident and the resident did say that “I don’t want any Black bastard”. Quickly I had to handle it because if I didn’t, it could....and I think that is what worked, so it was reported to the manager at that time. She came [and she said to the resident:] “what did you call her, what did you call her?” [I said:] “calm down, I was the one who was called Black bastard, you were not. First of all, am I not Black?” and everybody just went quiet, so then the manager said “Fine, okay, you are Black, but what about the bastard?” so then I said “how do you know I am not a bastard?” and then people just started laughing, and from that time on I was accepted. But it shouldn’t be that people should try to, but from that time onwards, the first thing, I was accepted, that is what happened.

Female, 48 years old, Ghanaian, Black African, Home manager, employer: nursing home, arrived in UK: 2000 - BJ009

It is clear from this story that the respondent was socially skilful and self-confident to use humour as a way to disarm the tension in the racist abuse, and turn the latent conflict around

to be socially inclusive of herself as well as the resident who had abused her. But it is equally evident that this strategy only worked because she could use the manager's firm intervention and zero-tolerance approach to display her own tolerance against. This situation is very different from other nurses' stories about how they have been told to tolerate and bear with patients' racist abuse. Comparing with this nurse's experience the similarities and contrasts are striking:

There have been a few issues with patients. There's one going on at the moment. Some have been very abusive and called me "Black bastard". When I complain about this in writing it just gets brushed under the desk. I didn't feel supported and ended up questioning my own role in the organisation.

Male, 31 years old, Ghanaian, Black African, D grade, employer: independent, arrived in UK: 2001 - DL039

It seems that confrontation is necessary in order to put a stop to abusive and discriminatory behaviour, and to clearly demonstrate support for the nurse being discriminated against. While the overseas-trained nurse may confront the abusers, the active involvement and support from the clinical manager appears crucial to its success, and a clear zero-tolerance approach by the manager can, as we have seen, allow the socially resourceful overseas-trained nurse to re-negotiate a positive social role for themselves.

9 Discussion and conclusions

We focus in this conclusion on the ways in which the understandings and experiences of UK healthcare recounted to us by overseas-trained staff hold up a mirror that enables British nurses, managers and doctors to examine and address current issues and problems in UK nursing practice, health service workforce organisation and education.

Some of the key results of this project thus relate to the ways in which the problems and confusions experienced by overseas-trained staff are rooted in some under-researched and poorly understood aspects of the NHS and the broader UK health services. We offer four examples here: the problematic role of hands-on-care within British nursing hierarchies and nursing practice; the system which we call “sponsored promotion” and the obscuring of that system beneath a formally open competitive promotion process; the relational nature of discrimination, and its implications for rethinking diversity management; and the role of nursing and care homes in NHS recruitment practice.

The first example shines a light on the problem of a care gap, which has persisted through several policy shifts since the foundation of the NHS. This care gap developed in part because of the rhetoric of a normative moral discourse in the UK which claims that caring is the “essence” of nursing. Our findings suggest that overseas-trained nurses have their own values of nursing which are both shaped by and challenge the normative British value that caring is at the heart of nursing. We argue that caring is not and never has been the moral essence of nursing. This is illustrated by overseas-trained nurses’ experiences of working in the NHS and care homes. While direct patient care is understood rhetorically to be central to nursing, it is constantly sidelined from the core of professional practice leaving overseas-trained nurses feeling devalued and de-skilled. Our study provides further evidence of a conflict at the heart of British nursing articulated through a critique of overseas-trained nurses which places them lower down the nursing hierarchy than their skills and experience merit.

We argue elsewhere (Allan under review) that the poor experiences of working in care homes as adaptation students with Health Care Assistances (HCAs) arise from an increasingly specialised post-registration nursing career in the UK compared to a more general orientation in overseas nursing, particularly nursing as practised in some African countries. As well as a discourse in the UK which privileges “basic” care over technical care, there is also a discourse where the delivery of basic care is delegated to the lowest paid in the workforce i.e. students, HCAs and overseas-trained nurses (Smith & Mackintosh under review). The

situation is compounded by an increasingly regulated context of care which seeks to avoid or at least contain risk (Allan under review). But we also argue that these experiences are overlaid with indirect racism which is reproduced at the system and interpersonal levels (see also Allan et al 2004).

Our second example concerns “sponsored promotion” into managerial grades (G and above) in nursing and midwifery (see section 6). The promotion system we see in the mirror of overseas-trained nurses’ experience is one which is formally competitive and based on merit, but which in practice operates through a mix of active sponsorship of individuals by managers and a culturally specific “code” of required responses and understandings. These responses and understandings require coaching and research by outsiders. These contradictions stand out sharply in overseas-trained nurses’ accounts and raise questions about the transparency of promotion practice in the NHS, the extent to which it is in practice based on merit, and the extent to which it avoids hierarchy and patronage. It may well be that attention to overseas-trained nurses’ critical assessment of their experience could help to strengthen merit-based promotion and improve the career experiences of British as well as overseas-trained nurses.

This analysis of promotion procedures informs our findings on discrimination, particularly the conceptualisation of both discrimination and support as relational processes operating within structures that constitute institutionalised disadvantage for overseas-trained staff. Whilst there are examples of good human relations practice in our data, there are also many examples of discrimination and frustration. In addition to analysing the relationship between direct and institutionalised discriminatory structures and practices the report breaks new ground by analysing in detail overseas-trained health professionals’ responses to the experience of discrimination, and the material effects both positive and negative of these responses. It highlights complex patterns of discouragement and support, of fitting in, alienation and withdrawal that shape people’s careers. It is clear that eradicating discriminatory processes requires far more than finding ways for overseas-trained staff to “fit in”; it requires a reshaping of knowledge, expectations and work processes, as well as support, to make better use of the skills of a highly diverse workforce and undercut frustration and withdrawal.

We have demonstrated how overseas-trained nurses may respond to perceived institutional and direct racial and ethnic discrimination by disengaging from careers. In this way the victims of discrimination become agents in their own oppression by reproducing its effects through inhibiting career progression. This widespread process of alienation and disengagement from careers reflects a hidden but potentially pervasive dimension of the

disadvantage that characterises marginalised position of many BME and particularly African staff in the NHS. In addition to further marginalising the victims of discrimination through their own actions, this process of disengagement from career progression has further negative effects. It can legitimise some of the common discourses that BME / overseas nurses are not interested in or capable of career progression. Thus withdrawal from career progression becomes an explanation in itself rather than a starting point for examining processes and structures in the NHS to explain why disengagement from career progression is so common in some groups of overseas trained staff. This can allow managers to evade their responsibility to address discriminatory practices, processes or institutional barriers, as the victims of discrimination render them irrelevant by their own actions of withdrawal.

The pivotal role of informal processes is not only evident in the way in which promotion appears to be facilitated, it is also a key explanatory factor in relation to the issue of complaints raised over clinical malpractice and the reasons overseas-trained nurses tend not to raise grievances over discrimination or other unequal treatment. This directs attention to the efficacy and importance of informal processes and, in particular, the crucial role of the clinical manager – whether a ward manager (Sister) in a NHS hospital or a home manager in a care home. Our data emphasise that it is the conduct and direct intervention of the clinical manager, which is the most effective tool to ensure fair and equal treatment in the workplace, and that this is best achieved through a zero-tolerance approach to discrimination and clear and transparent procedures for providing support and guidance to all members of staff.

Perhaps the most revealing finding of the study for our understanding of the UK health system is the key role played by care homes in adaptation and NHS recruitment. The care home sector is a key route to registration and NHS employment and supported by the current NMC processes and procedures. *En route* many homes provide poor support and preparation for NHS work and there is evidence of exploitative and distressing work conditions. But there are also examples of good practice which need to be supported and disseminated across the sector. Overall however, the situation we find in our study is that overseas-trained nurses' skills are propping up an under-paid, under-regulated care sector. The ills of that sector will not be put right until nurses undertaking essential nursing work within it, including overseas-trained nurses, are properly rewarded and supervised, and the sector treated as a properly professional element of UK health services as a whole.

These findings can be used to address home grown problems around the retention of nurses from BME backgrounds and the possible future retention of overseas-trained nurses if the NHS and care home sector fail a) to recognise their skills and expertise and b) fail to promote

them within the workforce. The retention issues for both British BME and overseas-trained nurses are the same: a failure to engage in working with a diverse, talented workforce.

10 Recommendations

We have framed our recommendations around a central concern for the NHS: staff morale and retention and ensuring resources are spent wisely by utilising skills within the workforce. Agenda for Change (AfC) and the Knowledge and Skills Framework (KSF) will address these issues for all NHS staff, but overseas-trained nurses need to have their requirements met as an explicit component of AfC and the KSF. We suggest patient care and staff retention would be improved through these recommendations:

Career progression

- Period of preceptorship after registering with the NMC;
- Personal development plans (PDPs) to be undertaken with overseas-trained nurses in NHS and elsewhere; PDPs could include interview training, writing curriculum vitae, planning a career;
- Formal systems of support in developing career progression skills and particularly formalising and making transparent systems of interview preparation.

Diversity management

- Support and guidelines for clinical ward managers to implement and monitor zero-tolerance policy (in the NHS; sisters and in care homes; home managers);
- Diversity awareness training for healthcare staff to include positive recognition of overseas-trained staff's skills and competencies and assistance in transferring these skills and competencies to the British setting;
- Inclusion of overseas-trained staff in developing and implementing local diversity management practices.

Mentoring

- Mentoring systems need to make training and learning needs of overseas-trained nurses visible and valued;
- Overseas-trained nurses in supervised practice need to be recognised as *trained nurses* and to be called "overseas-trained nurses" rather than students or learners;
- Review of mentor update courses to include diversity training/issues, language differences/support and emotional effects of migration;
- Mentoring systems to include support for mentors who mentor overseas-trained nurses.

Promotion

- Transparent promotion systems which emphasise merit rather than sponsorship;
- Increased flexibility in the recognition and use of talents and skills of overseas staff within Trusts;
- Review of portfolio evidence for previous overseas experience at registration/start of employment within Trust (which might include APEL as well as APL and APCL);
- Single assessment of particular skill or a period of supervised practice of a skill to ensure local safety standards are met;
- Ensuring formal procedures of feedback for unsuccessful candidates and ensuring that the problems or weaknesses are subsequently addressed by the applicant and their manager.

Health care practice/nature of nursing work

- Acceptance of cultural differences in nursing practice within standards of safe practice;
- Operationalising diversity in practice and improving working within diverse, multicultural teams;
- Information on Nursing and Midwifery Council, Department of Health, Care Home and Trust websites about register and different parts of the register;
- Information on Nursing and Midwifery Council, Department of Health, Care Home and Trust websites about nature of nursing and care work in UK and different roles of health care professions including Health Care Assistants;
- Information on Nursing and Midwifery Council, Department of Health, Care Home websites about what care home adaptation placements offer e.g. opportunity to enter UK labour market in a non-acute working environment;
- Information on Nursing and Midwifery Council, Department of Health, Care Home and Trust websites about differences between systems of training globally and expectations of UK employers.

Complaints

- Information on Nursing and Midwifery Council complaints procedures in UK and employment rights to be more effectively disseminated to overseas-trained nurses;
- Nursing and Midwifery Council to investigate the underlying reasons for the increase in reports of overseas-trained nurses' malpractice;
- Direct more attention to the importance of informal social processes that may prevent difficulties escalating into formal complaints and grievances.

Endnotes

¹ It should be noted that the Ethical recruitment guidelines are currently in a state of flux. They enshrined the rights not to discriminate against healthcare professionals on the basis of race or nationality, however due to recent changes (Making Migration Work for Britain) employers are now obliged to discriminate against non EU doctors and dentists.

² A Confederation of UK based African and Caribbean nursing associations formed 5 years ago.

³ Whilst both African and African Caribbean nurses and midwives claimed that African Caribbeans were more successful in terms of promotion there is no available statistical evidence to back this up. Interestingly this perception also challenges evidence that generally West Africans enjoy greater social mobility in the UK than African Caribbeans.

References

- Allan, H, & Larsen, J A, 2003, *We need respect: experiences of internationally recruited nurses in the UK*. Report to the Royal College of Nursing. www.rcn.org.uk.
- Allan, H, Larsen, J.A, Bryan, K & Smith, P.A, 2004, *The social reproduction of institutional racism: internationally recruited nurses' experiences of the British Health Services*. *Diversity and Health and Social Care* 1(2):117-126.
- Allan, H, 2006, *Mentoring overseas-trained nurses: a cautionary tale of managing diversity*. Paper presented at University of Surrey Learning & Teaching Symposium.
- Allan, H, under review, The rhetoric of caring and the recruitment of overseas nurses: the social production of a care gap, *Journal of Clinical Nursing Special Issue*: Editor Smith, P A.
- Allan, H, 2006, *Ethnicity, gender and migration experiences: what does a career mean for female nurse migrants in the UK?* Paper presented at the Royal College of Nursing International Research Conference Symposium, York, March 2006.
- Bach, S, 2003, *International migration of health workers: labour and social issues*, Geneva, International Labour Office.
- Ball J & Pike G, 2005, *Managing to work differently*. Royal College of Nursing, London.
- Buchan, J, & Calman, L, 2004, *The Global Shortage of Registered Nurses: an overview of issues and actions*, Geneva: International Council of Nurses.
- Carpenter, M, 1977, *The New Managerialism and Professionalism in Nursing*. In Stacey, M, Reid, M, Heath, C & Dingwall, R (eds) *Health and the Division of Labour*, London, Croom Helm.
- Carpenter, M, 1993, *The Subordination of Nurses in healthcare: towards a social divisions approach*. In Riska, E & Wegar, K (eds) *Gender Work and Medicine: Women and the Medical Division of Labour*.

Catton, H, 2004, cited by Mulholland, H *Reid reneges on overseas staff pledge*, Guardian (July 26 2004), <http://society.guardian.co.uk/NHSstaff/story/0,,1269447,00.html>

Choy, C C, 2003, *Empire of Care: Nursing and migration in Filipino American History*, Durham and London, Duke University Press.

Davies, C, 1995, *Gender and the Professional Predicament of Nursing*. Buckingham: Open University Press.

Department of Health, 2001, *Working together, learning together: a framework for lifelong learning for the NHS*, London, HMSO.

Department of Health, 2004a, *NHS Knowledge and Skills Framework*, London, HMSO.

Department of Health, 2004, *Code of practice for the international recruitment of healthcare professionals*, London.

Department of Health, 2005, *NHS Institute for Learning and Innovation*, www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT Accessed 27/04/06.

Esmail, A, Kalra, V & Abel, P, 2005, *A critical review of Leadership Interventions Aimed at People from Black and Minority Ethnic Groups*, The Health Foundation.

Findlay, A, 2002, *From brain exchange to brain gain: policy implications for the UK of recent trends in skilled migration from developing countries*, Geneva, International Labour Office, International Migration Branch.

Girard, R, 1986, *The Scapegoat*, Baltimore, Johns Hopkins University Press.

Hancock, P K, 2002, Commentary. A response to Diane Wickett and Helen McCutcheon, in *Nurse Education Today* 22(1):44-52, Issues of qualification assessment for nurses in a global market.

Henry, L, 2005, *Success and stagnation in the NHS: Older Ghanaian nurses and midwives reflections on career progression in the UK*, paper presented at the research workshop "Overseas healthcare workers' situation in the UK", Open University, London, 10 June 2005.

Henry, L, under review, Institutionalised disadvantage: Older Ghanaian nurses and midwives reflections on career progression and stagnation in the NHS, *Special Issue Journal of Clinical Nursing*.

Henry, L, 2006a, *Forms of racism and discrimination in career progression in the NHS: Evidence from Ghanaian nurses and midwives*, paper presented at Understanding & tackling ethnic inequalities in health. An ESRC Research Seminar Series.

Henry, L, 2006b, *The material effects of discursive responses to discrimination in career progression in the NHS: How Ghanaian nurses resist and entrench racism*, paper presented at Royal College of Nursing Symposium, International Research Conference, York, March 2006.

Henry, L, 2006c, *Disengagement and demoralisation: How the responses of some Ghanaian nurses to discrimination in the NHS entrenches marginalisation*, paper to be presented at the Globalisation of Nursing: Ethical, Legal and Political issues Conference, Guildford, July 2006.

Henry, L and Mohan, G, 2003, *Making Homes: The Ghanaian Diaspora, Institutions and Development*, *Journal of International Development*, 15, 611-622.

Iganski, P, Mason, D, Humphreys, A & Watkins, M, 2001, Equal opportunities and positive action in the British National Health Service: some lessons from the recruitment of minority ethnic groups to nursing and midwifery, *Ethnic and Racial Studies*, 24(2):294-317.

Iredale, R, Gender, 2004, immigration policies and accreditation: valuing the skills of professional women migrants, *Geoforum*, 36:155-166.

Jackson, M, 2005, *Existential Anthropology: Events, Exigencies and Effect.*, New York and Oxford, Berghahn Books.

Kingma, M, 2006, *Nurses on the move: migration and the global health care economy*, New York: Cornell, University Press.

Larsen, J A, 2005a, *Existential crisis and the social re-negotiation of life projects*, paper presented at the British Sociological Association Conference, York, March 2005.

Larsen, J A, 2005b, *Overseas nurses' embodiment of racist discrimination and career progression strategies*, paper presented at the research workshop "Overseas healthcare workers' situation in the UK", Open University, London, June 2005.

Larsen, J A, 2006a, *Fitting in and moving on: cultural habituation and career progression for overseas nurses'*, paper presented as part of the symposium "Agency and structure in equal opportunities for overseas nurses" at the RCN Research Conference, York, March 2006.

Larsen, J A, 2006b, *The micro sociology of discrimination: overseas nurses' experiences'*, paper presented at the British Sociological Association Conference, Harrogate, April 2006.

Larsen, J.A, Allan, H, Bryan, K & Smith, P.A, 2005, Overseas nurses' motivations for working in the UK: Globalization and life politics, *Work, Employment and Society*, 19(2): 349-368.

Mackintosh, M, Mensah, K, Henry, L and Rowson, M, 2006a, Aid, restitution and international fiscal redistribution in health care: implications of health professionals' migration, forthcoming in *Journal of International Development*.

Mackintosh, M, Raghuram, P and Henry, L, 2006b, African-trained doctors and nurses in the British health services: ethics, economics and political obligation, forthcoming in *Soundings*.

Mensah, K, Mackintosh, M M & Henry, L, 2005, *The skills drain of health professionals in the developing world*. London: Medact available online <http://www.medact.org/content/Skills%20drain/Mensah%20et%20al.%202005.pdf>.

Masterson A, 2002, Commentary, A response to Diane Wickett and Helen McCutcheon, Issues of qualification assessment for nurses in a global market, In *Nurse Education Today*, 22(1):57-59.

Melia, K, 1987, *Learning and working: the occupational socialisation of nurses*, London, Tavistock.

NHS Employers, 2005, *The Equality & Diversity Brochure*. www.nhsemployers.org/KeepingInTouch/publications_employer_excellence.asp

- NHS Modernisation Agency, 2005, *Breaking through Programme*, NHS Modernisation Agency Website.
www.leadership.modern.nhs.uk/ethnicdiversity/breakingthrough/default.aspx
- Nursing and Midwifery Council, 2005, *Statistical Analysis of the Register 1 April 2004 to 31 March 2005*, London.
<http://www.nmc-uk.org/nmc/main/publications/Annualstatistics20042005.pdf>
 Accessed 27/04/06
- Nursing & Midwifery Council *Overseas Nurses Programme*,
www.nmc-uk.org/aArticle.aspx?ArticleID+1653. Accessed 05/05/06
- Nursing & Midwifery Council, 2006, *A-Z Advice sheet Accreditation of prior and experiential learning (APEL) and credit accumulation transfer schemes (CATS)*, www.nmc-uk.org.
- Parrish, A & Pickersgill, F, 2005, Home Office considers special visa to support overseas-trained nurses, *Nursing Standard*, 19(46):12.
- Parry, O, Thomson, C & Fowkes, G, 1999, Life Course Data Collection: Qualitative Interviewing Using the Life Grid. *Sociological Research Online* 4(2):
<http://www.socresonline.org.uk/socresonline/4/2/parry.html>.
- Patton, M Q, 2002, *Qualitative Evaluation and Research Methods*, 3rd edition, Newbury Park, CA, Sage.
- Raghuram, P & Kofman, E, 2004, Out of Asia: skilling, re-skilling and deskilling of female migrants, *Women's Studies International Forum*, 27:95-100.
- Richman & Mercer, 2004, Modern language or spin: Nursing newspeak and organisational culture: new health scriptures, *Journal of Nursing Management*, 12(5), 290-298.
- Salvage, J, 1985, *The Politics of Nursing*, London, Scutari Press.
- Smith, P and Mackintosh M, under review, Profession, market and class: nurse migration and the remaking of hierarchy and disadvantage, submitted to *Special Issue of Journal of Clinical Nursing*.
- Stanley, E, 2006, *Working to sustain Progress. Black and minority ethnic non-executive directors in London*. London, Kings Fund.
- Trades Union Congress, 1999, *Black and Asian workers in the 1990s: black and excluded*, www.tuc.org.uk/em_research_tuc-365-f0.cfm
- Unison Overseas-trained nurses Forum Newsletter, 2006
www.unison.org.uk/acrobat/b1203.pdf
- Watson R, 2001, Friends in low places. Media Review, *Journal of Advanced Nursing*, 236(2), 321.
- Wickett D & McCutcheon H, 2002, Issues of qualification assessment for nurses in a global market, *Nurse Education Today*, 22(1): 44-52.
- Winkelmann-Gleed A, 2005, *Migrant Nurses Motivation, Integration and Contribution*. London, Routledge.

Appendix 1: The interview process

At the start of the interview, the interviewer went through the study information sheet, explaining its purpose and guaranteeing anonymity. The interviewee read and filled in the consent form, and if appropriate the interviewer asked permission to audio-record the conversation. To prepare the interviewee, the structure and key themes of the interview guide were presented before formally starting the interview and recording. The interview guide had five sections: “personal details; “work life: past, present and future”; “experiences working in the UK”; “the broader perspective”; and “finish”. The first provided general personal and current employment data. The second section provided an overview of the interviewee’s professional training, work experience and career development. Inspired by the “life grid” method (Parry et al. 1999) the research team had developed a “Work & Life Map” presented as an A3 sheet of paper with four columns: “time”; “education/work change/promotion”; “family events/home change/migration”; and “explanations and reasons”. Rather than being an end-goal in itself, the map served to facilitate a discussion about professional experiences and link these to personal or family events as well as migratory moves. It provided a biographical context for examining individual motivations for migrating to the UK and the circumstances around entry and possible later job shifts or promotions. The third section in the interview guide explored in detail experiences of working in the UK, the quality of adaptation and mentoring support, opportunities to use overseas-acquired skills, relationships with colleagues, managers and patients, social life in the UK and whether living here had changed the self. The fourth section addressed the interviewee’s obligations towards relatives in the home country and views on ethical recruitment policies. Finally, the interviewees were asked if they had anything to add in respect to the issue of equal opportunities for overseas-trained nurses in the UK.

In accordance with qualitative interview technique and the in-depth, semi-structured approach the structure of the interview rarely followed the interview guide “from a to z”, as the interviewer made sure to explore informants’ own stated concerns as they occurred, and encouraged a natural flow in the conversation. Following an interpretive and existential phenomenological approach the interviewer explored individual themes through dialogical investigation. The engagement in a dialogue places the other’s viewpoint on a similar footing as one’s own; and Jackson suggested that “[t]his demands that one find something in one’s own experience that is analogous to, or approximates the experience of the other, and may therefore bridge the gap between the two” (2005: 31). Methodologically, the researcher utilises the shared human condition as an inter-subjective starting point for understanding the other person’s particular situation (Jackson, 1998: 15). The dialogue represents the social and

shared meaning-frame that is at the centre of interpretive understanding: “Human sociality is thus no longer simply the object of our understanding, but the very method whereby we achieve it” (Jackson, 2005: 32).

The interviews generally lasted around one and a half hours. Interviews conducted as part of a workplace case study could be more compressed in time if they were conducted during work time or in a lunch break. In these situations the interviewer had to compress questions and had less time to explore in detail individual experiences. Some of these interviews lasted only between 30 and 60 minutes. Other interviews had no particular time constraints and they could last between two and three hours, allowing the interviewee to describe and elaborate on particular incidences and events.

The only exception to these individual semi-structured interviews were two group interviews; one was conducted in one of the workplaces and involved a married couple. One was a group of three nurses living and working together who were contacted via a network of overseas-trained nurses; they preferred to be interviewed together in their shared house. The same interview process was used.

Interviews with informants in the Ghanaian case study in the UK adopted a more informal approach with the interviewer encouraging the informants to reflect upon specific key events in their personal and professional lives in accordance with an interview guide. These key events included getting to the UK, getting their first job in the UK, getting their current job and their experiences of promotion and education and training in the UK with the interviewer engaging in dialogue to focus on key thematic issues such as equal opportunities, discrimination, aspirations, relationships with other ethnic groups in the workplace, relationships with managers, obligations to people and places in Ghana, support networks and adapting to the UK. This approach was supplemented by the interviewer asking the informants to reflect upon these and other key issues.

Semi structured interviews and focus groups with informants in Ghana used a more formal interview guide and were undertaken with the collaboration of a Ghanaian research partner. These interviews focused on three key issues:

1. their perceptions of careers in nursing and medicine in Ghana including, structure, progression and training
2. reasons for leaving and remaining in Ghana and migrants aspirations
3. methods of migration and sources of information on careers overseas.

The fieldwork in Ghana was undertaken by the Dr Henry and Dr Mensah. Dr Henry and Dr Mensah jointly drew up an interview schedule and jointly conducted interviews and focus groups with informants identified by Dr Mensah. The research had three elements: data gathering for joint research on healthcare professionals' sources of information and migration strategies; gathering data for REOH on career structures and organisational cultures in Ghana; and gathering data on Dr Mensah's research into the career aspirations of Ghanaian trained Healthcare professionals.

Appendix 2: Data management and analysis

Shortly after each interview the interviewer described the setting in an ethnographic-style note and detailed key points emerging from the conversation in order to capture immediate analytic insights. The audio-recordings were transcribed verbatim by an assistant and then coded by the researcher while simultaneously listening to the audio-recording and correcting the transcription where necessary. While coding, using the data analysis software NVivo, version 2.0, the researcher made case-specific notes to capture the in-depth insight emerging from the data.

Codes were negotiated and agreed in a collaborative effort by the researchers in order to facilitate across-case analysis to compare individual response to similar circumstances or events. The purpose and content of each code were defined in the software's "properties" function and a logbook of developments in the coding strategy was held to provide an audit trail of evidence. Each interview was given attributes detailing key variables to allow grouping of across-case data-retrieval. The first 3-5 interviews by each researcher were printed out with codes indicated and then verified by the research team, each suggesting corrections and comments before discussing these in order to achieve consensus. The corrections were then entered. The research team held regular meetings over the period of the project to discuss the coding strategy and empirical and theoretical insights as the research progressed.

The cumulative and negotiated data analysis process made active use of the diversity of perspectives and experiences represented by individuals in the research team:

- One White, female British nurse and social researcher;
- One mixed British-Caribbean male development-social researcher with overseas research experience;
- One White, male Danish immigrant and anthropologist-sociologist;
- One White, female British development-economist with extensive overseas experience;
- One White, female British nurse sociologist and social researcher with experience of having worked in other countries as an overseas-trained nurse teacher.

In the spirit of constructive collaboration and overall consensus on the qualitative and interpretive research methodology, the diversity of biographical, professional and theoretical perspectives stimulated a valuable richness and multi-dimensionality in the analytic process. The ongoing analysis of data was supported by regular engagement in presenting emerging

research findings to the academic community at research conferences as well as to the study's advisory board, which included people with in-depth knowledge of policy, clinical and career development issues relevant to the situation of overseas-trained nurses and other healthcare professionals.

Appendix 3: Tables showing place of birth and training

Place of birth		Place of training	
Australia	1	Australia	2
Bulgaria	1	Bulgaria	1
Germany	1	Ghana	23
Ghana	24	Guyana	2
Guyana	2	Holland	1
Holland	1	Iceland	1
Iceland	1	India	9
India	9	Kenya	1
Kenya	1	Malawi	1
Malawi	1	New Zealand	1
New Zealand	2	Nigeria	5
Nigeria	5	Pakistan	1
Pakistan	1	Philippines	26
Philippines	26	South Africa	8
South Africa	7	Spain	2
Spain	2	Sri Lanka	1
Sri Lanka	1	Sudan	1
UK (UK/Sudanese national)	1	UK	2
Ukraine	1	USSR	1
USA	1	Zambia	1
Zambia	1	Zimbabwe	3
Zimbabwe	3		