

“We need respect”:
experiences of internationally
recruited nurses in the UK

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Executive summary

The Royal College of Nursing (RCN) commissioned this report into the experiences of internationally recruited nurses (IRNs) working in the UK. The report complements previous RCN reports *International recruitment: United Kingdom case study* (RCN 2002b) and *Here to stay? International nurses in the UK* (RCN 2003).

The study explores the motivations and experiences of IRNs in order to understand why overseas nurses come to work in the UK, what experiences they undergo and whether they plan to stay in the UK, return to their countries of origin or go to another country to work after a short period.

This report presents data on the experiences of IRNs obtained through focus group interviews and pre-focus group questionnaire data. The research provides insights into the experiences of IRNs working in different sectors and geographical regions in the UK. Sixty-seven IRNs participated in 11 focus groups run on three sites: Leeds, Cardiff and London. The study included research participants from 18 different countries in Africa, South Asia, Australia, North America and various European countries. More than half had held senior nursing positions (F grade or above) in their home countries before coming to the UK, and they had many years of nursing experience (14.1 years on average). When taking part in the research they had, on average, been working as nurses in the UK for 3.8 years.

The experiences of IRNs working in the UK were shaped by their personal expectations. The study found that these expectations covered a range of different, but interconnected, motives: personal, professional, financial and social. On the personal level, it was found that while some came for a working holiday others intended to make a life change. IRNs expected to do nursing and to expand their knowledge of new practices and technologies. While some intended to make a living in the UK, others primarily came to work to support their families back home or save for retirement. These personal and financial motives closely related to a social motive to either bring their families to the UK or the intention to move back home as soon as sufficient savings had been made or the *holiday* was over.

The personal, social and financial aspects of IRNs' life in the UK provided a significant experiential context. Some had experiences with poor accommodation and lack of personal support, which reinforced feelings of isolation and homesickness. On the other hand, positive initial experiences and a supportive environment provided a good foundation for taking up the

challenge of working as a nurse in the UK. Some complained about the high level of UK taxation and others had had problems obtaining a mortgage. These experiences could persuade them against a more permanent stay and the decision to bring over their families.

The IRNs in this study came to the UK through different routes, some through a recruitment agency and others to visit relatives. Those who had been directly involved in setting the terms for their employment generally felt in control, while others frequently reported having been manipulated and cheated. In some cases, IRNs had experienced a very bad reception from their employer. Experiences were mixed regarding the support from the workplace. In general, IRNs were happy with the support recently provided in the NHS, while the adaptation in the independent sector was strongly criticised. IRNs called for better co-ordinated mentoring, more support from their UK colleagues and the establishment locally of IRN networks for mutual support.

Experiences of working in the UK varied widely between the NHS and the independent sector. In the independent sector IRNs were working as care assistants and felt isolated. Some reported bullying from care assistants and felt they were *policed*. The experience of not being allowed to use their nursing qualifications was also a problem to IRNs working in the NHS where they were prevented from using nursing skills they had practised in their home countries. IRNs generally reported that they had good relationships with patients, even if there could be some initial problems. Communication seemed to be the most difficult area here, not only because IRNs took time to become accustomed to local dialects and colloquialisms but also because colleagues and patients found it difficult to accept IRNs' different accents and dialects. Some felt stigmatised by the language difference and experienced a lack of willingness from others to try to understand them. IRNs experienced exploitation in various ways, but particularly from their managers who used them to cover undesirable shifts. This was especially problematic for IRNs because they did not feel respected and appreciated for their efforts.

The working experiences of IRNs unfolded in the health care system which, in many cases, were very different from what they were used to in their home countries. The focus group discussions allowed IRNs to reflect on these differences and how they might have shaped their experiences. In some cases apparently small and insignificant *silly* differences in daily practices could lead to unfortunate mistakes and unpleasant experiences. Differences in patterns of social interaction could make IRNs feel socially isolated or misunderstood. Debates over the modernisation of nursing practice were reflected in the discussions, where IRNs trained in developing countries requested more structure and discipline, whereas IRNs

from other western societies felt that nursing in the UK was hierarchical and old-fashioned. Also, some IRNs felt challenged by the high level of documentation required, which they felt meant that British nurses focused on the paperwork rather than the delivery of care. However, there was general agreement that British nursing was failing to provide *the basics* of nursing care and cleanliness. The requirements of British nursing left some IRNs with a feeling of being deskilled and that there was no joy in their job.

IRNs had frequent experiences of discrimination. In some cases this appeared as crude racism and, in other cases, white IRNs explained how they, also, felt discriminated against because they were foreign. Common to these experiences was that their qualifications as competent nurses were questioned. IRNs described how some patients initially avoided them, and that it could take time for their role as qualified nurses to be accepted. IRNs gave reports of being excluded from the solidarity of their UK colleagues, and that they were given special negative attention if they made any mistakes. They also felt the stigma of exclusion. IRNs described how they felt stereotyped in the UK as merely coming for the money and that this narrow-minded perception of them led to abuse and exploitation.

The experiences of IRNs coming to the UK were personally demanding. They found themselves in a foreign and often unfriendly environment and having to cope with pressures of new working practices. On top of this, many experienced a radical drop in status, coming from a senior nursing position in their home countries to working under the supervision of untrained care assistants in the independent sector. IRNs explained how this required personal strength and special coping strategies; they needed to be self-confident and stand up for themselves. Some IRNs said that they had had to change their personality to become more assertive. Some younger IRNs had strategies focused on gaining respect and appreciation, while some older IRNs explained that they had the experience and self-respect to endure the poor conditions while aiming to make maximum savings for their return back home. Moving job after having finished the adaptation period could be a useful strategy as it allowed the IRN to start afresh in a new place, fully accepted as a qualified nurse. The IRNs made various suggestions as to how they could be motivated to stay in the UK for a longer period, reflecting the points of criticism discussed in the groups. IRNs requested that their status as qualified nurses should be recognised, that their different cultural backgrounds should be acknowledged and that they, more fundamentally, should be “respected as human beings”.

This study suggests the following interrelated areas of recommendations:

Better pre-recruitment information material for future and potential IRNs informing them about life in the UK, differences of culture and local dialects and which types of work they may encounter. In particular this describes work in the NHS as well as in care homes.

Better matching between employers' needs and IRNs' professional qualifications as well as personal expectations about life in the UK. For example, are they coming for a temporary working holiday, to make savings while working for back home, or are they planning a permanent move?

Improving and regulating induction and adaptation courses for IRNs and, where possible, use of experienced IRNs as support (supervisors/mentors) for new IRNs.

Establish induction programmes for UK staff, who are working with IRNs. Induction programmes should aim to provide UK nurses with greater understanding and acceptance of professional and cultural difference (both professional and social) so that they are better able to support IRNs to integrate into UK nursing teams and to reach their full potential. The programmes should include information/discussion on:

- behavioural norms relating to the health care environment in the countries from which the IRNs come from and how this may differ from the UK setting. For example, how different forms of respect are shown to senior staff such as eye contact
- professional qualifications and nursing practice in source countries
- IRNs' previous professional experiences and how these may inform clinical practice in the UK health care setting
- increasing professional satisfaction and career prospects of IRNs by increasing the use of APEL and validation of other qualifications gained in the country of origin, to allow IRNs to develop career pathways and benefit from professional education opportunities available in the UK.

Preventing exploitation of IRNs would require the following actions:

- better enforcement of existing regulations by the relevant stakeholders (Government and NMC)
- introduction of new regulations which prevent those exploitative practices not currently covered by regulation
- raising awareness among IRNs of their employment rights to ensure that IRNs:

- make informed choices prior to signing contracts
- know when to seek help in challenging poor or abusive practice by their employers
- tackling racism in NHS and care homes and at an institutional level in health services
- encouraging the development of RCN local and regional support and discussion groups for IRNs and encouraging IRNs to become involved in all aspects of RCN activity. This recommendation includes encouraging IRNs to participate in professional specialism groups in the RCN and groups for black and minority ethnic (BME) nurses where appropriate.

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1. Introduction and overview of report

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The study explores the motivations and experiences of IRNs in order to understand why overseas nurses come to work in the UK, what experiences they undergo and whether they plan to stay in the UK, return to their countries of origin or go to another country to work after a short period.

The research questions were explored in primary data obtained in focus groups run on three sites in the UK with 67 IRNs. Additional data to inform the design of the focus group discussions was sought in a scoping exercise involving consultation with new research findings, and interviews with experts with accumulated secondary insight into the experiences of IRNs.

This report presents the primary data in chapters 4 to 10 that explore:

- the individual motives to come to work as IRNs in the UK
- personal experiences of IRNs when living in the UK
- the issues surrounding recruitment, reception and support on first arriving in the UK
- the experiences of working as a nurse in the UK
- the structural differences IRNs experience between nursing in the UK and their home countries
- their experiences of discrimination
- their coping strategies to manage their experiences and their wish for appreciation and trust from British nurses and employers.

The findings suggest a model of understanding IRNs' motivations for coming to work in the UK and their experiences while they live and work in the UK. The model suggests that professional and cultural expectations influence personal motivations before arrival as well as individual experiences while working as nurses in the UK. Henceforth, experiences of achievement as well as of discrimination are reflected on personal, cultural and professional levels.

2. Background and literature review

This chapter considers the background to the research in the context of the current demand for nurses and the increasing use of IRNs in the UK. A brief review of the current literature presents the existing knowledge and outlines the need for this research into the experiences of IRNs working and living in the UK.

There is an acute shortage of trained nurses in the UK, and it is likely that this will increase in the future. In 2000, two-thirds of registered nurses in the UK were aged 40 or older. More than 73,000 of these nurses were aged between 50 and 55 and would expect to withdraw from the nursing workforce in the next five to ten years. The problem of skills shortages is expected to be further aggravated in the future as there will be an increased demand for health care, mainly as a result of an ageing population (RCN 2002b).

Apart from strategies to increase the number of *home-grown* nurses, Government initiatives seek to meet the present and future demand for nurses by recruiting trained nurses overseas. Since the early 1990s the annual admission of IRNs has demonstrated a fivefold increase. In the last three years more than 30,000 new non-UK nurses have registered in the UK, with the number growing each year. In 2000/01 9,694 IRNs were registered, with the number rising to approximately 15,000 in 2001/02 (RCN 2003).

In an increasingly competitive global labour market where more and more countries with nursing shortages are recruiting from abroad (Royal College of Nursing 2002), a better understanding of IRNs' expectations and motivations is needed in order to attract nurses from overseas to work in the UK. An improved understanding might also facilitate greater satisfaction among IRNs and motivate them to stay in the UK for a longer period. At present, IRNs generally only work in the UK for a short period: 56% of IRNs who registered with UKCC in 1995 did not re-register in 1998 (Buchan and May 1999).

Recent policy documents seek to secure and improve the quality of the recruitment of IRNs. The Department of Health has published *Guidance on international nursing recruitment* (1999) and *Code of practice for NHS employers in the international recruitment of health care professionals* (2001), and the Royal College of Nursing has published *Internationally recruited nurses: good practice guidance for health care employers and RCN negotiators* (2002a).

A study (RCN 2002b) of the inflow of IRNs to the UK shows that three countries in recent years have been the main providers of IRNs: Philippines, South Africa and Australia. In the year 2001/02, these countries provided more than 10,000 nurses to the UK. Apart from these main providers, nurses have generally come from India, Zimbabwe and Nigeria. Countries in the European Union (EU) have traditionally provided a significant proportion of overseas nurses for the UK, but as the overall intake has grown its proportional significance has diminished, so that in 2001/02 only 13% IRNs came from the EU. IRNs generally come to work in England where demand for nurses is highest. The nurse workforce in England comprise 8.5% IRNs of which 7.8% points are from countries outside the EU. More than one in four (28%) of all registered nurses in Greater London are IRNs (RCN 2003: 10). These figures suggest that a significant proportion of IRNs, and possibly as many as one in two, work in the London area.

Existing research suggests that IRNs' individual motives for coming to work in the UK are very different. A study on nurse mobility (Buchan *et al.* 1997) found that some intended to make a permanent move while others intended to stay temporarily. A range of personal, career and financial reasons were suggested to motivate the individual nurses, but further research was called for to explore these. The differences in IRNs' motivations and intentions may relate to their countries of origin. For example, evidence suggests that IRNs from Australia often come to the UK for travelling reasons while the motivations of nurses from the Philippines may be related to career prospects and financial security (RCN 2002b). Buchan (RCN 2002b, 2003) makes the distinction between *push* and *pull* factors to motivate immigration. While the former refers to factors in the home country, such as unemployment and civil unrest, which push individuals to immigrate, the latter refers to factors which might pull immigrants to come to the receiving country, such as demand for workers and a general higher standard of living. In a recent study Buchan (RCN 2003: 26) found that, due to active recruitment by UK employers, it is *pull* rather than *push* which has determined the size of inflow' of IRNs to the UK.

This does not mean, however, that IRNs are passive objects of recruitment policies, nor that the international migration of nurses and other professionals is a recent phenomenon. Based on an in-depth ethnographic study among Nigerian immigrants in the USA, Reynolds (2002) argued that professionals' migration from developing countries to developed Western countries can be seen "as a form of economic and class stratification that began with imposition of a colonial system in which young newly educated men were to be employed as clerks and teachers whose labour would generate value in international circuits" (Reynolds 2002: 281). In the 1960s and 1970s the phenomenon of *brain drain* from developing countries

to developed countries was investigated (Mejia and Pizurki 1976) and the evidence revealed its systematic and vast scale. For example, in 1970 more Filipino nurses were registered in the USA and Canada than in the Philippines (Mejia 1978, in Martineau *et al.* 2002: 2).

In order to understand the patterns of workforce migration it is necessary to consider both macro and micro perspectives. Relevant factors include:

- 1) individual motivation
- 2) household decision-making strategies
- 3) disparities between place of origin and destination
- 4) the state of development of migration networks
- 5) migration regime, which includes international laws and institutions that facilitate, hinder, or in some other way shape migrant movement
- 6) the macro political economy that surrounds a migratory order (Van Hear 1998, in Reynolds 2002: 274).

As Buchan (RCN 2003) has pointed out in the case of IRNs' migration to the UK, it is necessary to keep in mind the importance of the institutional and otherwise structural regulations and policies that pull or restrict the individual migrants. But it is, also, relevant to consider the extent to which the migration represents what Reynolds describes as "a slow move towards *vertical integration* into globalised economies" (2002: 281s). Individuals and their personal and social strategies are key forces in the globalising process. Reynolds (2002: 279) points out that in order for people to emigrate from their home country they require *infrastructure* and *cultural migratory capital*. First, they need to have access to international flights and a government that will let them travel. Second, it is an obvious advantage for the emigrant if he or she has familiarity with life in the destination country, language competence, family bonds in the destination country and a long-standing tradition among their countrymen of migration. "One is far more likely to migrate successfully if one's own cultural traditions include migration" (Van Hear 1998: 38, in Reynolds 2002: 282).

While some of the above mentioned studies looked into the individual motivations as well as structural explanations for international workforce migration, this study is both narrower and broader by focusing on the experiences of IRNs in the UK. It is narrower in the sense that it does not allow a full, holistic consideration of the factors that might influence migration. It is broader in the sense that it is not exclusively concerned with individuals' motivations and structural explanations for migration, but with the IRNs' experiences of living and working as nurses in the UK.

A range of issues is relevant when investigating the experiences of immigrants while living and working in the destination country. Existing evidence suggests the possibility that IRNs meet prejudice and racism and that they are treated as unequal compared to British nurses. A recent survey of British ethnic minority nurses working in the NHS found perceived racial harassment in the workplace (Shields and Price 2002). Nearly 40% of ethnic minority nurses experienced racial harassment from work colleagues, while 64% suffered racial harassment from patients. Not surprisingly, it was found that these experiences had an unfortunate impact on job satisfaction and job retention. In a recent study including interviews with managers in the health care sector Buchan (RCN 2003: 19-20) found that racism was perceived to be a problem for IRNs, both in relation to colleagues and patients.

The possibility of prejudice and discrimination towards IRNs has been apparent in the media. It was reported in the editorial of the newspaper *Daily Mail* (5 August 2002) that one of the unintended consequences of the NHS “drive to recruit nursing staff from overseas is the arrival here of scores of workers already suffering from the Aids virus”. Statements like this reflect xenophobic notions from the public and the possibility of a “moral panic” (Hall *et al.* 1978). Furthermore, negative public representations of IRNs are likely to influence IRNs’ experiences of racism or harassment. Another factor that adds to the possibility of discrimination and shapes the experiences of immigrant workers in the UK is the media discourse on immigration and asylum seekers (Anthias 1999).

A survey among IRNs (MORI 2002) demonstrated that nurses from different countries of origin had different experiences of discrimination. Nurses from Nigeria, Zimbabwe and Philippines all gave high indications of racism as the single worst aspect about living in the UK. However, nurses from these two African countries stood out from the other groups when it came to their experiences of not being respected by patients and colleagues. The findings suggested that issues of racism could be involved, but the survey data did not explore in detail how individuals’ experiences related to particular circumstances. Hence, qualitative research on the IRNs’ experiences is required to explore the severity and extent of discrimination, and to document how this relates to the ethnicity or countries of origin of different groups of IRNs.

The nature of the problem demands close attention not only to the actual situation of IRNs as they work and live in the UK, but also to the cultural shaping of their experiences. This study addresses individuals’ experiences, expectations, opinions and motivation as they work and live in a culturally and socially unfamiliar environment. An in-depth examination of these experiences, and the meanings they have for individual IRNs, needs to take account of their

previous experiences in the context of the different social and cultural traditions in their respective countries of origin. Individuals' experiences are shaped by their expectations and previous experiences, that is, the life they take for granted in their natural "being-in-the-world" (Csordas 1994; Merleau-Ponty 1992; Schultz 1972).

Therefore, this study addresses cultural differences and how they influence the experiences of IRNs while working in the UK. Apart from general differences in beliefs, habits and opinions, differences in professional practice and traditions are also relevant to consider. IRNs who are trained and have previous working experience in their home countries are accustomed to a particular role and status of nurses, compared to the role and status of nurses in the UK (Holden and Littlewood 1991). Such cultural differences and variations in professional practice might influence the experiences of individual IRNs when working and living in the UK. The study of IRNs' experiences in the UK therefore demands close attention to various aspects and an awareness of how they might interrelate. In the next chapter we will discuss the methodological concerns and describe the methods we have applied to meet the task.

3. Methodology and methods

This chapter provides an overview of the research design, including the focus of the study and a discussion of the strengths and limitations of the chosen methods. To answer the research questions of this study, data was generated in two stages involving secondary and primary insights into the experiences of IRNs.

Stage 1: Secondary data - scoping exercise

Existing research being undertaken by Professor James Buchan (RCN 2002b, 2003) was reviewed to provide knowledge of general demographic and statistical issues, such as which countries provide IRNs and where in the UK they generally find work.

This study's research questions relating to IRNs' experiences in the UK were further developed and verified by one face-to-face and two telephone interviews with UK expert representatives in the field of internationally recruited nurses. The three interviewees were:

- an RCN regional officer with experience of dealing with IRN employment issues in the field
- an RCN officer based in RCN headquarters with responsibility for issues concerning IRNs
- Professor James Buchan.

This scoping exercise provided key information to generate an overview of the situation of IRNs in the UK and inform the sampling for the focus group interviews and facilitate the research questions to be refined, in order to address important aspects of the IRNs' experiences (Miles and Huberman 1994: 16-39).

Stage 2: Primary data – focus groups

Focus group interview is an efficient method to explore various opinions and beliefs held in a particular population, since the participants are placed in a social situation where they engage in a dialogue to reflect on specific issues (Morgan 1997).

The focus group interview has been defined as “a discussion in which a small group of people, under the guidance of a facilitator, talk about topics selected for investigation” (Howard et al 1989 cited by Macleod Clark et al 1996: 143). Focus group interviews “capitalize (sic) on the interactions within a group to elicit rich experiential data” (Ashbury 1995: 414). As such, the focus groups facilitate sharing and discussion of each participant’s experiences producing a group dynamic providing a shared group view of individuals’ experiences or allowing differing views to stand out and be articulated. Kitzinger (1994) also argues that focus groups using pre-existing groups provide a replica of the natural setting where ideas are formed and decisions made; they replicate “natural clusterings of people” (Kitzinger 1994: 105).

However, an argument against the use of an existing social group as a sample for a focus group is that it can replicate already existing power relations and social roles within the group and restrict individual participants in sharing their personal views (Morgan 1997). By setting up a new social formation, the individual members are allowed a minimal degree of pre-established social constraint and the participants can benefit from a maximal level of individual freedom to present their views, protected and supported by the focus group facilitator or moderator. Hence, the focus group interview is a flexible method that can be applied for various purposes: either to illuminate concerns and power relations within an existing social group or to expose and, indeed, provoke the exchange of individuals’ personal views and experiences. In this study, the purpose of the sampling was the latter: to let individual IRNs present their personal experiences and concerns and to allow similar and contrasting views to be articulated.

A number of methodological issues have been addressed in critiques of focus group interviews. Firstly, Webb & Kevern (2001) call for in-depth consideration of the methodological rationale underpinning the use of focus groups interviews. The use of focus groups in this study was dictated by the widespread distribution of IRNs in the UK and the practicality of achieving in-depth insights into the personal experiences of a relatively large and broad spectrum of overseas nurses. This compares to arranging individual in-depth interviews or conducting a survey. Focus group interviews were also chosen to assist in exploring sensitive issues that were of concern for IRNs living in the UK. Given the nature of IRNs’ isolation in the UK, in retrospect, the focus groups were an opportunity for IRNs to come together and voice collective concerns.

Webb & Kevern (2001) argue that the process of the interviews and analysis of focus group data need to be clearly addressed. Reed & Payton (1997) discuss Webb & Kevern’s second

point as an issue of validity. Reed & Payton argue that, while focus group interviews have face validity because the data is credible as the process allows each participant's comment to be challenged within the group, they also need to show that they "reflect what they are supposed to reflect" - content validity (1997: 770). They argue that focus groups have content validity if they reflect the process of developing a group perspective through the "display of cultural and moral forms" (following Silverman 1985 cited by Reed & Payton 1997: 770). In order for statements and views presented in focus group interviews to have content validity it is thus crucial that the implicit understandings and cultural context are made explicit in the process of analysis.

In this study attention has been made to sample and conduct the focus groups in a way that allowed the focus group participants to supplement and challenge each other's views and experiences (face validity). At the same time this addresses the cultural context and implicit understandings underpinning and shaping the experiences of individual IRNs (content validity).

Sampling for focus groups

Sampling was a two-stage process. In order to include experiences of IRNs in different geographical areas in the UK 2,200 IRNs were selected from the RCN database in three different regions: Cardiff, Leeds and London. These sites were selected by examining the concentration of IRNs in RCN membership by region. Scotland and Wales had similar numbers, but IRNs were more widely distributed in Scotland, so Wales was chosen as travelling was thought to be a potential factor in preventing IRNs from participating in the study. London and Leeds were selected because of high density RCN membership. It is estimated that as many as one in every four nurses working in London is an IRN (RCN 2003).

The 2,200 selected IRNs in the three regions were sent a letter by the RCN detailing the purpose of the study and the researchers attached a paper containing information about the research (see appendix 1). If they were interested in taking part in the research the IRNs were requested to contact the researchers by telephone or by returning a slip with their contact details. Details about the IRNs were received on telephone by the researchers who used the Access database to hold data which would facilitate purposeful sampling following a maximum variation strategy (Patton 1990: 169-83) to include IRNs with different backgrounds, experiences and views. The database included contact details and factual information: age, gender, nationality, ethnicity, marital status, number of children, living arrangements, whether they support their family financially, number of years qualified as a nurse, date of commencing work as a nurse in the UK, current sector of employment and

current nursing grade. During the short telephone interview IRNs were also asked some general attitude questions: whether they were generally happy or unhappy with staying in the UK (on a three point scale) and whether they were generally satisfied or dissatisfied with the working conditions in the UK. The database also allowed some detail of explanation for IRNs to express their concerns, how long they were planning to stay in the UK and what were their main reasons for either wanting to stay or wanting to leave. Finally, the IRNs were asked whether they would be able to attend a focus group in the period when meetings were expected to take place in their respective regions and they were asked how they could best be contacted to arrange the details of the meeting.

The data was useful for the researchers in providing general insights into the various experiences and concerns of IRNs. The researchers gained a broad understanding that sensitised them to particular issues that could be explored more fully during the focus group discussions. Originally, it was planned that the information from the initial telephone interviews could be used in the sampling for individual focus groups, allowing a controlled degree of similarity and variability in the participants' background, actual experiences and views. By presenting, in each focus group, a variety of views and experiences in the context of some similarity in the national and ethnic background, it was predicted that culture-specific experiences and expectations could be more easily articulated and challenged. It was believed that this would strengthen content validity and face validity of the data (see earlier discussion). It had been the aim that each group should have representatives from different national and ethnic backgrounds while at the same time more than one participant should represent each background. This would allow optimal ground for presenting various experiences while, simultaneously, it could be explored whether personal experiences and views were specific to the particular backgrounds of participants.

In practice, however, it proved that the degree of detail in the data from the initial telephone interviews with IRNs could not be exploited fully in the sampling to set up the individual focus groups. This was principally due to the impracticability of knowing precisely when each focus group participant would be available. The IRNs would have to come in their free time or take a day off work and it was rarely possible for the IRNs to know well in advance when they would have time. When selecting participants for the focus groups, maximum variation was sought with regard to nationality, ethnicity, gender and current nursing grade. Different attitudes were also considered in the sampling to include both those with primarily positive experiences and those with primarily negative experiences. The selected participants were then sent a letter inviting them to take part in one of two groups on different days and various times (morning or afternoon); the letter also included details of the venue (the local

RCN office) and how to get there. The invited IRNs were requested to call back to the researchers detailing the time of their choosing.

Forty invitation letters were sent out in both London and Leeds. The initial response had been much lower in Cardiff; only 27 had called or written to express their interest to take part in the study. In an attempt to increase the number of participants in Cardiff, these 27 IRNs were requested to ask other IRNs whether they would also like to take part in the research, and a separate letter from the researchers directed to these new research recruits was included (see appendix 2). Even if not hugely successful, this method of “snowballing” provided some new participants. However, not all participants invited for the focus groups in Cardiff, Leeds and London were able to attend. Apart from the mentioned difficulty of finding the free time, a contributing factor might have been that the facility to reimburse travel expenses had not been clarified when the invitation letters were sent out. Altogether 67 turned up for the focus group meetings, representing an overall response rate of 63%. However, the attendance varied between the regions: 27 (68%) in London, 25 (63%) in Leeds and 15 (56%) in Cardiff. For one of the focus groups in Cardiff only one participant turned up and an individual interview was alternatively arranged with one of the researchers. When another further one participant turned up, 45 minutes late, the other researcher conducted a second individual interview in a separate room.

Research participant profile

On arrival the IRNs were requested to fill in a pre-focus group questionnaire providing factual details of the participants (see appendix 3). This data established a profile of the IRNs who took part in the research. Table 3.1 shows their nationalities listed alphabetically. Eighteen different countries were represented within the sample. Of the 67 nurses who took part in the focus groups a clear majority – 45 (67%) – came from African countries; 11 (16%) came from South Asia (Philippines, India or Pakistan); seven (10%) were from Australia, Canada, New Zealand or the USA; and only four (6%) came from European countries. Nigeria and South Africa were the largest contributors of internationally recruited nurses to the focus groups, 17 and 12 participants respectively. The Philippines, Zimbabwe, Zambia and Australia contributed between seven and four participants, while Ghana, India and Pakistan contributed three or two. Nine internationally recruited nurses were the sole representatives from their respective countries of origin in this study.

Table 3.1: Nationality of focus group participants

	Cardiff (N=15)	Leeds (N=25)	London (N=27)	Total (N=67)
Australia		1	3	4
Canada		1		1
Ethiopia			1	1
Finland		1		1
Germany			1	1
Ghana		2	1	3
India	1	1		2
Kenya			1	1
New Zealand			1	1
Nigeria	3	4	10	17
Pakistan		2		2
Philippines	2	4	1	7
South Africa	4	4	4	12
Sweden	1			1
Ukraine			1	1
USA			1	1
Zambia	3	2		5
Zimbabwe	1	3	2	6

In the pre-focus group questionnaire the participants were asked to indicate their ethnicity. While most replied by giving their racial background (as the notion of ethnicity is generally understood in the UK [Census 2001]) a few either specified their nationality (for example, Filipino) or their ethnic group (for example, Zulu). The replies have, however, been standardised to fit the UK custom, as indicated in table 3.2. A clear majority of 41 (61%) were black, 13 (19%) were white, of which three came from either South Africa or Zimbabwe, 11 (16%) were South Asian, and two were of mixed race.

Table 3.2: Participants' ethnicity

	Cardiff (N=15)	Leeds (N=25)	London (N=27)	Total (N=67)
Black	10	15	16	41
White	2	3	8	13
South Asian	3	7	1	11
Mixed race	0	0	2	2

Only nine (13%) male nurses took part in the study, approximately reflecting the 15% proportion of male nurses among IRNs in the UK (RCN 2003). In the nursing profession there is a general dominance of women both nationally and internationally.¹

¹ Nationally, there are 355,550 female and 44,570 male nurses in the UK. Internationally males contribute up to 11% of the nursing workforce (Department of Health (2002) *NHS workforce statistics 1991 – 2001*. Report of the ICN Workforce Forum).

As illustrated in table 3.3 the average age of the participants was 41 years old, ranging between 25 and 61 years of age. There were only minor differences in the average age between the three regions investigated. The average annual salary was just above £18,000, and London stood out as offering a higher salary. This would be expected due to the London weighting allowance. On average the IRNs who took part in the study had 14.1 years of work experience as nurses before starting work in the UK. Hence, the participants generally were already very experienced professionally when they arrived in the UK. There was some difference between the three regions, with Cardiff representing the most experienced (16.5 years) and Leeds the least (10 years).

Table 3.3: Participants' average age, salary, work experience and stay in the UK

	Cardiff (N=15)	Leeds (N=25)	London (N=27)	Total (N=67)
Average age	43	39	41	41
Average salary (UK pounds per year)	17,310	17,690	19,225	18,184
Average length of work experience in home country (in years)	16.5	10.0	14.1	14.1
Average length of stay in UK (in years)	2.6	3.5	4.6	3.8

On average, the participants had worked in the UK for 3.8 years. There was, again, some difference between the three regions, and this time London emerged as having the highest average of 4.6 years. However, the further breakdown of the participants' length of stay in the UK in table 3.4 demonstrates that this average is achieved through a few (3) very high scores (one of which was more than 30 years).

Table 3.4: Average length of stay in the UK - in subgroups

Length of stay in UK	Number of participants				Average length of stay (in years)
	Cardiff (N=15)	Leeds (N=25)	London (N=27)	Total (N=67)	
Less than 1 year	2	5	7	14	0.5
Between 1-10 years	12	18	17	47	2.9
More than 10 years	1	2	3	6	18.9

Table 3.5 shows the current nursing grade held by the IRNs who took part in the study. 33 (49%) of them reported to have a D grade, 17 (25%) had an E grade, while nine (13%) had either an F or G grade, and only one had an H grade. Seven of the participants did not report

their current nursing grade. It is, however, likely that the majority of these had either a D or an E grade, since six of them had been working in the UK for less than two years.²

Table 3.5: The current nursing grade of IRNs

Nursing grade	Cardiff (N=15)	Leeds (N=25)	London (N=27)	Total (N=67)
D	5	16	12	33
E	3	4	10	17
F	1	2	2	5
G	1	1	2	4
H	0	0	1	1
Not reported	5	2	0	7

The professional experience and qualifications of the IRNs is further illuminated in table 3.6. In the pre-focus group questionnaire, the participants were asked to indicate the nursing grade they held before starting work in the UK because it would translate in the equivalent UK grading system. The table proves that the majority of the IRNs who took part in the study were in senior positions before coming to the UK. Thirteen (19%) held positions in management or nurse education. 25 (37%) held positions equivalent to between F and I grade. Only 19 (28%) had a D or an E grade when they left their home countries. Apart from a higher level of missing information on this issue in Leeds, there does not seem to be any significant deviation between the regions.

Table 3.6: The equivalent nursing grade of IRNs before coming to the UK

Equivalent nursing grade	Cardiff (N=15)	Leeds (N=25)	London (N=27)	Total (N=67)
D	5	2	4	11
E	2	3	3	8
F	0	5	2	7
G	2	2	6	10
H	0	2	0	2
I	1	1	4	6
Management/education	5	3	5	13
Not reported	0	7	3	10

Arrangement of focus group interviews

The focus group interviews lasted two hours and were held at regional RCN premises in the participants' free time. Local RCN officers facilitated setting up the focus group interviews, and tea, coffee and biscuits were served. Two researchers were present during the focus group interviews: one in the role of moderator and one in the role of observer. While the moderator presented the issues to be discussed and ensured the involvement of all participants, the

² We were told by one IRN that when she was negotiating her contract, she had been told that xxx NHS trusts did

observer made notes on the dynamics of the group, specifying contributions of individual participants and paying attention to the presentation of different experiences and opinions by various participants (Morgan 1997). The researchers took turns to function as moderator and observer. The presence of two researchers in the course of the interviews allowed for a more accurate and detailed analysis of the data in a subsequent dialogue between the researchers.³ Further, the notes on the social dynamics were useful when analysing the transcript from the focus group interviews, which were audio-recorded.

At the beginning of each focus group (after having completed the pre-interview questionnaire) the participants were asked to present themselves indicating name, working place, nursing grade, years working in the UK and country of origin. Together with the observational notes, the presentation procedure facilitated voice recognition to identify the participants talking during the discussion.

The focus groups were organised around five questions. The opening question was deliberately very broad and open to allow various experiences and views to be presented freely. The following questions were more specific and it was often the case that key aspects had already been discussed in the opening discussion, which allowed the moderator to move on quickly after having made sure that everybody had expressed their views on the subject. These were the questions the IRNs were asked:

1. what are your experiences of working as a nurse in the UK?
2. what has been done to support you in your work as a nurse in the UK?
3. what expectations have you had of work and life in the UK?
4. how does the role of the nurse in the UK compare to your home country?
5. what would motivate you to stay and work in the UK for a longer period?

The moderator presented the first question to be discussed. The question was written on a flip-chart and the moderator read it out and asked the participants to use a few minutes to write down their initial thoughts on a piece of paper in front of them. This method strengthens individual reflectivity and it allows the moderator to more easily draw the quiet participants into the discussion by asking whether they have written down some points that they would like to share. The moderator took care to make sure that all participants had a chance to speak and that none were too dominating.

not employ IRNs on grades higher than D. (*female, 55 years old, Zimbabwean, white, E grade*)

³ Observation notes were particularly helpful when transcription proved difficult and were included as data in the analysis stage.

Data analysis

The analysis of the focus group data started shortly after each focus group interview when the two researchers made analytical comments on the main themes addressed during each focus group interview. This initial analysis creates reflective data similar to the field notes created when doing ethnography (Savage 2001).⁴

An external clerical assistant transcribed the audio-recorded focus group interviews. In the quotations, the symbol ‘...’ indicates that material has been edited out, ‘[]’ indicates that explanatory material has been inserted, an explanatory text in block letters indicates sound, while block letters indicate the interviewers’ questions and inverted commas indicate a quote within the quote. The transcribed data was managed and analysed using the qualitative data analysis software *NVivo*, version 1.3, (Richards 1999) allowing strategies of both case analysis and cross-case analysis to be performed (Patton 1990: 376). The data was coded using broad empirical themes and by specifying individual participants. The researcher who sat as observer in the focus group interview coded the transcript using his or her observational notes as support to indicate which participant was speaking. Occasionally, the observer made corrections or fill in omissions in the transcript, which at times the clerical assistant found it hard to understand the dialects or accents of individual IRNs.

Analytic procedures were integrated with the coding process. When setting up and revising the coding system the researchers used the *properties* function in *NVivo* to reflect on each code and make comments on the purpose, focus and possible overlapping with other codes. Regularly, full reports on the coding system (called *node report* in *NVivo*) were inserted in a log book. They were set up as a document in the *project folder*, where the researchers reflected on the development of the coding in order to establish a *chain of evidence* to support the reliability of the research (Yin 1994: 98ff.). Furthermore, while coding, each researcher kept a record of analytic observations of particular importance to capture and articulate insights emerging from the close familiarity with the course of discussion in each focus group. This was a single-case analytic strategy. A printout was made of the transcript with the codes indicated as ‘node stripes’ and the other researcher read it through to make additions or comment on the coding. Then the corrections to the coding were entered in *NVivo*. The procedure strengthened the reliability of the coding of the transcripts and the validity of the coding categories as they were developed in a dialogue with the data.

⁴ These proved a rich source of analysis as discussion on observations from each interview took place over the two days spent on site and formed the basis of initial coding.

Having completed coding and re-coding all the focus group interviews, the data were analysed in *NVivo*. Applying a cross-case analytic strategy, text sections from different focus group interviews were retrieved by searching the individual codes. This procedure allowed relevant data on particular subjects to be presented. The retrieved text sections were printed out and allowed the researcher to go through them all to get an overview of sub-themes within the code and the various views represented. This formed the basis for the individual chapters where codes were grouped together in relevant themes, as illustrated in table 3.7.

Table 3.7: Overview of codes used to provide data for specific chapters

Chapters	Data coded as:
Chapter 4: motivations and expectations	<ul style="list-style-type: none"> • Motives to come • Expectations of UK
Chapter 5: experiences in the UK	<ul style="list-style-type: none"> • Life in UK • Psychological
Chapter 6: recruitment, reception and support	<ul style="list-style-type: none"> • Recruitment • Support
Chapter 7: working as a nurse in the UK	<ul style="list-style-type: none"> • Nurse role comparison • Qualification recognition • NHS vs care home • Relation to colleagues • Relation to patients • Language • Exploitation
Chapter 8: comparing health care systems and culture	<ul style="list-style-type: none"> • Health care comparison • Culture home • Culture UK
Chapter 9: discrimination – colour or culture	<ul style="list-style-type: none"> • Discrimination • Others' perceptions
Chapter 10: coping strategies	<ul style="list-style-type: none"> • Career strategies • Motives to stay

The documents with the single-case analytic observations were reviewed to supplement observations arising from the cross-case strategy. Throughout, the researchers worked together on the data analysis and shared progress through the coding and the further analytical stages. The final analysis produced a model for understanding the data that is presented in chapters 4 to 10.

Ethics

This research proposal was submitted to the University of Surrey's Advisory Committee on Ethics. Confidentiality was maintained throughout the project following the Data Protection Act (1998). Identities of participants were protected in all communications and activities during the research. Stakeholders' views were represented confidentially and they were equally and fairly treated throughout the research by sharing information (Guba & Lincoln

1989). The processes used of informed consent and sharing of information of the research findings are also advocated as ways of working in the Department of Health guidelines on research governance (Department of Health 2001).

Consent to participating was initially given when participants chose whether to contact the researchers for further information prior to agreeing to participate in the focus group interviews. All interviewees were aware that publication using data from the research was to be published on the RCN web site, the *RCN Bulletin* and that academic articles would be written and published later in the year. In addition, participants were advised that if they wished to contact the researchers they could email or telephone to discuss issues arising from the interviews.

4. Motivations and expectations

This chapter presents the motivations of IRNs to come and work as nurses in the UK, and it outlines their preceding expectations. As discussed in Chapter 2, IRNs' motives have been presented as a question of *push* and *pull* factors (RCN 2002b, 2003). However, this pair of concepts is based on a macro structural theoretical approach. The financial and general social situation in the home countries which *push* nurses to leave or opportunities in the UK which *pull* them to come are best studied from a politico-economical and historical perspective. From the micro perspective of the individual nurses, the distinction between push and pull translates to factors that motivate them to leave their countries and factors that motivate them to come to the UK. There was difficulty in arranging focus groups where all participants shared background (nationality and ethnicity) with some other participants in the same focus group (see chapter 3 on sampling). Therefore, the discussions provided more detailed and in-depth data on their motives to come to the UK: that is, the *pull* factors. Therefore, in this study the micro perspective on push factors will only be addressed sporadically.⁵

During the focus groups, participants mentioned personal, professional, and financial as well as social reasons for coming to work as nurses in the UK. These dimensions were given weight variously by individual IRNs, and they interrelated in complex fashions. For example, across the different nationalities of IRNs it was mentioned that they came to experience another culture and way of life in the UK. They also said that they expected professional development and exposure to high levels of nursing practice, and that the financial rewards from their employment would allow them to meet their social obligations. The motives of each IRN were multifaceted. However, the various aspects are here singled out in an ideal typical fashion in order for their respective importance to stand out.

Personal motive

When talking about their motives to come to work in the UK a strong theme was their *personal* ambitions and aspirations. IRNs shared an urge for adventure and to experience another part of the world. As illustrated in these quotations:

⁵ We recommend that a study of push factors motivating IRNs to come to work in the UK should be based on a research methodology including a politico-economical and historical analysis of the relevant countries, as well as individual interviews with IRNs allowing personal and sensitive issues to be addressed in depth.

I had the intuition like I'm urged to go abroad to go and work...
(female, 46 years old, South African, black, D grade)

I signed [the work contract] because it was an opportunity to go abroad and you're young and you want to travel abroad.
(male, 35 years old, Zambian, black, E grade)

... it's just this idea of wanting to branch out, you know, to experience other worlds, to see what it is like...
(female, 30 years old, Nigerian, black, G grade)

Discussions in the groups revealed that there were some individually different dimensions to the travelling experience. For some, it was the mere fact of having a chance to see and experience a different way of life. An Australian male participant in a Leeds group said that it was his impression that most of the nurses from his country who come to the UK spend most of their free time going out to clubs and pubs and during holidays they travel around Europe. However, this is only for a limited period of time, after which they either go back to pursue a professional career in their country of origin, or, if they stay, their career strategy takes a more focused direction. During the discussion in a London group a participant explained:

[My reason for coming was] travelling, and nursing was a means to an end. But the longer you stay here – because I speak from a southern hemisphere environment, most people come over to do their two years stint, travel through Europe and then go back and then you start in your profession that you studied and you carry on. I think once you're over that two year period one, you realise that you have to do something in your profession, so you sort of start going up the ranks and then to be able to travel.
(female, 30 years old, South African, white, E grade)

The data indicates that this *working holiday strategy* relates specifically to white nurses coming from previous British colonies. However, the relatively small number of participants cautions generalisation.

I wanted to come overseas to travel and to see the country that my ancestors came from.
(female, 55 years old, Zimbabwean, white, E grade)

Some individual statements also indicated that this strategy could apply particularly to nurses coming to work in London, which offers rich possibilities for young professionals looking for the nightlife and cultural experiences in a major European capital. A Canadian nurse in one of the Leeds focus groups explained that she originally came to work in London for this purpose, but when she got married and decided to stay, she moved up to a more affordable northern

region of England. For some IRNs the working holiday strategy even meant that they had been willing to take a pay-cut. As the Canadian nurse explained:

It wasn't to my financial gain to move to this country. I took a salary cut from forty thousand a year Canadian [17,200 pounds sterling] to less than thirteen thousand [pounds sterling], but I used the situation to my advantage in the sense of I was going to travel and that's why I came over here.
(female, 33 years old, Canadian, white, E grade)

For other participants, the possibility to use their professional qualifications to allow travelling related more profoundly to the way of life they expected in the UK. Some explained how social and cultural values enjoyed in the UK allow them a lifestyle they cannot exercise in their countries of origin. A Nigerian woman explained how the independent lifestyle in the UK had attracted her to come here to work:

... here in Britain everybody is independent, you don't need to depend on anybody or anything, you want to get your job, get your house, get life going, everything is at your service, all you need to do is to ask for information on how to get things done and get them done quickly, you know. So that's just, back home ... you know, most children could stay with their parents until death do they part and the parents take absolute responsibility of them and even like for the males who get married the parents still look after the kids, the wife and everything. ... So that's just what I appreciate, so, because I love to be independent.
(female, 30 years old, Nigerian, black, G grade)

Within the overall travelling motive we call this a *life change strategy*. A balance of push and pull factors could be involved, as further illustrated by the example of a woman who related that she had divorced from her husband and was looking for a new start in the UK.

We left because you know what Africa is. I would only speak of Zimbabwe, we used to have the real beautiful life, I could afford to live day to day, I drove, I had a fantastic job, but circumstances make you change. I got divorced ... and I couldn't make ends meet at all and I needed the change of life after a marriage of twenty-one years.
(female, 47 years old, Zimbabwean, black, D grade)

Several participants had travelled extensively before coming to the UK and they had a wide scope of international experience. The data indicates that these IRNs share an appetite for travelling and adventure. This became apparent in some discussions of their experiences with their colleagues and, more specifically, the issue of discrimination and racism in the UK (to be explored further in chapter 9). The IRNs criticised some of their UK colleagues' narrow perception of the world and their lack of appreciation of human differences. Particularly, they were astonished and amused by the fact that some of their UK colleagues had never travelled abroad.

Professional motive

A second major theme mentioned by the IRNs in the focus group discussions was their wish for professional development, for exposure to a high level of nursing practice and the possibilities of further education (see chapter 8). They had come to *do nursing*.

What I'm here for, because my aim is to come and nurse the patients...
(female, 53 years old, South African, black, D grade)

The participants shared an expectation of a high professional standard of nursing and that the most advanced technical equipment would be at their disposal.

I expected clean hospitals, I expected, you know, very high quality of care, friendly nurses.
(female, 31 years old, Kenyan, black, D grade)

For some, these expectations related generally to the recognition of the UK as a developed country. For others, the expectations related more specifically to British colonial history and the ideal of Britain being a nursing world leader historically. Their expectations were also supported by the use of British teaching material in training nurses in former British colonies.

...when I was a student nurse our tutor used to say: "Oh, we're following the British system." ...I said to her: "Well, because we follow the British system in South Africa as a British colony [inaudible]...I'm going to fit in."
(female, 52 years old, South African, black, E grade)

Hence, the IRNs expected that they would become exposed to the most advanced nursing practices.

I was just expecting everything, as I say, a higher standard because we're told: "Oh, where you are going." And when you read [inaudible]...sending you like job descriptions and other things, oh, they are so well typed and they are so informative and you just say: "Oh, I do like England. I am going somewhere."
(female, 54 years old, South African, black, D grade)

[M]ost nurses have very good backgrounds and they're very comfortable at home, they just came for experience, most want to come and experience nursing in Britain because depending on where you work you may not be that exposed to some of the things ... So it gives you a wider scope to reap experience of practice and decide which area you want to be proficient in like because, uhm, here you have broad scope of specialisation and you've got a lot of choice like if you don't want to go into clinical nursing you could go into the district, you could go into, uhm, teaching, administration, social services.
(female, 30 years old, Nigerian, black, G grade)

I expected high technology when I came.
(female, 49 years old, South African, black, grade not reported)

Several emphasised the positive value of possibilities for further education and study.

...I was thinking: "Oh, this is where we learn everything from." And so I expected to learn a lot and be able to take back something to South Africa.
(female, 50 years old, South African, white, D grade)

I expected a kind of academic research institution to work and the kind of support educationally and I wasn't expecting a place where you would be left alone, I expected somewhere you would have a lot of support and where you'd be geared up to work and put in the best and achieve something great. And then also I expected a salary, something to really live on that, you know, get good... But the most important thing I expected from the NHS or any working situation is educationally backed up, a place where you can really put in what you have been taught and where you can really, you know, push yourself from time to time and achieve a lot of results.
(female, 37 years old, Nigerian, black, D grade)

[O]ne thing that in Finland what I couldn't do was that I couldn't study, like they didn't invest the nurses to study. Like now I've been able to do my Masters ... and doing all sorts of things and I have been able to take part [in] lots of study days and I believe that in my old job I couldn't do that in Finland in the same way that I have been able to do it here and I think that has been one of the good things that at least I have been working and we have been able to study and develop yourself here.
(female, 30 years old, Finnish, white, F grade)

Nurses from former British colonies tended to expect to become exposed to the highest standard of nursing and the most advanced equipment which they could only read about in their home countries in (often British) teaching material. On the other hand, IRNs from other Western countries expected there to be some differences, but only minor.

I expected it to be very similar to my training.
(female, 30 years old, Australian, mixed race, G grade)

I think that my expectations were naïve when I came here because I'd never been to the UK prior to the job experience so I didn't know what to expect, how the hospitals were run, how they even looked.
(female, 33 years old, Canadian, white, E grade)

Financial motive

IRNs were motivated to come and work in the UK by the prospect of earning a living. Some IRNs were motivated by the sheer possibility of making a living and working in their profession - since overproduction of nurses in their countries of origin could make it difficult

to find work. Others were motivated by the fact that their earnings would allow them to save or send money to the family back home, and that even a modest amount would be very valuable there due to the current strength of the British currency. This, latter, motivation could be labelled working for back home.

As an example of the *making a living* motivation, a Filipino nurse explained that newly educated nurses in the Philippines often find it difficult to find a good job, and in some instances they have to gain professional working experience doing voluntary jobs in hospitals. In this perspective finding a job as a nurse abroad provides an appealing alternative. However, the national overproduction of nurses can in some cases be a deliberate economic strategy. In other cases, the international employment strategy can represent an individual's immediate response to a national and confined overproduction of nurses. As a Finnish nurse explained:

... one of the reasons why I came was that in Finland it was very difficult to get like full-time jobs.
(female, 30 years old, Finnish, white, F grade)

Another aspect of the motive of making a living has already been explored in the discussion of IRNs who came to work and travel in Europe even if they experienced a drop in pay.

While there could be a difficult employment situation in the home countries of IRNs, their financial motive could also be dominated by the wish to be working for back home. Another Filipino woman said that her motives to come were 70 per cent for the money, and she explained that the money allowed her to help her family back in the Philippines and her savings could provide her with financial security for her retirement. Supporting the observation made in chapter 2 that there is a longstanding tradition in the Philippines for large numbers of nurses to be working abroad (Mejia 1978). The Filipino nurse explained that in her country it was a common arrangement that the person in the family who had gone to school would go to work abroad and send back money to help the family and possibly allow another family member to receive an education. In this way, the financial ambitions were part of a general family strategy of financial survival and progression. But even if the money was a main reason for her to come she emphasised that it was also important for her to have a chance to improve her professional skills, experience life in the UK and give her children an advantage in life by letting them experience another culture.

A Filipino nurse had previously worked in America and expected to achieve a similar living standard in the UK:

Before, when I was still out of UK, I'm expecting that it's like America ...within one year I could have my home and my car.

(male, 46 years old, Filipino, South Asian, D grade)

In some cases participants explained that they suffered a decrease in their personal living standards by coming to work in the UK, but their savings would have a high purchasing power in their countries of origin. As a South African participant explained in a discussion:

That's why I came also here, because of the currency, that's when you look at the pound, or the pound is equivalent to so much, then you could look at, it's not much what we are getting here in fact, it's only the currency that is helping us, but when you use it at home, it will help you and you will manage to do whatever you want it to do. ... the cost of living with the Rand is not doing well, so when you take a pound here, a pound is basically, we are having better opportunity of taking those pounds, money to live and your children can get something.

(female, 54 years old, South African, black, D grade)

Hence, the financial motivation of individual IRNs is complex and directly interrelated with macro-economical issues of global exploitation and the relative financial power between nations. Due to global monetary inequality, we can observe the paradoxical situation that overseas nurses are attracted to come and work in the UK and experience a lower standard of life than a nursing salary in their country of origin would allow. But, at the same time, their modest savings as immigrant workers provide a substantial financial security in their countries of origin.

The data indicates that this motive to work for back home was most strongly represented among nurses from developing countries (due to the relative benefit from the strong British currency). The data further suggests that there could be a difference in the strategies between younger and older nurses. The younger might come both to make a living and be working for back home, and they might bring along their family and stay for a longer period or, perhaps, permanently. Older nurses from developing countries, however, tend to be planning to stay for a shorter period in the UK to use their last working years not so much to make a living here as to make savings to support their family and improve their welfare in retirement.

Back at home, I said I would retire at 55. I am 54 this year, so next year I was going to stop working, but now I said: "OK, if I am still OK here I can do another year" just to make the pension up.

(female, 54 years old, South African, black, D grade)

Social motive

As the presentation of IRNs' financial motives has already revealed, it could be difficult to separate this from a social motive. A participant put it like this:

I came here really to see how things were done and also meet my social economic obligations.

(female, 52 years old, South African, black, D grade)

She continued, explaining that apart from securing her family obligations she would also like to contribute to the society at large.

I will go back home and when I get back home I'm going to use some of the little knowledge that I've observed here to do something better for my community now. ... I would need to plough back, because I was educated by the tax payers' money at home and I need to give back a little bit of what I've gained here, right? There are a lot of nursing homes around here and back home young people are dying from HIV and AIDS, probably we'll have older people who will have nobody to care for them. Probably the knowledge I've gained in the nursing homes I will be able to have a nursing home somewhere and plan it.

(female, 52 years old, South African, black, D grade)

Family obligations were integral to the working for back home motive. Another type of social motivation to come to the UK was related by a number of participants who had come to be with their spouse who had been studying or working here. The importance of family ties was also apparent in the description by a Nigerian woman who explained that she had been inspired to come to the UK by her aunt who had been working as a nurse in the UK for more than twenty years.

The personal and social motives could at times be interwoven through the social status enjoyed by overseas nurses in their countries of origin.

I just enjoy travelling and when the opportunity came, because even in Africa I worked in Nigeria, I worked in Zambia and I enjoyed it when I went back home because of, you know, the relationship, the respect you get and, I mean, I go to some [social gathering] and everybody stand up, I was nurse superintendent, I used to, I was nurse midwife ... people stand up for you, people treat you well...in the hospital, you know, they're so nice, that, I enjoyed that bit.

(female, 37 years old, Nigerian, black, D grade)

A different type of social motive related to the life change strategy. Some explained that they would like their children or grandchildren to have an advantage in life by growing up in the UK, receiving British schooling and becoming familiarised with UK culture. Hence, in some cases the prospect of life change was not so much an individual achievement as an indication of the course of life of their family.

Conclusion

Discussions in the focus groups revealed that these various dimensions – summarised as personal, professional, financial and social – were all important motives for IRNs to come to work in the UK. As the presentation reveals, they are often interwoven in complex ways and the strategies and motives of individual IRNs tend to change over time.

Therefore, this data only allows a restricted degree of analytic typification of IRNs' motives based on single parameters. All seem to come with some degree of personal wish for adventure and travel, but the data indicates that nurses with British ancestors from former British colonies or from western European countries come for a travelling holiday, and that London is a preferred place of work. Other motives might also be relevant to this group, such as unemployment in the home country or better possibilities for further education in the UK. Nurses from developing countries tended to come to experience life in the UK, to be exposed to the high standards of nursing practice in the UK and to experience professional advancement. Also, the financial dimension seemed to play an important role for this group, and they expected to be able to meet social-economic obligations to their families. Some older nurses were here with the prospect to save as much as possible to allow a better retirement and support for their families back home.

In all cases, the move to the UK involved uncertainty and was not an all-win situation. A South African participant perhaps expressed this most clearly. She said she was concerned that the strategy of individual nurses in her country to work abroad impoverishes the society at large. However, the financial gain she could make for her family outweighed the larger perspective.

... we are having better opportunity of taking those pounds, money to live and your children can get something. That is why our hospitals are empty at home, they are suffering, our people are suffering. Our parents are suffering, they go to hospital, all the nurses are in the UK, because of the money.
(female, 54 years old, South African, black, D grade)

The move also involved personal sacrifice, not only for those who were living very basically to allow more savings, but also due to the mere fact of being socially uprooted. And it was not a simple option to just return if the expectations were not met. Sometimes huge financial commitments were made to arrange the travel and pay for adaptation courses; some IRNs have paid recruitment agencies up to £1,200 (RCN 2003: 17). For others it could be a question of not letting down the expectations of the family or trying to avoid losing face.

But you've left your position over there to come here and it's difficult to go back because it's like "Oh, what have you achieved so far?"
(female, 37 years old, Nigerian, black, D grade)

More generally, the risk involved that IRNs would have to find out whether their motives and expectations would be met by their actual experiences. The motives provided a prelude and context for their subsequent experiences, providing expectations and setting goals. It is to these experiences we will now turn.

5. Experiences in the UK

As discussed in the previous chapter on the IRNs' motives to come to work in the UK, a range of issues were relevant, summarised as personal, professional, financial and social. All these various aspects of life are important to the total experience of the IRNs as they live in the UK. This study, however, focuses on the professional aspects of the experiences. This is due, partly, to the aim of the study that is to provide recommendations to improve the conditions of professional recruitment, adaptation and working as nurses in the UK. Another reason is methodological: the focus on the professional dimension is created by the social dynamic of the focus group method employed, where the discussion naturally centred around the field of experiences they had in common – being overseas nurses working in the UK.

However, the personal, social and financial aspects of their experiences in the UK often provided an important background, or context, for understanding the professional experiences. Therefore, this chapter presents a broader basis to inform the understanding of specific issues regarding the IRNs' experiences working as nurses in the UK. This outline is based on information presented as context around discussions in the focus groups.⁶ Key issues revolved around basic feelings of being happy, comfortable and feeling appreciated in contrast to being unhappy, insecure, feeling isolated and not cared for. Apart from social support from family and colleagues, important aspects were the quality of the accommodation and financial issues.

Living conditions

The material and social circumstances often reinforced each other, and some described how they experienced that shortly after arriving how nobody really cared for them or how they felt.

... I was in [a care] home in one of the rooms. You stay there the first week, second, third week, fourth week, fifth week, three months, and they don't do anything for you. You have foods from home, but you don't have access to anywhere to cook them. The thing is that if you come in in such a manner, at least you should be accepted and appreciated, not like just in the common room. Not getting any peace, you are not in a comfortable bed. When working here you talk about accommodation, it means a lot - privacy, everything, you know. When that thing is not there, how do you want to feel?
(female, 39 years old, Nigerian, black, D grade)

⁶ We recommend that a more detailed study of the personal, social and financial experiences of IRNs would include qualitative methods suited to generate such sensitive and culturally-implicit data – for example, in-depth individual interviews, life stories, self-reporting narrative methods and participant observation among groups of immigrant workers.

... where I come from we used to drive our own selves and here you have to wait in the bus stop ... and it's cold. You need basic things, shelter, you know, to boost yourself, you know. You know when I go home I'm going to my home and then you're leaving these rented houses, they give you scrap furniture to start with and you get in then, when I first got into where I'm staying I couldn't even sit in those seats. I could just feel something creeping out of the place and then you say "So this is how they think of me, they think I come from the dumps" you know?
(female, 49 years old, South African, black, grade not reported)

Quality of life in the UK was dependent on the material and financial conditions. Some explained that it had involved considerable costs for them to make the move to the UK, involving expenses for the travel and fees for the adaptation courses. These financial obligations can often restrict the IRNs' perceived degree of freedom. Some IRNs also complained about the level of tax that they are obliged to contribute. They felt that they did not get anything back. As two Filipino nurses put it:

...one thing I hate right here is your tax man!
(male, 46 years old, Filipino, South Asian, D grade)

Talking about tax and things like that, what actually frustrates me is that I came here legally, so did everyone else, legally, I paid everything that a British citizen pays for, but what do I get in return? Instead, I suppose, fine, we have refugees and everything, they're getting far more than I do. I get nothing back, I pay the National Insurance, I pay the tax, what do I gain from that?
(female, 30 years old, Filipino, South Asian, E grade)

The sensation among IRNs of not getting anything back from income tax was related to the double burden they carried of ensuring the welfare of their families back home by sending money and, at the same time, contributing to the British welfare system. Hence, the difference between the private and family based welfare model of their home country and the universal welfare model in the UK created a double financial burden for IRNs. A way to overcome this financial difficulty was bringing their family to the UK so that they could enjoy the benefit from their tax contributions through the state schooling and health care systems. A South African woman explained how it had been favourable for her son to join her so that he could receive treatment for his chronic (and expensive) medical condition.

[My son] came four months later while I wasn't prepared but he had to come, and I would say it's the biggest bonus I have got because the health care he's getting is excellent. ... For him I think it's the best thing.
(female, 47 years old, Zimbabwean, black, D grade)

Another financial difficulty was related more to the social status of the IRNs. Being immigrant workers meant that they found it difficult to find better accommodation and they could be excluded from getting a mortgage and buying their own house.

I can't get a council house. Like he's saying [referring to a Filipino participant], you can't even get a car. You want to buy something, they'll ask you "Where did you live before?" Where did I live before? In South Africa! Your credit record, where is my credit? I don't have a credit record here. It is very, very frustrating...
(female, 49 years old, South African, black, grade not reported)

The discussion in this focus group, at certain points, became particularly focused on the financial and material conditions of IRNs. Another participant in the group explained that, after a difficult start, she had finally been able to get a mortgage and now had a positive outlook on the future.

We were three in a room when we came, married ladies, which is not even [considered appropriate] in our culture for married ladies to be in the same room. Three in a room! Eventually what we did was to rent. I went, I was supposed to go and rent an accommodation which was even quite much, rented accommodation and afterwards I wanted to get a mortgage, I was told, like you said, no credit facility ... Luckily now I've got one, I had to have so many struggles ... when put everything together, deduct then with tax on all the bills and everything, you come back with nothing. ... but I know as time goes on, because I'm positive, I know as time goes on I will be okay because my husband is still looking for a job in this area.
(female, 37 years old, Nigerian, black, D grade)

Some felt that they could have got better support with these personal and financial matters. The South African woman quoted above suggested that professional bodies such as the RCN could provide better support.

It is really frustrating, especially the RCN, which is supposed to be looking after you. They tell you you can get this loan for housing mortgage, you can get a car, this, that, you phone these numbers which are there in the bulletin, you hit the wall. ... they know us, we've come here, you know, even RCN. I actually get irritated when I see these discussion groups about sharing the diversity or whatever we call it, it just irritates me because sharing and then what?
(female, 49 years old, South African, black, grade not reported)

Discussions also revealed that some had found it a bit overwhelming to arrange all the practical and bureaucratic issues that had to be in place when starting a life in a new country. Issues could span from small, everyday things such as knowing where to buy the milk and various special food, getting accustomed to the British system of having the hot and cold water taps separated and issues such as how to arrange a National Insurance number. For some, transition to life in the UK was very difficult, not only because of the material or

practical circumstances, but also on a much more basic and profound level: they felt homesick. A Nigerian woman described the impression she had got from some of her fellow IRNs.

Most people [IRNs] come in and they, come in and stay for like one, two years then go back ... within two, three weeks, one month you start getting homesick, within three weeks or a month, higher six months so you can have your home leave and when you go that's the end of it, nobody comes back. ...once the nurses go they don't come back. You have in so many places where once you will hear them say "She's going on leave, she may not come back." ... just can't stand it anymore, go back home where you're very happy, you're accepted, you know, being loved, you know, shown the care.

(female, 30 years old, Nigerian, black, G grade)

Family and social life

Radically different experiences were expressed in some other focus groups. Some IRNs seemed not to bother too much about the material conditions and the standard of their accommodation. Instead, they focused more on the social dimension of their spare time. A Canadian nurse who had come to work in London with the purpose of having a working holiday (as discussed in chapter 4) perhaps expressed this most strongly.

... the positive was because I was in London, uhm, I was in the heart of the city, so fifty percent of your life is work, fifty percent is, you know, the heartbeat of the city which you choose to live in and so that was enjoyable because that's why you'd come to London, why you'd choose to come to London. And so I enjoyed that social aspect of it and being able to socialise with people in the accommodations that were, you know, foreign nurses, but it was also students lived in the accommodations, doctors, other nurses and so on and so forth, so there was a real mix and there was a social club as well in a part of the hospital as well, but, uhm, and you just networked from that.

(female, 33 years old, Canadian, white, E grade)

Hence, the data points towards the importance of personal expectations and socio-cultural competencies of the individual nurses. Some IRNs felt comfortable and positively challenged by the life offered to them by the British society and way of life. For others, this life was unfamiliar and they did not aspire to become part of it, as a South African woman explained:

I've tried my best to make friends, but still I find it difficult within the work situation clearly because I'm, I'm not smoking, I don't go to clubs and [inaudible]...so like I'm isolated and whenever they invite me I will always put my excuses because I'm not used to that life, it's so difficult for me and well, I don't know, and in the end I decided to bring my children over, so I'm much happy.

(female, 49 years old, South African, black, D grade)

IRNs often spoke about how they felt isolated, particularly in the first period of their stay in the UK. The large proportion of IRNs working in the independent sector (RCN 2003: 11), where the staff cover generally is lower than in the NHS, could contribute to their feelings of isolation. But the isolation could also result from being the only IRN on the ward. For some, like the Canadian nurse quoted above, the feeling of being isolated was restricted to the workplace, and this issue will be discussed in more depth later as an aspect of professional support (see chapter 6). It seems that the nurses who came for a working holiday could tolerate the isolation at work, as long as they were successful in their efforts to establish the free time social contacts they largely came here for. But for other IRNs the feeling of being isolated could be more comprehensive and unbearable. These were the ones who did not have the social support of either a strong already existing immigrant community and/or family living together with them. A Filipino woman described how she initially felt very unhappy living in the UK as her husband and child were still living in the Philippines. Later they decided all to move to live with her in the UK and she explained how she now felt much happier. A Nigerian woman described what she had observed among some IRNs:

Most of them [IRNs] that come in here just themselves, no family at all, so it's a big problem, they don't have anybody to fall back on to anything because I see most of them coming to work and go back home very depressed. You know, you weep your eyes out, nobody to console you, nobody to talk to, when you're ill nobody to ... look after you, to find out how you're faring, you know, that kind of thing, so but it's not the same at home. At home you always people coming in to see you, asking how you're faring, asking to help where necessary...
(female, 30 years old, Nigerian, black, G grade)

IRNs talked about how it had been very difficult and psychologically demanding for them to be separated from their families. Describing how it was for her to leave her son, a participant explained:

But I tell you ... it's terrible, it's the most terrible thing you have done. It's actually, I don't think it's even, I don't know what the kids, [when we talk on the telephone] I always ask my son: "How did you feel?" It's not a nice experience at all.
(female, 47 years old, Zimbabwean, black, D grade)

Being separated from their families meant that they had special needs. A woman told how her manager had taken special consideration by allowing her sometimes to stay on the telephone for half an hour talking to her family. However, such stories were rare, and sometimes their request for consideration were flatly denied, as this participant explained:

I had a problem with my children in South Africa, so I really needed to go there. They said: "No, because you came here with your contract of this month." [I said:]

“No? Even if it’s a contract, I’m having a problem, a family problem?” Then I did not understand. So now I just felt as if maybe we foreigners sometimes we come here just to be used. If we work that’s it, if you’re having a problem it’s not their business. Here where I’m coming from now if I just request a special day off to attend meetings I will be questioned many things as if I’m just going to rest or I’m not allowed. In fact of course here there’s a kind of lifestyle that all people want to go away any time they want to leave, but not with me, I’m not, I’m not free, I don’t feel free still in these three years here.

(female, 49 years old, South African, black, D grade)

Others explained how this lack of consideration not always came from the management, but from their UK colleagues. A participant explained that it had been a cause of criticism and jealousy that she had been allowed four weeks holiday leave to go and visit her family. This was, however, not a uniform picture. A Canadian participant said that one of the clear benefits of her work in the NHS was that it allowed her to take time off to travel and visit her family.

If you work a week of nights you have a week off and you add a week and that can actually work out to be fourteen weeks off a year, if you really want to, and that would be one of the main reasons of the benefits package of why I stay here, that’s what I put down on the form. Uhm, and that supports my work because that gives me a break from work and re-energises me to come back to work, the benefits package of that, being able to go home and see family and things like that.

(female, 33 years old, Canadian, white, E grade)

As mentioned, bringing over the family had been a solution for some of the IRNs who had decided that they would stay and live in the UK for a longer period and that it could be beneficial to their children and spouses. But it also involved some problems if, for example, the spouse would find it difficult to get a job. It meant changing the perspective from the life in their country of origin to a fundamentally new way of life in the UK. A Filipino nurse explained how she was concerned about the cultural differences and how British values and moral standards would affect her children. She hoped that she and her husband would be able to protect them from any harmful influences from the liberal attitudes between the sexes and to drugs and alcohol.

The alternative to bringing over your family is creating a new family in the UK. Some participants explained that they had met their partner here, as this Finnish woman:

... there’s so many things that I would be happier in my own country, but also that I met my partner here, he’s British and in one way you learn to cope. ... in the end for me the happiness has been the job satisfaction, always the main thing. And then I’ve been here six years old, yeah, there is lots of things that I don’t like and what I would do different, but then in the end I think, oh, there is also lots of things what, the weather is horrible and, you know, there’s lots of different things, but I think the main thing is that if I’m, I feel that it’s happy and I wouldn’t feel that if I would

have to go back. I always think that things haven't been changed in Finland, but I know things have and I don't follow what is happening there, but there is also good things about I think all. I have learned a lot.
(female, 30 years old, Finnish, white, F grade)

Conclusion

This chapter has shown how aspects of the personal life of IRNs were crucial to the quality of life they experienced in the UK. While their income provided the financial means to provide material necessities and accommodation, their status as immigrant workers could limit their options, for example, when trying to get a mortgage.

Significantly, IRNs emphasised the importance of social relations. Many were suffering during their absence from their families and made arrangements for them to join them in the UK. This does not mean, however, that only those who brought over their family or those who could easily integrate into the British way of life were the only IRNs who had positive experiences living and working in the UK. Some described how, after a while, they found ways to live their own lives and were able to cope. Even if they initially felt isolated, with time they were able to find strength in their professional role.

I thought you can't avoid being there, isolated if you are a minority. ... In the independent sector I was really isolated, but I concentrated on my job, that's all. ... I'm not isolated and I can entertain myself here and there. But at first it's tough, even where to get your food from Africa, wait with the buses, everything here to understand. ... The isolation is no longer there now, maybe because I've stayed for about three years now it's much better.
(female, 46 years old, Ghanaian, black, G grade)

Well, at the moment I don't see things like I did in the past because I, you know, learnt a lot from what people I like here and I just, I just go with it. Uhm, I'm confident to tell people what I don't want, which I wasn't initially and that makes me feel, feel, so now I hardly remember that time. When I'm on the ward it takes ages for me to take, I know sometimes I'll finish my shift and go home, relax, because I feel confident I've given the same care like any other person is giving theirs and I'm one of the team and, you know, and I've got the courage now to tell people what I think is wrong, what I don't want and so the going home and cry and everything has stopped for some time now.
(female, 44 years old, Ghanaian, black, grade not reported)

However, in some cases IRNs felt that they were not properly appreciated and respected at their workplace, and this meant that their strategy of coping took a radically different direction. Instead of finding ways to use their professional qualifications to feel personal satisfaction they guarded them to avoid feeling exploited (these issues will be discussed

further in chapter 7). This strategy did not involve staying in the UK for a longer period of time.

Well like I said, we tend to keep our skills in our pockets and watch. To be honest with you John⁷, I'm counting the days when I'll be going back home. It's not worth it to work here as a nurse.
(female, 52 years old, South African, black, D grade)

The private lives of IRNs is crucial when considering their experiences when living in the UK, and their motivations for staying or leaving. However, experiences related to their work as nurses in the UK are the main focus of this research, and they will be examined in detail in the following chapters.

⁷ Interviewer John Aggergaard Larsen.

6. Recruitment, reception and support

This chapter provides a chronological overview of IRNs' experiences from when they were recruited and arrived in the UK until they started work. In particular, it describes the various means of support provided through adaptation and induction programmes as well as mentor systems and support provided by colleagues, managers and professional bodies.

Recruitment

The participants in this study came to work as nurses in the UK through different channels. Some came through recruitment agencies either based overseas or in the UK and others came to the UK as visitors. For some the recruitment procedure was unproblematic.

...it was quite a simple process, but lots of paperwork...
(female, 30 years old, Finnish, white, F grade)

Those who had a clear idea of what they wanted and who were in a position to negotiate the terms of their employment seemed to have experienced fewer problems.

I decided that I wanted to come overseas to travel and to see the country that my ancestors came from, so I went to an agency in Cape Town and I actually told them exactly what I wanted. ... I had all the application forms from all the hospitals, all the different hospitals in Britain but I just had no idea, I didn't know what I was coming to and I didn't know which one to apply for, so I ended up in this agency and I said to her: "Look, this is the situation, I just don't know which one to go to." So she said: "Doesn't matter, you pay me." I had to pay her money and then she organised it all and I got an interview with the sister in charge of the ward that I went to in Reading and she already had my CV, so she could see on my CV what she wanted whether I met her criteria. So that was ironed out because she was sitting in Britain and I was sitting in Cape Town on the telephone, but she had my CV in front of her and I was telling her what I wanted. ... I didn't need to come, I just wanted to come, so I sort of called the shots before I came.
(female, 55 years old, Zimbabwean, white, E grade)

I chose the city I was going to work in, I interviewed for the job that I wanted and got what I wanted.
(female, 33 years old, Canadian, white, E grade)

Others had a less clear idea what they were going in to. They assumed that the information they received was correct and that they, as nurses, would be working in a proper place. Due to economic and technological disadvantage, some were perhaps not in a position to check the information thoroughly, as this Nigerian nurse explained.

I looked, I checked through: “Okay, this is what I’m going into, the place where I’m going...” And on getting here I discover that it wasn’t, even the tutor they are not ready to supervise, to come down, to look at what you are doing. The mentor they are not there and at the end the place is not audited, so you stand to lose and [inaudible]...and forgetting that back home the access to internet is not there where you can log in and check where [inaudible]...to see whether the places are creditable, no, because it happens back home, you cannot, you cannot, uhm, go into college of nursing without that place being accredited. You cannot do your practice in a hospital whereby it’s not recognised
(female, 36 years old, Nigerian, black, D grade)

Participants described how the promises they had been made by the agencies had not been met.

I was recruited from home, not from people here but a nursing recruitment agent back home, which they sent us here for a nursing home and when we came here it was all fake, so we had to find our ways, we had to like start applying to NHS, all the hospitals [inaudible]...for adaptation and then finished and now working where I did my adaptation.
(female, 25 years old, Nigerian, black, D grade)

[I came] through an agency back home and I think I had the same experience with her, we were promised a kind of adaptation institution around here and see if everything is ready but then it wasn’t true. So I stayed home for about two, three months applying here and there for adaptation, but then, you know, before I finally got somewhere in a nursing home for adaptation...
(female, 37 years old, Nigerian, black, D grade)

A Filipino nurse explained how he had been naïve and signed three different contracts bearing different commissions. He suggested that the UK government should have better control to safeguard the contracts of IRNs. It appeared that those who had been recruited directly by the UK employer were in a better situation.

I was recruited by an agency and then fortunately the person who interviewed me there is the person that I work for, so when I came here I did not expect to be in a senior grade. She took me as a senior person, but she told me: “Because you’ll be new in the institution I can appreciate your experience and all that, we will start you, you will have other people who will be senior to you.” So that hasn’t been a problem to me. I just wanted to make that point that I was very, very fortunate, I haven’t had any frustration except for accommodation.
(female, 49 years old, South African, black, grade not reported)

Others came to the UK on holiday or to visit families.

For me I was recruited differently because my husband is working in here before, so I just came in. I was working in the Middle East and then I came in here just for a visit because I don’t want to leave my job in there, in the Middle East, so I just came

in here for a visit and then he told me “Why don’t you apply?” So I attempt for applying here and then they need nurses in the theatres and that’s where I’ve been in. When after I filed my application form went back to Middle East and then gave my work permit, then I came in here.

(female, 33 years old, Filipino, South Asian, D grade)

I came in as a visitor and fortunately my friend was already working here, so I stayed in the house of the family. Then [inaudible]...I wanted to go to an NHS hospital so [inaudible]...the following day they phoned me to say: “You were successful. Now you wait for the next interview.”

(female, 36 years old, Zimbabwean, black, D grade)

A Nigerian woman described her difficulties working without getting paid and how the care home she was working for kept on extending the length of her adaptation to bind her to the workplace and pay her a lower salary (see also chapter 7).

In fact I’ve been looking for adaptation school since 1990 because I come here every year on holidays, but it was only this year that I was able to get this school for one-thousand-five-hundred pounds.... I would be working for ages before you can get a NHS adaptation school. So I got it through an agency... I came just as I’m on holidays. Then when I got in [inaudible]...there was no induction [inaudible]...started working as a carer and you know with visiting the UK you cannot work, so I was working for no money three days in the week and the adaptation school no money. So when they know that we know our stuff they started to putting us, we charge the floors. They are just exploiting us...

(female, 54 years old, Nigerian, black, D grade)

Reception

When arriving in the UK, IRNs had different experiences ranging from very negative to very positive. Some very bad first impressions are reflected in these two stories:

First time I was here I worked as an agency nurse, uhm, recruited from Australia and was promised to be sort of met at the airport, have accommodation all ready for me and all these sorts of things and I found it very frustrating in terms of the fact that when I did get here, uhm, the accommodation hadn’t been arranged and when I rang them to say when I was going to be met at the airport or in my actual case I was being met at a motel and the day that they were actually picking me up it was like, uhm: “Well there’s been a change of plans, we can’t come and pick you up.” And I just demanded that they come and I be picked up because I had no idea where the accommodation was going to be and all that stuff. So I found that very frustrating as a sort of new start here, sort of being sort of left in the middle of London and the actual accommodation was quite a way outside of London and I was expected then to, with all my baggage, to try and find my own way to this accommodation. The accommodation turned out to be that they hadn’t been paying the rent properly as well, so after three months of being there we were then thrown out. The landlord came around and said: “Look”, you know, “you’re supposed to moving out this weekend.” So that’s what, it initially started off to be, uhm, quite frustrating.

(male, 35 years old, Australian, white, F grade)

On getting here the first experience was at the airport, I don't know where Surrey is, my first time of coming to, not coming to England, but coming to that side of England to work. So I got there, I phoned the nursing home: "I'm at the airport, you said you were sending somebody to collect me." "Oh, it's a pity the driver is not here." Anyway, I said: "So what am I to do?" She said: "Stay there until we send a driver." I was at the airport, I think we arrived in the morning, I was in the airport until 4pm waiting for transport to come and collect me. Checking everybody with these, you know, these signs you hold. ... Nobody came. I phoned and she said: "Oh, is the driver not there yet?" I said: "No driver." She said: "Okay, I'll see to it, I'll phone you back." I said: "Well how do you phone me?" Anyway there was a number on the phone I used so I give her that number and I stood there with my luggage by my side. So I waited again, nothing happened, so I started asking from the people there: "Sorry, how do I get there?" Someone said: "Go down, get a coach." Oh my god, it was a nasty experience. ... So I had to then walk because I didn't know my way I go in here. Anyway, at last I found a place to get the, uhm, coach and it took me to Woking. And from Woking I had to phone again to the nursing home: "I'm now at Woking, how do I get to you?" She said: "Take a taxi." "How do I take a taxi? I have no money, nothing on me. I haven't got English money to take a taxi." (She said): "Okay, take a taxi, when you get to the nursing home we pay the driver." So I finally got a taxi that took me there and they paid the driver. On getting there I was asked to sleep in one of the resident's room. I mean, you know, a patient's room. There wasn't a patient there. The light wasn't quite good enough for me to see the sheets I was lying on. In the next morning when I woke up there was daylight, I could see I was lying on urine ... Not quite two months after that I had a urine infection. So that was the experience I had. They promised to give me a place to live and so on, nothing came up.
(female, 54 years old, Nigerian, black, E grade)

Even if other participants in the study described similar problematic experiences with the reception, these two stories stand out as particularly appalling. It is perhaps worth noticing that the worst experiences seem to come from IRNs who were recruited by a care home or for agency work. Even if some of these smaller employers might be less well equipped to arrange the reception, this does not mean, however, that nurses recruited to work for the NHS only had good experiences when arriving, nor does it mean that smaller employers were not able to arrange a good reception. In general, however, managers have expressed that they have learned from their previous mistakes and are now providing planned programmes of 'meet and greet' and induction for new IRNs (RCN 2003: 18). During the focus groups some IRNs told about their good experiences with the receptions arranged by their UK employers.

My reception was very good, when I got to the airport there was somebody who took me to some, to a place and even there I found somebody waiting for me there and my first experience, my first day I was taken into a hotel. That's where I slept overnight, which was welcome, I welcomed because I was very tired from travelling and then the following day I was taken to another place, which I did not know when I came, though they did explain that I'd be taken to another place. So when I arrived at this place again, they were expecting me, they had made arrangements, I was

accommodated for ten days in a bed and breakfast and then the day after they assisted me to get an accommodation that they had promised.
(female, 52 years old, South African, black, D grade)

Adaptation and induction

The experiences with adaptation and induction programmes were mixed and even in cases where IRNs overwhelmingly had positive experiences they often suggested improvements. Several IRNs felt that some of the courses had been too intense and that they had experienced information-overload – not being able to take it all in. Another general recommendation was that they could have a better cultural introduction to the local dialect and colloquialisms as well as British nursing practices. Some also felt that it would be beneficial if the UK staff had been better introduced to the arrival of the IRNs and possibly informed about culture and nursing practices in their home countries. This would provide a basis for a general improvement of mutual communication, understanding and support (see also chapter 8 on a discussion of cultural differences and communication difficulties).

IRNs had different experiences with adaptation and induction due to the complexity of regulations, depending on which country the IRNs had trained in, as well as the regulative changes imposed within the recent years. For example, while nurses trained in the EU and some Commonwealth countries (for example, South Africa and Australia) do not need to undergo an adaptation period, others are required to undergo an individually adjusted adaptation period. A Swedish nurse explained her experience with the adaptation at a time before Sweden had joined the EU. Due to the complexity of supranational regulations to control the flow of professional workforce between nations she could have avoided the adaptation requirement. However, she preferred to have this opportunity to become familiarised with nursing in the UK and to adapt to cultural and language differences.

I had nine months introduction to services in Britain, I know it was because at that time in 1990 when I started to work here Sweden wasn't part of the EC, so we were sort of our qualification was not, they did not recognise it, so I had to do nine months to be qualified as a nurse here, so I was sort of a student nurse for nine months, although I was qualified in Sweden. And many of my friends they said: "Go over and work in Denmark for a month or so and you can then go straight into work in Britain." Because of course Denmark was in the EC. But I thought, I thought I quite would like an introduction to, to British nurses, that's why I'm happy to take on that service, even nine months, and I was moved every two weeks or three from different wards and I felt communication was definitely, the hardest thing was answering the phone and the British medical language so just syringes, you know, things like that you do not know. You know diagnosis in Latin because that's something probably taught all over the world, but you don't know the little bits of English from training really.

(female, 36 years old, Swede, white, F grade)

Other IRNs had not had such an introduction to British culture and nursing practices, and started work immediately.

I started work about four days after I arrived here and I [was] just literally given my patient and just told, and I just got on with it. ... I think I went to one orientation day. ... But that was just a day I think I had, but like she [another focus group participant] said, it was about four days after I arrived in the country and I got my uniforms in the morning and I was expected to start work at one o'clock in the afternoon, and that was it.

(female, 47 years old, Australian, white, E grade)

My personal experience, now the day I came into UK the following morning I was asked to work twelve hours straight ahead. No prepare, you know, nobody, no induction, nothing and, uhm, I realised something that is I think when they bring nurses from abroad to undergo adaptation what they do they just use us as carers that, you know, it's always there, bring them and let's use them for some time.

(female, 42 years old, Nigerian, black, D grade)

When I actually went to the hospital for the first time they weren't expecting me, uhm, they had no form of orientation programme organised for me, there was no policy and procedure manual for me to be able to if, instead of asking somebody every time: "How do I do this?" Or: "If somebody dies in the department what do I do?" You know, what's expected. Uhm, so there was nothing I could go and use as a reference and sort of try and find out than, what I would consider being annoying, in asking people all the time I could actually look something up and say: "Right, I do it this way." Uhm, especially with the broad range of, uhm, religions over here as well it sort of, it was quite [inaudible]...for the different types of religions as to what is expected to be done with a body and all that sort of stuff. So that was frustrating in that way.

(male, 35 years old, Australian, white, F grade)

When you come you're meant to be introduced into the UK, the United Kingdom nursing because definitely it's going to be different, it's really different from nursing back home and also, when you're coming from home and you're being, because they recruit you and put you in a specialist area, because that's where they're short, and they put you there and expect you to sort yourself out. You ask an assistant on the ward and they expect you to know it. ...they expect you to know everything. It's not possible.

(female, 25 years old, Nigerian, black, D grade)

Several IRNs described how it is expected by their UK colleagues that from the moment they arrive they will already know everything even if some nursing practices in the UK can be quite particular and unfamiliar (see chapter 8 for a further discussion). Apart from the use of different equipment the paperwork was often mentioned.

...this culture of filling in forms and protocol, people are so involved in it when you have arrived, say you arrived today, you start, you don't know about this culture. Some people are not, they don't tell you how, they say: "Oh, you are a registered

nurse here.” I’m sure it’s a two-way thing, even the people here they don’t know what we need to know, we also don’t, it becomes a problem. You are a registered nurse here, you can do every: “Oh, you have been a nurse for twenty-five years.” And you hardly know where to and you end up saying “God, help me.”
(female, 52 years old, South African, black, E grade)

These quotes illustrate the frustration some IRNs experienced due to lack of information and orientation. One nurse was so desperate about the situation that she was planning to return back home as soon as possible. Some IRNs had expected a standardised adaptation programme, and were surprised to find that it was practice related and dependent on individual progress.

I expected when I was doing the adaptation ...a classroom set-up, hence formal lectures to say: “In the UK this is the policy, these are the conditions and these are the expectations of a nurse in the UK. It’s now different from your country because of ABCD.” But instead it was just, they’re just using us ... They said: “No, you are just given a booklet [inaudible]...” It’s up to you, it depends on how fast you go. It’s up to you, no-one follows up what you have to do, no-one sits down with you to say: “This is [inaudible]...what you are doing.” That’s what I expected.
(female, 36 years old, Zimbabwean, black, D grade)

This last quote is interesting as it shows the mismatch between IRNs’ expectations and the provision of support by the British employer that is regulated by the Nursing and Midwifery Council (NMC). Self-directed learning with the adaptee setting their own goals and being supported by mentors is congruent with British educational policy (Life Long Learning 2002). Even if the adaptation should be adjusted to individual needs, this participant felt that the professional qualifications and experience of IRNs were not taken into consideration when arranging staff training. Because of this, she felt that instead of improving your skills the training could have the effect that it undermined your skills and professional self-confidence.

... where I am now we have like a D grade development ...so you go for a study day and all the staff. I only have one problem with that because when you’re coming from, let’s say you are from overseas, you’re coming into the country, you’re not newly qualified, like I’ve been working for the last eight years and when I was in Bristol I was a D grade and then I moved up to E grade. The problem I find like if you have some experience actually the development can destroy you instead of making you a better nurse... Nobody wants to know, you are a D grade, you have to start from the anatomy and physiology, you have to do the IV courses, which is fine, but I think they should make it, they should assess where to fix each and every person.
(female, 31 years old, Kenyan, black, D grade)

Other issues concerned experiences of being de-skilled: IRNs who did their adaptation in a care home were generally unhappy. They had expected to be introduced to a high standard of

nursing work, and instead they found themselves being asked to undertake unqualified care work. Similarly, case studies of managers' views have documented that the adaptation provided for IRNs in the independent sector is inadequate (RCN 2003: 13). This was a matter of considerable concern and distress for the IRNs who took part in the focus group discussions.

I'm wondering about the adaptation. It's supposed to be converting to whatever nursing situations in the UK, but every time I think back thinking of what I did do in the adaptation period it was nothing, you know, like nursing things, it was more of being a nurse aid or a carer. There's really nothing you learn during that adaptation period.

(female, 39 years old, Zimbabwean, black, D grade)

In the nursing home with adaptation like we were talking about that we are not classified really as nurses. Our adaptation is we do it together with the carers and the thing that we are being taught there mostly is caring, not nursing.

(male, 30 years old, Pakistani, South Asian, D grade)

There was no description in the Philippines and there are no nursing homes. It was strange when I worked in a nursing home. I felt bullied, discriminated and abused and was made to cry in front of patients by staff. I was doing carers' jobs which was inappropriate. But if there was no cover, I was told I had to stay until cover could be arranged.

(female, 30 years old, Philippines, South Asian, E grade)

Apart from the disappointment of not using their skills as nurses and missing the chance to become exposed to high quality nursing practice, several IRNs felt humiliated by the fact that the unskilled carers in care homes were set to introduce them to the work and function as their supervisors.

... they [care assistants] are given an upper hand to like show you what to do when it's not supposed to be the case. You're not supposed to be shown that by carers [inaudible]... a senior RGN and not the carers.

(female, 34 years old, Zambian, black, D grade)

You ask an assistant and they expect you to know. The assistants say 'where did you train? Didn't you learn this?' Yes I did but I've had no practice. It's entirely different

(female, 25 years old, Nigeria, black, D grade)

... you cannot imagine a situation where you are being, you are being handed by an untrained person supervising your own job as a qualified nurse ...

(male, 39 years old, Nigerian, black, D grade)

Apart from the feeling of their professional qualification not being respected, some IRNs explained that by letting the care assistants supervise them they were not given a proper introduction to the nursing work and responsibilities.

...what I expected as a nurse nobody showed me and after that three days the carer orientated me, showed me the residence and partly during the mornings as if I'm coming to be a carer... Weekend came, I was left now to run the whole home now knowing nothing, no full orientation [inaudible]...and I don't know, but I felt like going back because I thought: "What if I make a mistake now?" And what I'm saying is that was the frustration and there was no job satisfaction anymore.
(female, 49 years old, South African, black, D grade)

Another problem was the financial burden of having to pay to do the adaptation.

You know, when we're coming to doing the adaptation we are made to pay a huge amount and we need to support our families back at home, but then when we come here, like we've already said, as qualified nurses, we're made to pay, I mean we're paid as carers instead of D grade or whatever scale of, you know. Instead of us being paid as qualified nurses looking at the amount of money that we've spent it really takes us a long time really to recover. We're meant to support our families back at home, we're meant to look after ourselves here, it's so devastating at the time, besides the experience that we get here.
(female, 34 years old, Zambian, black, D grade)

These concerns related specifically to IRNs recruited to work in care homes. In the NHS it seems that participants were overall content with the adaptation. Here they felt that they upgraded their professional skills to British nursing practice.

I think, looking at the adaptation course and the induction course, adaptation is quite important because, for example, because our wardens [inaudible]...we have most of this equipment in Saudi [where he had also worked]. The only thing that we haven't got in Saudi was the, a pump, the feeding pump, which whenever you come for adaptation course you are taught how to use too many machines. In my country, I must confess, we haven't got most of this [inaudible]...machines. So it's good to go into an adaptation course. After the adaptation course if you are asked to go to a particular ward you have applied for then you go to an induction to that ward to know whatever the policy and procedure of that section is.
(male, 49 years old, Nigerian, black, E grade)

Experiences with induction courses at hospitals were generally described as positive.

I arrived in Reading at the Royal Berkshire and they had an international nurse trainer who ran a course that was for three weeks and it was absolutely brilliant. She actually took all the international nurses and we went through every single thing, the manual handling and the [inaudible]...life support and all those, everything, so by the time we actually went on to the ward we had been completely taken through that

trust's policies and everything and I don't know whether they had the same thing here or not, but that hospital because they relied so much on international nurses they had somebody that was employed full time just to look after them. So I must admit, when I got here that support, if you ever had any problem you could go back to that, you know.

(female, 55 years old, Zimbabwean, white, E grade)

Similarly, an IRN explained how the induction programme in the care home had been eye opening, for example by being taught how to help residents if they have fallen. Many IRNs explained that they did not have care home for elderly in their home countries and that it was a new experience to work as a nurse in such a place.

... the first time experience to work in elderly people's [inaudible]...no idea about this thing and we don't know their needs, their habits, what they like, dislike.

(male, 36 years old, Pakistani, South Asian, D grade)

Even if there was a general impression of satisfaction with the training provided in the NHS, few expressed such exhilarated approval as this Zimbabwean nurse who had recently changed job from a care home to the NHS.

... the NHS orientation programme I've just finished it about three months ago. ... It's just what you expect as a nurse, it's everything, it's everyone is there to tell you. Of course you get one or two different people who are just, it's their problem, but everyone is there for you, the support, the emotional, everything [inaudible]...everything is there professionally. Everything is just there. Communication channels are always open, professional development is just at your fingertips, mention one day, the next day you are at it. There's no issues, it's a question of asking your manager, so approachable. ... Not that we are perfect, no, but I'd come from a department sort of which was the nearest to the [inaudible]...things had to be done correctly. The emotional support in the NHS is so fantastic that I don't have any stress anymore. In the nursing home I think I used to cry every day.

(female, 47 years old, Zimbabwean, black, D grade)

A Canadian participant in the same group commented that it must be a different NHS she is working for – she could not recognise the description. However, she did admit that the NHS in this respect had changed a lot in recent years, and that the adaptation and induction provided for the IRNs who come now is much better than it was when she came to the UK 14 years ago.

The mentor system

There was general agreement among the IRNs that it is valuable and necessary to be assigned a mentor who can introduce them to working practices and provide on-the-spot help and advice when they encountered problems.

The system is different here, you need someone to put you through ... you ask so many persons and it's quite annoying at times and you are expected to know [inaudible]...and keep asking, you go to the libraries, you read the UKAS, you have to research, do a lot of paperwork to like get to know things but you don't really, you really need someone to put you through the system, you know, but when there's nobody there really to help you out and there's no way you can just come to a strange country, a different country from yours with different culture, backgrounds and everything and expect to stand on your feet. You keep falling and falling and standing and falling and standing until you can stand, but you really need a stone to step on somehow, you know.

(female, 25 years old, Nigerian, black, D grade)

So I found it was easier for me to pour it [the difficulties I experienced with new nursing practices] out on to my mentor and then she would sort of explain to me that things are now different from what it used to be before.

(female, 56 years old, Zimbabwean, black, D grade)

Sometimes, the support required could also be of a personal nature.

I had a mentor as well, but soon after a while I was doing the refresher course and I was able to open up more to my mentor than to the rest of the people I was working with because there was so much bullying in my team ... I needed a shoulder to cry on.

(female, 56 years old, Zimbabwean, black, D grade)

One suggested that in order for the mentor to have a better understanding for the difficulties IRNs experience it would be ideal if she had experience as an IRN herself.

If you had somebody that was, that is established in that hospital or unit that had worked their way up from being a foreign nurse, worked their way up the system, if you had [inaudible]...tell you that when I started here I felt exactly the same and what things I encountered that she should be aware of and therefore do this and this and this and that can help you in making things easier. I think that will help a great deal.

(female, 30 years old, South African, white, E grade)

Some NHS organisations have recognised the benefits of such a *buddy system* and that earlier arrived IRNs can provide valuable support for new IRNs (RCN 2003: 19). However, several participants in the focus groups had been disappointed with the support they had received from their mentor. They had to fight to receive support.

I was given a mentor, but ... I was disappointed because my mentor wasn't up to date. I mean she wasn't putting me, uhm, putting me through properly, you know. I have to press on her, to be running after her [inaudible]...what to do please because I have got a book to sign, so I would check into the book and, uhm, run to her and there's this general assumption that I should know everything and I came to England purposely to be [inaudible]...and to update my knowledge in [inaudible]...practice and, uhm, I get from it different cultural background and but in here I expected her to have given me proper induction. ... I have to use my initiative most of the time and [inaudible]...and you know here the amount of documentation, the way of doing things is quite different from where I'm coming from but my mentor they are impatient. She's impatient with me.

(female, 36 years old, Nigerian, black, D grade)

Others complained that it was difficult to access their mentor due to different working schedules.

My mentor personally was not working with me until I asked. Ideally I should have been working with my mentor and, you know, asking questions but you see they're put in on some nice duty where my mentor is not night duty and they're probably using us as carers.

(female, 42 years old, Nigerian, black, D grade)

You have a mentor, you don't work with your mentor, you don't see your mentor, you're on early shifts, you're on day shifts, she's on night, you're on night, she's on day and she has to assess you. You work with her maybe once in a month. ... you need someone to put you through.

(female, 25 years old, Nigerian, black, D grade)

... in the department we were given mentors but like my mentor really I've never met her today. ... she was in her day of sick leave and we've never met, so I'm still waiting for the day because she's coming back on 20th February and maybe she's going to start showing me things, I don't know, just great expectations. But most of the time she's, she's sick, if she's not sick she's on annual leave, but she's still alive I'm sure. I don't know.

(female, 52 years old, South African, black, E grade)

A different problem concerned the motivation of the mentors and the procedures of appointing suitable mentors for IRNs.

... mentors are very hit and miss, so that, and often very reluctant to take on that role anyway, it's allocated and they don't want to do it. There's no place where you can get general information about any education that's happening and nobody sends out flyers to say this course or this study day is happening, it's all [inaudible]...all over the place. I mean if you want any kind of support at all you have to get, you have to find your own group of people and people are very afraid and don't want to be involved anyway, so it's really

(female, 28 years old, New Zealander, white, H grade)

I actually was told to pick my own mentor, I didn't really know those people. It just needs more structure, objectives and things to achieve.
(female, 47 years old, Australian, white, E grade)

But even in cases where the mentor was available and ready to help the IRN to adapt to new practice and new technology, there could be a problem in the relationship. As described in chapter 3 the IRNs who took part in this study were generally very experienced before arriving and, in many cases, they had held senior positions in their home countries. They found it humiliating and professionally degrading if a mentor was insensitive in front of patients, and, as an unfortunate consequence, this could result in the IRN not asking for advice and help in the future. A focus group participant described her fellow IRN's experience:

... there's no professionalism in their teaching. The mentor would say maybe in front of the patients: "Oh, you mean you don't know how to use this. Come, come, I'll show you". So everyone around looks. The mentor is a very young girl who is so fast in her grades, is an F grade, God knows how, and then my friend is very experienced nurse, who has been working for maybe the past 25 years abroad, teaching as well and so on, and she feels so ... so then she feels: "I will stop asking". If you ask this girl she will say: "Come, come, come", you know, in front of everyone. "You don't know how to use this, come, I'll show you." I don't know, I don't like that attitude.
(female, 40 years old, Zambian, black, E grade)

Another research participant described how she felt abandoned by her mentor after a new introduction pack had been introduced and the new large group of IRNs had arrived.

... You try to get to your mentor, you try to get to your ward manager, like me, actually I don't really have a mentor because I came here, I had a mentor, fine, they said she is my mentor. Okay, then the next batch of people that came to the hospital were the Filipinos and the trust recruited them from the Philippines and then she had the trust pack, but there was a consultancy that recruited us and posted us to the hospitals ... so we had a different pack. And my pack was going on well and I was fine until she came with her own pack, so we had to, because our mentor was like the teaching assessment nurse of the ward, of the department, so when she saw that pack she said she didn't know anything about my pack and I was just dumped, completely. She said I had to look for somewhere else to work when I finished my adaptation, I had to do this, I wasn't protected from the work, so I was really down. I had to like go to the ward manager ... I had to wait for her at her car, wait for her, I was like a pest, I had to look for her because fine, the ward is quite busy, it's very busy, but you have to, I had to stay after work, she had to put, she said the next time she didn't see me I could call the police for her and all that and she ended up not seeing me. You really have to move to get what you want.
(female, 25 years old, Nigerian, black, D grade)

It was a recurrent theme in the IRNs' descriptions that they had to be very outgoing and assertive to get the help and guidance they needed.

Support from colleagues

While some IRNs had positive experiences in all the focus groups, other participants described their UK colleagues as, at best, unprepared and indifferent to providing support, and in other cases IRNs felt that their UK colleagues were directly hostile. A South African woman described the experiences she and another nurse from Johannesburg had when they came to the UK:

We were very miserable. You know if you are miserable, you know, three months is a very, very long time, yeah, but we stayed there for six months and our initial contract was six months, we were given six months. So we stayed for that six months and at the end of we were very frustrated. ... If you go on duty you don't enjoy anything, you know, people are just, those people were just not prepared to orientate us. We thought because it was a foreign country for us, new environment and new everything, different from the standards that we maintain in South Africa and even equipment, everything was just different. So we thought at least we would be given good orientation just to, to settle. ... We really needed, you know, orientation, good orientation. ... You know we were not at all involved in the work that other resident nurses are involved in when they come in. It [the way our UK colleagues approached us] was a matter of: "Don't you know how to check BM⁸?" ... Those apparatus were new to us, but the people were so busy, John⁹, they didn't, you know, they had no time to tell us, to teach us anything.
(female, 65 years old, South African, black, D grade)

An Indian nurse in the same focus group related her experience when meeting her colleagues and the difference she perceived between being a student and working on a ward.

When I came, you know, when I landed here I found people were very friendly and very good because I came as a student and I looked from the perspective of the student. I really was impressed and I was impressed in the way Wales was like similar like [inaudible]...is all green, North India and I was very impressed, I loved the country, I love the people, the bond was there ... But coming to my nursing experience when I started work I felt that, you know, there are people, elements around ... which undermine you as a new person and they take advantage of you because that time you are trying to grasp, trying to build up yourself, relationships and [inaudible]...people try to take everything, you know.
(female, 53 years old, Indian, South Asian, E grade)

... you go to all these English nurses, you can't even ask anything because they say to you: "Sorry, I don't know." ... nobody is interested to say anything to you.
(female, age not reported, German, white, F grade)

⁸ Reference is being made to testing residents' blood sugar levels.

⁹ Interviewer John Aggergaard Larsen.

In another group, a nurse from Australia suggested that this difficulty could be related to a general professional culture that lacked open discussion and commitment to learning from experience and errors. This nurse felt that everybody was too concerned about covering themselves. In another group it was suggested that the negative experience perhaps was more generally related to British culture.

... maybe it's just the cultural thing, it's very difficult because people are not very open because like they're not very open to criticise you or to, yeah, so you really have to work your way through. You have to maybe have close friends who later on you can ask maybe if everything is alright or not ... about how things really work and most people don't tell me, even tell me the wrong thing. Unless it's really, really bad nobody would tell you: "This is wrong." They'll keep quiet about it, smile about it and then maybe later on you hear about it maybe in the coffee room.
(female, 31 years old, Kenyan, black, D grade)

In the nursing home, I used to cry every day. You didn't know who to tell...you just kept quiet
(female, 47 years old, Zimbabwe, black, D grade)

You know such stress will break you down if you are a young nurse I think but because I was too old, you just look at your objective "what do I want?" Then stick to it
(female, 47 years old, Zimbabwe, black, D grade)

As a result many IRNs described how they felt isolated and had to struggle to get support.

You really have to push your way through to be supported, you have to push your way. You don't just sit and accept support, you have to like make them support you because when you start work in a new place you're like with new people and you don't expect [inaudible]...especially when the ward is a busy ward. If it's a busy ward you have to walk up to them and say: "I need support." Not just maybe someone is trying to pick something from the treatment room when your colleague has to ask you something and then she's like: "Oh, I'm in a hurry, come in" or something. You have to like be observant and know when to ask for support and it's when it's less busy.
(female, 25 years old, Nigerian, black, D grade)

... when I first started it seemed to be a negative note of I wasn't welcome in my job and I wasn't welcomed in the NHS and it spun off from there and it took, that was the first two years from when I lived here until I changed my job. ... when you're not initially, you know, not accepted or you feel like you're not being accepted you play into that role I think as well until you become more experienced and in the system because it's different to the experience at home, you come to a different country, even though I speak the same language and so on and so forth the culture of how nurses are is different here than it is at home.
(female, 33 years old, Canadian, white, E grade)

Even if the negative experiences dominated in the discussions of the focus groups, some had also had positive experiences of support. One IRN originally came to work in a care home where she received no support but she had later changed job:

... in the NHS I found out that there's no blame culture, you are supported through and through, through mistakes, through good work, through everything and you get reports. I think I had three so far from the general manager and they tell you really if you are not doing well or if you are doing well about it, so I really like the support.
(female, 47 years old, Zimbabwean, black, D grade)

Such positive descriptions were, however, rare. One participant explained how she had received a very sparse orientation but had been given some papers and had to approach her colleagues to ask for help.

... it was probably good for me because they already took other nurses from South Africa in the place, so I sort of fed back on them more than the people around me. My white colleagues they would say: "Mary¹⁰ if you don't ask questions I won't know that you don't know." Right, so I had to get it into my head that I have to ask questions, nobody would tell me anything. Right, so it went on like that.
(female, 52 years old, South African, black, D grade)

It was mentioned frequently that other overseas nurses represented the optimal and preferred source of support.

... most of the support one could say you got from your fellow black colleagues, when wemy day to day it was like this, you take out your frustration that you've had and then we look at it and say: "You know, we could have looked at it this way. It's not really like that." You know.
(female, 52 years old, South African, black, D grade)

... where I've worked now for almost two years is, uhm, because it's all foreign nurses there's a band of everybody helps each other out because we're all in the same boat.
(female, 33 years old, Canadian, white, E grade)

It was suggested that IRNs should get together to share experiences and provide mutual support.

I think that I will put it this way, if there will be a forum in each hospital that is what we do back home whereas maybe once in a month the nurses will sit together and have a meeting, they will share our experience: "This is what is going on in my own ward. This is what is going on in my own ward." They will gain from there, give suggestions and they go back and make corrections.
(female, 40 years old, Nigerian, black, D grade)

¹⁰ A pseudonym has been used to protect the anonymity of participants.

I think in some sense when we started there were very few foreign nurses in the hospital itself and I think in the separate units where we worked we sort of paved the way because our experience is they learn how we perceive things and I think that made it easier for the next big group that came in. “Well these people found this and this and this difficult, so what can we do to improve that for the next?” Especially with this huge recruitment going on.
(female, 30 years old, South African, white, E grade)

Support from managers

The focus group discussions revealed that the manager played a significant role in ensuring that IRNs were supported and welcomed by their UK colleagues. IRNs found it important that their managers informed the workplace properly about their arrival.

This friend of mine, one of my colleagues in the ward said to me: “Do you know that we did not orientate you, because the management never told us that there were two of you coming from abroad.” And then she said: “Well, we didn’t know about you and that’s why we didn’t orientate you.” You know, she said that to me, like, innocently, and what was surprising when we were talking, I said to her: “It’s surprising that I’ve been watching, you know, like new nurses being recruited, new British nurses, and the time you take with them.” Nobody takes time with us, it’s just “go and do the BMs”, nobody says like “we’ll go with you and show you how to do the BMs”. In any case we just remain back for 6 months and then off we went after 6 months.
(female, 65 years old, South African, black, D grade)

I think the managers when they receive foreign nurses, especially black, at least if the colour is like you are they will maybe easily accept them, but if the colour is different everybody will look at you with a suspicious eye. They don’t know exactly what you are capable of doing, they don’t really trust you, but if the manager will stand by you, inform all the carers that they’re there to say: “This [inaudible]... is a qualified nurse” where she’s coming from. “And she’s able to do this and this and this and whilst here she just doing this adaptation for three months, that’s to get used to the way we do things here.” And even if possible she takes you in other residents homes to tell: “This is our new nurse, you’ll see her doing some caring duties at times, but she’s a qualified nurse, she’s just going to get used to how we go about things here.” I think maybe that can help.
(female, 35 years old, Zambian, black, D grade)

The IRNs felt that managers could provide better support by assuring not only colleagues but also patients about their professional competencies.

...the managers should be able to build the confidence of the clients in us that we’re trained...
(female, 42 years old, Nigerian, black, D grade)

I think that there's a real big problem with management, management here are not instructed as to how to deal with the international nurses.
(female, 55 years old, Zimbabwean, white, E grade)

Sometimes it seemed that the managers themselves were not welcoming or they were not sure about the competencies of the IRNs and how they could contribute to the work.

When I came to the country and started my job I sat with, uhm, the general manager, who I asked to see, she didn't ask to introduce herself to me. Uhm, I do introduce myself and she said, she said that she had no choice with me coming for the job, that she was told that I was coming to this job and she, she seemed to tell me that she was unprepared for me starting, starting to work at that time saying: "I didn't hire you, it's not my choice." And, uhm, it started off very negative in my first two weeks and as long as I stayed in that job it continued to be a negative experience.
(female, 33 years old, Canadian, white, E grade)

[There is a] lack of recognition, lack of trust and confidence from, you know, our own manager and staff, our senior staff.
(male, 30 years old, Pakistani, South Asian, D grade)

The manager said: "I don't have a clue what to do because you are the first people to come here." And we're left [inaudible]...of the care assistant and it was very bad, you know? It's like you know they ridicule you, they sort of look at you and [inaudible]...and, you know, you look at each other. ...and you say to yourself: "What is this all about?" You go back to the manager and it was the manager, the only person I approached [inaudible]...he didn't know anything at all.
(male, 27 years old, Filipino, South Asian, D grade)

IRNs who had experiences from working in a care home talked about the difficult relationship to the care assistants (see also chapter 7). IRNs often felt bullied and manipulated by care assistants who were talking badly about them to the manager or matron behind their back.

Because the matron hasn't got any time to come and see you on the ward or in the home to come and supervise your project or anything. He will now live on what the carer told her.
(male, 39 years old, Nigerian, black, D grade)

In order to survive the bullying and keep professional standards, one IRN had developed a strategy of approaching the manager.

The managers I admit I don't know whether it was because of the owners of the homes or of them because the information would be hidden from you, you wouldn't know what to do. The policies like that, administrative or medicine or something like that, but real big issues which should be communicated to you are not there. ...

What I learned was get your facts right, approach the manager professionally always...
(female, 47 years old, Zimbabwean, black, D grade)

Even if experiences of struggling to gain support from the managers were predominant in the discussions, some had had very positive experiences.

And the support that we got is that the manager as much as he was not present with us in the day to day [inaudible]...of the work he has promised us that: "My door is open, you can come in when you have any concerns." And we did make use of that and there were meetings scheduled where we'd come together as qualified [nurses], both black and white, to discuss our differences because we felt very frustrated that sometimes they would talk behind our backs and not tell us what they have done.
(female, 52 years old, South African, black, D grade)

... we do our call theatre work and you're the only person on call, you're the only nurse that does it, so the support I've had is my boss has given me her number at home and I've had to call her once at one o'clock in the morning for an emergency procedure. Uhm, so that's been very very, uhm, supportive and accessible, accessible support to me at night time when you're on your own...
(female, 33 years old, Canadian, white, E grade)

Support from professional organisations

Professional organisations such as the RCN and the NMC (formerly the UKCC) had proved valuable as a source of support and backing for several of the participants in the study.

Sometimes, the organisations offered general information about UK practice.

When I go to UK the second week I go to UK I joined the Royal College of Nursing ... and I'm happy and grateful that I did the time I joined it because there are still some of my colleagues that they are practising, they are yet to join, they have missed out [inaudible]...Royal College of Nursing I did my support, not my mentor, not those that I'm working with, not those [inaudible]...on to how things are being done in UK, the kind of practice, the legal aspect of things, documentation, all this PREP I know everything, even when they had their conference. ... Open my eyes to see things in UK because it was second or third month when I came that they had their annual conference down in Harrogate and I attended [inaudible]...because I just want to know what my mentor, other nurses are not telling me properly [inaudible]...nobody to put me through, so when I got there I opened my eyes and see some things. I gained a little as a starter, then I said I would continue. I started [inaudible]... *Nursing Standard* for some things, reading article, looking at things and how to [inaudible]...all sort of things like that [inaudible]...it will not relate to my area of practice but I will attend just to learn, maybe I will be able to learn new things and when I have problem [inaudible]...when nobody, even in my place of work they are not ready to listening to you, they just "okay" when you ask [inaudible]...you find your way out.
(female, 36 years old, Nigerian, black, D grade)

It is obvious from this description that the contact to the professional body was a support as an information-seeking strategy for an assertive IRN. In this way, the IRNs feel that they are given a voice through the RCN.

... the joining of the RCN has helped tremendously, it feels like it's given me a voice, even though I haven't had to access the RCN, uhm, that much. I've had my membership for three years and in the last year for 2002 I've accessed the RCN a lot, so it's really come as a good voice for me for the last year. ... I can't find that information in the NHS now, it's not available. If there's nothing written down, not that I've seen, I'm sure maybe there is, but the RCN has it written down and it gives you that information and you have it at home in a booklet and they update that and give you a new booklet every year. So that has been a tremendous support. Also there's an RCN steward... that's been identified in the hospital ... that name is put up so you can access that information.

(female, 33 years old, Canadian, white, E grade)

Some participants told about how the RCN had helped them with legislative matters in situations where they felt exploited by their employers.

It was only when I joined RCN to find out the truth. At the time they [the employers] collected my passport, my card and my certificates from me. ... He told me people are coming for an inspection and he held on to these for more than three months until I told him "I'm sorry, I need to go to Nigeria on holiday and I will need every document with me." That was when he gave them back to me. I was threatened to be reported on so many things, trivial issues and all these things. He told me I cannot leave that job until I finish the two years.

(male, 49 years old, Nigerian, black, E grade)

I noticed with the adaptation I had to run to the Royal College of Nursing for help, for support because it was becoming too much. Three months after I pay one-thousand-five-hundred pounds you didn't listen, four months you didn't, six you didn't. I came here, I met the officer, this regional officer and they ask many questions, I filled some forms and they saw that they [my employers] are really exploiting me. ... so in fact if not for them maybe we should have spent a year because they released me before the lady that I met there, they released me five weeks before her because they took my case up, they look into all my past and they came on to the ward to see where I work practically and they found me very good. So I owe them a lot of thanks.

(female, 54 years old, Nigerian, black, D grade)

Even if the participants in this research generally had positive experiences with professional bodies, a few also mentioned some problematic experiences. It must, however, be noted that this research was conducted in collaboration with the RCN and that there could be a possible bias in the self-selected sample towards IRNs with positive experiences with the RCN. One IRN told that she had been living in the UK with her husband and that she found that the biggest problem was to be recognised as a nurse and get started working towards being

professionally recognised in the UK. She had written to the NMC to learn what she should do, and they replied that they would look into her situation. For two years she got no reply and it was only after working as a volunteer at King's College Hospital and her manager had sent a letter to the NMC that she was enrolled in the adaptation procedure. As mentioned in chapter 4, some IRNs were not satisfied with the help the RCN provided to arrange mortgages and other personal or financial issues. Another IRN asked this critical question:

I would like to ask the NMC how they actually think a nurse coming to the UK can organise her own training, find accommodation and adapt herself to culture and custom...but expecting someone to cope with culture shock, organise their own accommodation, money and then find a hospital who will take the adaptation is unrealistic and they are vulnerable to sharks who just exploit them for work without pay.

(female, age not indicated, Germany, white, F grade midwife)

An IRN from Nigeria said that there was a need for more support from the NMC to regulate the use of IRNs in the UK. He suggested that the NMC should make a list of hospitals and care homes with suitable and approved adaptation and induction procedures for taking in IRNs. This would give the individual IRNs more support and provide them with an easy opportunity to complain if standards are not met.

Conclusion

The general impression is that IRNs had a better experience with recruitment and reception the more direct contact they had to their potential UK employer. Direct contact ensured they were in a position to negotiate their working conditions before leaving their home countries. As requested by some IRNs in this study, there seems to be a need for further or better regulation of the procedures of recruitment and the agencies involved both in the UK and overseas. Likewise, information about hospitals, care homes and nursing agencies with good quality adaptation procedures should be easily available to IRNs considering coming to work in the UK.

The data indicates that the adaptation and induction programmes in the NHS have been improved considerably in recent years. The first substantial inflows of IRNs to the UK seem to have generated important knowledge locally about best practice procedures. As this Canadian nurse commented when hearing about a South African nurse's experiences:

Her experience in the private sector was my experience years ago with the NHS. I'm still with the same hospital the last five years moved around departments, but when I started my experiences, the negatives that you highlighted were the same. But now you've come into the NHS and you've highlighted some positives that's

what I see what's happening with the new recruits now, where I'm getting the tail spin of it because it's a positive for everybody. So I've seen a change from that to that. ... So the system is changing subtly, it's not perfect, I wouldn't say it's perfect...

(female, 33 years old, Canadian, white, E grade)

The data suggests that the situation in care homes is lagging well behind this development in the NHS. Some situations are appalling, leaving the IRNs to work without any proper induction and under miserable conditions. The IRNs generally need much better support in their daily work, and it is essential that efforts are made to improve communication between IRNs and their UK colleagues. Often there seemed to be no awareness of, or interest in, the competencies and needs of IRNs. They felt that they were left by themselves to look for essential information and support to carry out their work. As this South African nurse remarked, the learning also takes place on a local and interpersonal level, between every IRN and their employers and colleagues.

Where I'm working they were receiving nurses from outside for the first time, so it's a learning curve for both of us. They are afraid what we are going to do, we are, we are wary of what they would do to us. So all of us we have our back up. So in the ten months that I have been there I've found that things are getting better in terms of knowing who I am, as how far I would go and where they are and how far they would go.

(female, 52 years old, South African, black, D grade)

In the next four chapters we will discuss in detail the IRNs' experiences of working in the UK as well as their experiences of the health care system and exposure to the British culture.

7. Working as a nurse in the UK

In the last chapter we presented IRNs' experiences of their recruitment, reception into the UK and support once they arrived in the UK. Now, we present their experiences of working as nurses in the UK. A key feature of their experiences was the sense that everything about British nursing was different. This feeling of nursing differently was particularly felt in relation to carers in independent care homes. IRNs made some interesting comparisons between the NHS and private care homes that affected their relationships with colleagues and patients and the problems they experienced in communicating with colleagues and patients. In this chapter, we also present some of their explanations of these experiences. These explanations were encompassed in a sense of exploitation experienced as a trained nurse working in a system which did not value either their experience or their qualifications. IRNs felt the need to be appreciated. In the next chapter we explore how cultural differences and the British health care system shaped their experiences and in chapter 9 we go on to explore how this sense of exploitation was also framed by their experiences of racism and difference.

Working in the independent sector

IRNs' experiences and frustrations with British nursing and the British health care system were captured in the comparisons they made between nursing in the NHS and the independent care sector.¹¹ For many of them, relationships with carers in this sector and their experiences of their adaptation programme had been negative. These experiences had lasted until they had transferred to the NHS although a few IRNs had found congenial employers in the independent sector. For example, one IRN had challenged the system in the care home she worked in and now had responsibility for managing IRNs working in the home.

IRNs' experiences of caring in the independent sector reflect the wider issues related to shortage of nurses in the health care sector in the UK. It also reveals the division between social and nursing care that emerged in the late in the last century (Cumberledge Report 1986; Community Care Act 1990), and the debate over the nature of nursing discussed in chapter 8.

¹¹ IRNs called this sector care homes, nursing homes or private homes. For this report, we have chosen to refer to this sector as the independent sector.

To send a carer the nursing responsibilities and want the registered nurse to go and do the carer's job. So that is where the problems always come in and you always find out that nurses, I suspect most especially in [care] homes, are expected to do the caring job and then they won't really have time to do the real nursing duties, which they have been registered to practice, so that brings conflict at all times.
(female, 30 years old, Nigeria, black, D grade)

Not only did IRNs feel that working in the independent sector did not allow them sufficient possibility to do "real nursing duties", they also felt that the care assistants disregarded the quality of their work. IRNs experienced this as humiliating and degrading.

With the care assistants at the homes, they are most respected. [These] people are taken to know everything...even when you say that they are not cleaning patients, they don't care, they say: "She's wasting time, she's only done one patient and we've done five." When you are trying to do the correct thing, you are told you are wasting time.
(female, 54 years old, South Africa, black, D grade)

In general, IRNs working in the independent sector gave an impression of poor working relationships with the care assistants, characterised by lack of recognition and trust.

They really make you suffer the carers...but what I learned was to cover your back, always document, always do your job professionally, that's the independent sector.
(female, 47 years old, Zimbabwe, black, D grade)

And they sometimes mislead you, yes. They are aware that this one's new and they tend to toss you around, tell you things that "no this isn't done and you must do it like this". Now at least you can bring back your nursing experience. Some of the things they tell you cannot be told by anybody coming off the street and you just say "okay" then you'll find out from the manager how things are done.
(female, 53 years old, South Africa, black, D grade)

I would tell the carers "I think we should do it like this" ...they would not come to me and ask me anything. They would rather phone the matron at home...I was feeling undermined as if they didn't take me as a qualified person. Even the matron I thought she maybe doesn't believe that I've undergone training.
(female, 49 years old, South Africa, black, D grade)

Several IRNs spoke about how the carers did not respect them and that they were often by-passed when carers reported problems directly to the managers.

The carers jump to the managers, they by-pass you, they go to the managers and talk about you. The management listen to the carers. They support the carers.
(female, 52 years old, India, South Asian, E grade)

Backstabbing is there. If only they could have some basic training you know, in etiquette, ethics of nursing... language is another thing. Lots of swearing, even by

senior managers. Say “bloody this and that” in the presence of sick people. I am offended and the language, the professionalism is slipping.
(female, 52 years old, India, South Asian, E grade)

Private management they think they’re paying from their own pockets to the black people. In front of them we’re all blacks, coloured.
(male, 30 years old, Pakistan, South Asian, D grade)

Their experiences as employees are developed in chapter 8. Here we consider IRNs’ understanding of their experiences in the independent sector as exploitation in more depth. IRNs’ difficult relationships were explained by the different ways of nursing experienced in their home countries and the poor standards of training which carers received in the UK. If IRNs had no experience of carers, then they found their own role as nurses in the UK concerned with the *basic nursing care* not working alongside carers thrown into confusion, as this quote suggests:

One of the biggest things I’ve noticed is in New Zealand we don’t have carers, so we do everything, we wash the patient, we, you know, walk them, sit them in the chair, we do so much and I think here that basic stuff is missed. The nurses say, you know, are focussing on all these other bigger things and, you know, they don’t spend the time with the patients that we did at home and I think that that’s really sad and I’ve be devastated if New Zealand goes that way, having carers. It’s all registered nurses on the ward. And I also agree about the respect from patients for nurses, in New Zealand like nursing has been voted for five years in a row the most respected profession in the country and we do have that respect and I don’t think it happens here from patients.
(female, 50 years old, New Zealand, white, H grade)

Other IRNs working in private care homes emphasised the poor training and differences in understanding of the nature of nursing care that led to difficulties between themselves and carers. This may be due partly to the differences that exist between qualified nurses and IRNs as to the nature of nursing and partly due to the lack of carers overseas as the quote above shows. The difficulties IRNs face may also influence this when arriving in the UK as adaptee nurses. They described such experiences as demeaning to their previously publicly acknowledged status as registered nurses. Their relationships with carers were therefore fraught with difficulties around negotiating roles and authority as nurses (see chapter 8 for further discussion of IRNs’ experiences of exploitation and their feelings of lack of recognition of their qualifications). The perceived differences between the UK experience and overseas experience is illustrated in the quotes below:

One lady was a cleaner in the home where I was working. The other day someone suggested she got a job as a care assistant. At home, the health assistants have been in basic training, they went to college of 2 years. We call them nursing aids. They do really basic things in college.

(female, 33 years old, Philippines, South Asian, E grade)

Well, in private hospitals we have carers. We have carers in private hospitals, but we, uhm, their scope of practice is limited. The carers work hand in hand with the registered nurses, they assist the nurses in carrying out their duties and responsibilities. They are not even empowered to look after the, uhm, the patient at no time. So that's just the difference, whereas here when you're in nursing homes you see the carers have got responsible for the care of whatever residents or client or whatever, then it is just the duty of the registered nurse to give medication and other things, but that's not as in my home country.

(female, 30 years old, Nigeria, black, D grade)

Their experiences were also framed by the context of their understanding of being a nurse and therefore by their expectations of British nursing. For many, being employed as a carer during an adaptation course was inconsistent with their expectations of nursing more generally and with their expectations of British nursing (see chapter 4). Their status as registered nurses was negotiated in their relationships with carers during their adaptation courses. For many IRNs leaving their original employer, when they had completed their adaptation course either to work in another care home or transfer to the NHS, was the only means of regaining their registered nurse status (see chapter 10 on IRNs' coping strategies).

Even if the IRNs generally expressed more positive experiences with the NHS than with the independent sector, it is important to be aware of the point made in chapter 6 that, in recent years, the attitude to and reception of IRNs in the NHS has improved considerably in many places due to the experiences already gained. This does not mean, however, that working in the NHS was perceived as unproblematic by the IRNs, as we will now discuss in more depth.

Qualifications not recognised

The NMC's arrangements for admitting overseas nurses to the British register of nurses are clearly set out on the website. The rationale given for the regulation of overseas registration is to "assure patients the standards required [of IRNs] are consistent, robust and at least the same as would be expected of a UK-trained practitioner [and those nurses trained in the European Union]" (www.nmc-uk.org 2003). As such, IRNs are required to pass a language test if trained in a country where English is not the primary language, satisfy the NMC that their training is of the same standard as the UK and undertake supervised practice if not. It was clear that many of the IRNs we interviewed did not agree with these conditions and felt

aggrieved that their qualifications were not recognised in the UK. Their feelings were compounded by their experiences of adaptation courses, which, as we have seen, gave them experiences in care homes caring for the elderly rather than nursing (as they would understand nursing). Similarly, managers have pointed out that the adaptation in care homes is not providing sufficient qualification for IRNs who move on to work in the NHS (RCN 2003: 13). Furthermore, IRNs' poor experiences of adaptation courses were made worse by their poor relationships with carers, low pay and exploitative conditions of employment (see chapter 7).

These are their experiences of feeling their qualifications were not recognised fairly:

I was saying to Helen¹² earlier about the UKCC programme that the path that you go through is a straightforward competency based thing that you have to fill out. There's nothing in the competency, there's nothing in the package that makes you compare your competencies from wherever you come from, wherever you trained. If you know how to do intravenous canulation in the Philippines and in Africa there is nothing in the pack that says "okay, the reason why British nurses are not allowed to do this is because" so and so. "But we recognise that you have these skills, you have been trained to do these skills and there will come a point in your career we can leap forward from this, we can use your experience."
(female, 46 years old, Zimbabwe, black, D grade)

Most of the time what I have noticed here in England is like when you come with your experience you're just going to last because most of the things you are limited to do like he has already mentioned, a simple intravenous infusion, when you are supposed to do they'll ask you have you trained in England and when you say no then they will tell you that you are not allowed to do that. A simple thing that you can do to save the life of the patients.
(female, 46 years old, South Africa, black, D grade)

It should be personal like a whole group. Like now I attend study days with people who just qualified, I'm in the same group as them, but I would say I've been here for two years old, sometimes I feel worse than I came here because most of the [inaudible]... some of the skills I had they're dead because I don't have a chance to use them. I just have to go according to how it's written down and the support might be good for somebody who's new, but I think it's destroying me
(female, 31 years old, Kenya, black, D grade)

They [the carers] determine your fate and ... to continue to be a carer because you cannot imagine a situation where you are being, you are being handled by an untrained person supervising your own job as a qualified nurse from another country, because these are the people the matron will call to the office and start asking about you as a person that [inaudible]... the matron himself who could sign the paper [NMC mentorship]
(male, 39 years old, Nigeria, black, D grade)

¹² Interviewer Helen Allan.

IRNs in the focus groups suggested that what was needed were explanations as to the rationale for the registration process as well as the adaptation course. In particular, they appreciated the need for an adaptation course that introduced them to British nursing and new technology but were unconvinced that it was appropriate that these were undertaken in independent care homes while caring for the elderly. They evidently understood this as a method of filling shortages in care homes. This exchange from a focus group in Leeds shows their understanding of the adaptation course quite clearly:

It's like clarifying what you can do and what you cannot do and making him understand why you cannot start a drip, why you cannot canulate, giving you a reason why you cannot do that, because of litigation. But we weren't told about that. This was supposed to be covered during the adaptation period.

Yeah.

But instead of cover it's actually put in issues with letting us do care work. That's not a nurse's job, they should give us clear cut information about why we cannot catheterise when I have been trained for twenty years to doing catheterisation, but now I can't do it.

Another IRN described her feelings of working as a carer while waiting for her PIN number from the NMC as humiliating even though she appreciated the reason for having to undergo some form of adaptation to work in the UK:

Well my experiences working in the UK as a nurse I felt my motivation from my country has not been met. Like I told you I've been here for the past eight months or seven months and I've not got my pin number. Yeah, and so I feel I'm still working as a carer, you know, as a qualified nurse. I graduated from school of nursing 1987 and up to now I'm still working as a carer here and that wasn't my, you know

INTENTION?

Yeah, my intention of what it looks like in the UK even before coming here. I felt if one has to undergo adaptation whichever being, you know, whether NHS or in a nursing home it should be purely nursing practice and much so your qualification as a nurse should be respected and maybe, you know, making you, subjecting you under the carers or what they call it. It's not carers, it's actually humiliating.
(female, 34 years old, Zimbabwe, black, D grade)

Given the extent of IRNs' negative feelings towards, and poor experiences of, their adaptation courses, this issue could also be seen in the context of the discrimination reported by IRNs (see chapter 9). That is, their experiences of their adaptation courses may have been worsened by the lack of nursing on many of the adaptation courses and their experiences of discrimination. One quote sums up this unspoken feeling about the underlying purpose of adaptation courses:

We African nurses come into this country. It's to work in a challenging environment, but when you come on adaptation you are expecting to be adapted as a nurse, not adapt as a carer. If you're going to work in a home if you're working under supervision of a nurse that's much better, but when a senior carer [inaudible]... allocate duties to you it's actually really humiliating. You feel like "well, where is the nursing ...here?" And, as she says, when you actually get your pin number then you have to work in that home, will the senior carer recognise you and acknowledge you? I don't think so because they'll still think: "She was a carer here and how can she be a qualified nurse today?" And: "We used to show her what to do."

(female, 36 years old, Nigeria, black, D grade)

Relationships with colleagues

The most difficult working relationships with colleagues described by IRNs were those with carers. IRNs described managers in the NHS as being different to care home managers, more hierarchical and formal (see chapter 8). The managers in the independent sector were described in relation to the position of carers who were relied upon to run the care homes. In this system, IRNs felt largely ignored by managers and policed by carers. There was a sense of IRNs not being allowed to upset the status quo that relied upon a balance of power between managers and carers:

The problem is not the carers themselves, it's their supervisors [inaudible]... the matron or the RGN. It's like they've given them leeway to say they have been there longer and they're senior carers so they know what they're doing, they can tell you what to do and obviously when you're new in place you sort of don't know who's who and who to ask for and where to go.

(female, 40 years old, Zambia, black, E grade)

The manager herself was good, but you know ... It's like you are left at the mercy of carers.

(female, 35 years old, Zambia, black, D grade)

You cannot go to the manager because the manager listens to the carers, the carers will go report you to the manager. You cannot go to your fellow nurses because the nurses are also listening to the carers.

(female, 42 years old, Zimbabwe, black, D grade)

Their relationships with carers were fraught with negotiating status and authority that proved difficult for them. These difficulties are shaped by their discomfort with being a nurse in the UK and their experiences of being adaptation nurses and exploitative working conditions (see chapter 8).

Problem is like no matter how if they know you are an overseas qualified nurse the way you are being approached or addressed is quite different completely from the so called UK trained nurses because they look at you as if you don't have anything

upstairs at all. They look at you as if you don't know anything relating to nursing. So such attitude actually demoralise human being because you look at nursing as nursing and nursing in every ramification of nursing.
(female, 34 years old, Zambia, black, D grade)

One IRN explained that he felt that IRNs were treated unsympathetically, as if IRNs were not accorded an emotional status:

Yeah I think people ought to be I do not want to put the blame on people here but I think they need to feel more emotions....sympathy...more sympathy.
(male, 30 years old, Pakistan, South Asian, D grade)

However, another IRN explained that he dealt with colleagues who did not respect him by being more aggressive than the last IRN:

Now I prove my work, my knowledge, okay? ... the most important thing [is that] they believe in me now. But there are some who are quite bullying around me, so sometimes they poke me, I poke them twice...before I am a small fish, now I'm a shark, okay?
(male, 45 years old, Philippines, South Asian, E grade)

We explore this aspect of IRNs' experiences further when we discuss their wish for appreciation and trust towards the end of this chapter.

IRNs' relationships with their colleagues were also subject to a chronological influence and there were some examples of IRNs recognising that as the first overseas nurse in a particular environment, this had made the situation and their experiences worse. This quote shows how one IRN had challenged the situation she found herself in by networking with other IRNs:

There were two ladies that came before me in the three months before me and when I sit with them they tell me their experiences. They say it was hard more than it was hard for me. For me it was a little bit better because I had them to fall back onto, but I had to sit, we had together to sit and say: "Look here, let's look at this thing in another way. These people they don't know us, we don't know them, they are also learning what we are and what we're capable of, let's go out and show them what we can do." And this is what we started doing, to show them what we can do. You know, it's interesting for me now to find them coming to me and saying: "Mary, so and so is doing this, what do you think we must do?" But it's something that I think we have had a breakthrough to break this wall, right? I'm not saying everything is rosy, we still have problems of administration, policies are not okay.
(female, 52 years old, South Africa, black, D grade)

Relationships with patients

IRNs had mixed experiences with their relationships with patients. Some felt that their cultural values and respect for the elderly equipped them for a better attitude toward older

patients in care homes that was in turn appreciated by the patients themselves. As this quote suggests:

Because of the culture in the UK it doesn't discriminate whether you are 60, 40, 20, there is no common language used to appreciate [inaudible]... nobody will give this 60 year old person, nobody will give this person a seat.
(female, 39 years old, Nigeria, black, D grade)

You have different approaches to what's [inaudible]... towards caring for the aged, which is completely out of place here, you find the elderly is kept in the home, whereas in my own area we keep them at home, give them all the love they want and they are well supported, until death do they part.
(female, 30 years old, Nigeria, black, D grade)

Others felt that in comparison with their colleagues, relationships with patients were easier to negotiate as these exchanges show:

I think there's a lot more problem with regards to both colleagues rather than patients because patients are more understanding ...
(female, 46 years old, Nigeria, black, D grade)

Yeah
(female, 46 years old, Nigeria, black, D grade)

...we look after them and they can understand when we, you know, when we have the communication with them...
(female, 46 years old, Nigeria, black, D grade)

...patients are more, have more confidence in me than the British nurses. They always call for me: "Oh, where's that nurse? She's so kind." You know, they are so different from...
(female, 46 years old, Nigeria, black, D grade)

...from our colleagues.
(female, 46 years old, Nigeria, black, D grade)

Some IRNs had experienced negative attitudes from patients that included asking white staff for information and pills rather than accepting them from an IRN, bypassing an IRN who might be caring for them to ask a white staff member for information. Sometimes, this white staff member could be a carer who was unqualified and this increased IRNs' experiences of discrimination and being valued less than British nurses are. IRNs also gave examples of relatives asking for information from white staff in preference to IRNs who might be caring for the patient on a daily basis and have more up-to-date information.

These quotes show the extent to which IRNs experienced such problems that were interpreted as discrimination:

I'm working in York and it's a very old town, so people are born and bred there and nurses were the people who trained there, so there's a lot of negativity. They are not yet used to a black person. At the nursing home, we have relatives who [have] no confidence in you. When a relative comes to ask a question about a resident, they see a black nurse at the station and she will pass looking for white nurse. But what surprises me, is that that very white person will come back to me to get the information.

(female, 46 years old, Zimbabwe, black, D grade)

And in this exchange:

You try to suggest something important [inaudible]...for the patient, they refuse because of that lack of trust, lack of confidence in you, after two days they do the same thing.

(female, 39 years old, Zimbabwe, black, D grade)

Exactly.

(female, 46 years old, Zimbabwe, black, D grade)

They do the same thing they refused two days ago. But if it another, especially an indigenous.

(female, 39 years old, Zimbabwe, black, D grade)

AND YOU FEEL THAT IT HAS SOMETHING TO DO WITH YOU BEING FOREIGN.¹³

Yes.

AND MAYBE RACISM?

Because of that there's no trust, you can [inaudible]... but there are a few that tell you [that] you are competent to do this because we know these things, but there are some they can totally refuse.

(male, 35 years old, Zambia, black, E grade)

At first sight they don't have a problem, they just accept you. Once they have been introduced to you "this is the new nurse who's going to be looking after you" then it goes just like that. You do get the exception at times, I mean there are always exceptions really, someone [inaudible]...and they can make you really, make your life hard, but on the overall I think there's general acceptance from patients as compared to our colleagues.

(female, 46 years old, Zimbabwe, black, D grade)

They can make your life miserable. They can easily "no, I don't want you to care for me" and you feel bad. And now coming back to how [inaudible]...most of them you cannot simply tell by the way they do things [inaudible]...they refuse you, say maybe you don't know. They do the same thing [inaudible]...they can't accept, they can't [inaudible]...they can't appreciate that. Those are the things, but generally a few, some relatives they ... accept it. One or two [have] got this black thing...

(female, 46 years old, Zimbabwe, black, D grade)

IRNs also gave examples of how they managed more assertively negative reactions from patients in their nursing roles. These actions were obviously protective of themselves but also reminded their patients that the NHS had changed and that they saw themselves as a benefit to the NHS.

I've had people refuse myself and South Africans because he didn't like where we came from. We said to the gentleman: "This is all you've got and if we weren't in this country, you'd have no nurses to take care of you."
(female, 33 years old, Canada, white, E grade)

Communication difficulties

IRNs felt that their communication skills towards both colleagues and patients had suffered while working in the UK. As communication is a key skill for nurses internationally and one that is learnt and honed during a career (*Making a difference* 1999 and *Fitness for practice* 1999) this experience gave the IRNs a sensation of being *deskilled*.

Some frustration about language. The first 3 months was the hardest when you had to translate everything in your head and you questioned your own ability to work as you felt. I noticed people were frustrated that they had to use sign language to say "would you like a cup of tea?"
(female, 30 years old, Finland, white, F grade)

I'm not black but I have a strong accent and as soon as I open my mouth, patients ask me "do you speak English? Where did you receive your education? Is it the same as here?" It's really hurtful and you need to improve yourself because people look at you with prejudice.
(female, 30 years old, Ukrainian, white, E grade)

I'm a quiet person so I listen and I put in...Here I have had to really listen and try to participate. I was isolated and maybe didn't communicate. ... I am sociable when I'm used to you but when you're quiet, they think you're stupid
(female, 47 years old, Zimbabwe, black, D grade)

A main, but not exclusive, reason for the communication difficulties was language differences due to different dialects and accents (see also the discussion of cultural differences in chapter 8). IRNs initially struggled to become familiarised with local dialects and colloquialisms, as discussed in chapter 6. This was surprising for some IRNs who had expected the British to speak *Oxford English* as they had been taught in school in their home countries, but it was a problem they could overcome relatively quickly after a period of settling in.

¹³ Interviewer John Aggergaard Larsen.

They speak English, they are English but they don't know English. When you hear the Oxford English when I came here... all the pronunciation, but they are English. Most of them is not the English we know.
(female, 34 years old, India, South Asian, F grade)

Recruits from other countries need to be moulded into the culture here, even the language. When somebody says "boos" stop, you don't know what they're saying.
(female, 54 years old, South Africa, black, D grade)

A more severe and persistent language difficulty was the difficulty with which their UK colleagues and patients could understand and become familiarised with the IRNs' accents or dialects. This was a problem for IRNs who had English as a main language in their home country such as: India; Nigeria; Zimbabwe; or South Africa. In these examples it would be more accurate to define their version of the English language as a dialect. A dialect is not only characterised by a certain pronunciation and grammatical structure but also intonation and style of talking.

When I first came here, I found it difficult to even open my mouth because whatever you say, they say "I can't understand what you're saying". I said: "It's impossible for me to speak here, I can't speak my language, I'm speaking English." We are taught in my country to speak English and I cannot communicate because I am black, because I am not trained or brought up in England and it's unfortunate.
(female, 44 years old, Nigeria, black, D grade)

I think it's demoralising. When I got here I couldn't even order milk over the phone because she couldn't understand me. But now I've got to the point when they talk to me and I can't understand ... I say "slow down".
(female, 30 years old, South Africa, white, E grade)

Some IRNs felt that the language barrier became a vehicle for racism among British nurses and carers. As we discuss in chapter 9, racism was explored in depth in the focus groups and there was discussion of how IRNs' experiences could be indications of racism or discrimination based on culture. This was evident in their descriptions of language and non-verbal communication as a marker of difference (Banton 1994). This IRN had experienced problems because she was used to talking loudly and assertively in her home country, which had been interpreted as "shouting" and "being rude" in the UK:

The other thing I want to talk about is the difference between our sense of humour and the white people's sense of humour. Like most of the time I had a problem when I first came, people used to think that I'm rude because my voice is rich, that's what I tell them, we're not shouting, we've got rich voices. So the problem is each time you talk, they think you're shouting until such time as they understand "it's okay, she's not shouting at us". That's the problem I encountered, it was frustrating to me.
(female, 44 years old, Nigeria, black, D grade)

By explaining that the style of talking was a cultural difference and, in the UK context, reinterpreting it as “talking in a rich voice” rather than “shouting”, the problem had been overcome. However, as the following quotes show, such experiences did produce negative experiences for IRNs:

Then it got to the stage where I cannot even give report. They would be giggling, laughing. I said: “Please listen. Listen to what I’m saying, I cannot in a day or week [learn to speak in a British dialect]... my pronunciation [is different, but] it’s English I’m speaking.”

(female, 46 years old, South Africa, black, D grade)

Like I’m the one saying “shit it’s falling down”, then they say I’m rude, but somebody white say “shit”, nothing is said.

(male, 34 years old, Pakistan, South Asian, D grade)

I just want to say one thing...the United Kingdom they rule the world, they rule Asia, they don’t know one word of Asian languages but we are so happy we know one word of English.

(female, 34 years old, India, South Asian, F grade)

Yes she was told, she cannot speak English, her accent was different to us [Nigerian]. Us Africans, we can differentiate but she was told patients cannot understand her, she cannot communicate with patients, everybody on the ward was not nice to her.

(female, 44 years old, Nigeria, black, D grade)

They keep on laughing at me. Why? My term for IVI. They say “put IVI” so they keep on laughing because ...okay in England I don’t know your terms. Don’t laugh at me, don’t insult me, don’t humiliate me.

(male, 36 years old, Philippines, South Asian, E grade)

Clearly, IRNs felt that their ability to speak English affected their relationships with colleagues and patients. They did not deny the necessity of IRNs being able to communicate effectively with patients but they raised, in their discussion of language and racism, the need for both British staff and IRNs to tackle this issue together rather than laying the blame at the IRNs’ door. One IRN summed this up by saying:

Communication is a stigma for overseas nurses. We are seen as poor communicators when that is not so. Communication problems should be recognised as stigma.

(female, 53 years old, India, South Asian, E grade)

In some cases the IRNs felt that the language problems stigmatised them by labelling them as *different* and *difficult* – and, thereby, offering their UK colleagues an excuse for *not trying* to understand. The IRNs’ statements indicate a real need for health care staff to increase their efforts to communicate with IRNs. Learning to communicate across various English dialects

and accents is not only a question of trying to understand and accepting the language differences, but also of confronting them, as this quote illustrates:

I think people here they sort of don't ... have the patience to listen because no matter how bad their accent, if you make, let's say if you're travelling around the world, sometimes you don't even understand what people say but because you want to understand you make the effort. Here people say, I've had this many times, people say: "Oh, well if people come to England they must try and speak English. We haven't gone to their countries so they must speak English." I notice where I work some South Asians they call the toes fingers and everybody was writing that these people have painful fingers, they're painful. I said: "Why are always people here having painful fingers?" Because I didn't know why, they said: "Oh, because they have diabetes." I said: "Oh, well you know in South Africa they usually have the complication of painful toes" ... And in the book there was nothing, then it worried me, I asked one Asian doctor I said: "Why are these people mostly Asian they have painful fingers?" He said: "Oh, there is no word [inaudible]... fingers for the feet." I said: "Oh, you mean like toes?" He said: "Yeah, there is no word toes." But these people have lived in this country for ages, for more than fifty years calling the toes fingers and nobody has picked it up because people are expected to be precise in what they are saying.
(female, 52 years old, South African, E grade)

Exploitation

For the IRNs who arrived in the UK and were unable to practise until they had successfully completed an adaptation course, their position as an adaptee student often employed in a care home as a C grade was humiliating, demoralising. As we have seen above, this has led to poor relationships with British carers. IRNs felt that privately run adaptation courses exploited IRNs by postponing registration. Some IRNs felt that adaptation was an arbitrary process and that the NMC had a role to play in ensuring that unscrupulous agencies did not recruit IRNs to work in care homes with the promise of registration and supervised practice.

She [manager] doesn't want to get the pin number [for me]. I think she's expecting cheaper labour or something like that because before I got my pin number she just say, in our nursing home we've got two different like different wards, two units, so she used to say: "I am in the office, so you can take charge at the moment." And I can give medications and do everything as a trained nurse on behalf of her, she's in the office so I can do for her. Once I'd got my pin number, I didn't receive my pin number in my hand, but I paid my money there, she won't give me charge nurse, like she will definitely she will make sure I'm working as a care assistant like.
(female, 34 years old, India, South Asian, E grade)

The matron I work with I think she was expecting really cheap labour because I remember when we came over she said, uhm, she asked us to fill up a form, I think it was to convert the salary that we were earning from the Philippines and convert it into the exchange rate that was going on ... and she commented something really, really annoyed me, she said: "Well, it's a good opportunity to come over here then, it's a whole lot of money isn't it?"
(male, 27 years old, Philippines, South Asian, D grade)

The experiences of being exploited during the adaptation period as carers in the independent sector has already been discussed earlier in this chapter and in chapter 6. Other IRNs felt that this exploitation continued after they registered and that negotiating staff nurse status with employers and colleagues was difficult as these quotes suggest:

But the thing is a couple of months after, after I received my pin number I was asked to do a senior's job. Every night in the nursing home somebody had to stand as a senior. I understand it's a health authority policy that there has to be a senior nurse in the unit and in the entire nursing home every night. So what she did was she didn't hire a lot of senior nurses, what she did was she used these D grade nurses to stand up as senior nurses to fill up the numbers.
(male, 27 years old, Philippines, South Asian, D grade)

Usually on the weekends I'm covering the shifts ... and like the sick leave and everything like that. The manager says: "Oh, you're doing a very fine job, I will try to increase your payments." When after a few months I'm doing same ... I'm asking after two months: "Look [inaudible]... payment?" Every time it's: "We can't." Soon after they got a new staff registered nurse, they are paying one pound extra more than me.... Yes, when I ask him he said he can't: "There's a limited amount, I can't. I spoke to the authorities." They don't want to increase the payments, the limited amount for this home, but they're paying extra to the white nurses.
(female, 44 years old, Nigeria, black, D grade)

They don't allow us to practise as a professional and especially... you are just like a carer... they believe what does she know?
(female, 40 years old, Nigeria, black, D grade)

One IRN described the immigration of IRNs and their use in the British workforce to make up shortages in British nurses as *slavery*:

Yeah, slavery and if I have to say, slavery. Slavery is relative because if you have to look at the two angles it's like okay, you sought for labour from somewhere. Okay, you bring your labour to the country, the labour is going to contribute one thing or the other to the upliftment of the health sector in the country. It's not to downgrade the health sector.
(male, 39 years old, Nigeria, black, D grade)

Terms and conditions

Grading in the UK has traditionally been structured around the responsibility of the role rather than being based on the experience brought to the role. Therefore, many IRNs are employed as D grade staff nurses but expect to bring their experience of nursing as senior nurses in their home countries to the role in the UK. This leaves them feeling exploited as they feel they nurse according to their experience rather than to the responsibilities of the role. These problems with the grading structure are, of course, what have prompted the introduction of

Agenda for Change (DH 2002). Also, managers have expressed concern that some IRNs are undervalued in the grading system when they are first employed, and that it could be appropriate to recognise their experience and skills by immediate appointment to grade E or equivalent (RCN 2003: 21).

The experiences of the IRNs we interviewed suggest that grading may be one facet of their experiences of exploitation, a mismatch of understanding around how pay is structured in the UK. There is also another factor which may be shaping and adding to their experiences of exploitation, namely, whether IRNs are being employed on one grade and are being asked to take on responsibilities for another, higher, grade.

I'm sure almost everyone when they came here ... When you look at the, when you talk about the same salaries and money they don't look at the experience you have. Of course the man has to be paid according to the experience ... the money should be added. ... They are using our experience as if, but they're using our experience but paying us as if I'm just qualified.
(male, 27 years old, Philippines, South Asian, D grade)

One Canadian put her feelings about being exploited succinctly:

I'm here to work as one nurse, not as two, meaning working the extra shifts because they don't have staff and I've always been pressured into picking up shifts.
(female, 33 years old, Canada, white, E grade)

Many IRNs felt that British nurses generally experience poorer working conditions and longer hours compared to their experiences overseas (see chapter 8). Those who had worked in North America or Saudi Arabia complained about the poorer pay in the UK (see also the discussion of economy in chapter 5). For the IRNs, these general poor working conditions were worsened by not being recognised as a qualified nurse during the adaptation period and also later, by being given the least desirable shifts, forcing them to work unsocial hours.

Because Friday night comes, it's just a mass exodus of all the indigenous people and all of a sudden all the immigrants come out and just the whole hospital system is run over the weekend by immigrant people. You know, you actually never see, you hardly ever see an English or a Welsh person over the weekend, it's nearly all, well not so much here, but definitely in England, you know.
(female, 55 years old, Zimbabwe, white, E grade)

In some cases, IRNs felt that their situation did not allow them any option to reject these undesirable working hours. They had social and financial obligations that forced them to consent.

Not much has been really done to really support us, for instance when for those three months of adaptation we're supposed to have the days off ...you see us working they will just tell you have to work, just to survive. Back home we know what we need and we know we need money, I mean part of why we came here. I think there should be some, a standard, you know, rule as to how much to be paid within those three months and even after the three months while awaiting our pin numbers it differs anyway from hospital to hospital and home to home. Some pay good money, you know, not as a carer while waiting for the pin, whereas some still consider to pay you as the carers.

(female, 44 years old, Ghana, black, D grade)

In other cases the exploitation was more direct and manipulative, leaving the IRNs with feelings of abuse, neglect and despair.

But even then sometimes I do nights, night duty on Thursday, the following day on Friday they're expecting me to wake up at one o'clock and cover the shift and I become very tired and I'm telling but they don't want to listen to me ... Sometimes they don't even inform you. Maybe someone on night duty is not coming tonight, they will just put you without informing you that you will cover that shift.

(female, 54 years old, South Africa, black, D grade)

The long shift can be very tiring and you see just we came, they just call us, it's just we coming down, you just have to come and cover this duty. You know, others will just phone in they are not coming, no problem, they call the overseas nurses. No compensation, the Saturday duty, the Sunday duty, there is no difference, Christmas no difference in my home, for instance, which is, which is frustrating.

(female, 42 years old, Nigeria, black, D grade)

Yesterday I said that I was offered, I did a long day and I was supposed to be off at half-past-seven, knowing that the trains, you know, at night, they are not, you know, the services are not working well and I asked to go earlier, they refused. One of them come at one o'clock, yet I was working the whole weekend and I was long day on Monday. One of them came at one o'clock and the matron finished at four o'clock, but they just leave me there and they went home, I had to stay until half-past-seven, in such a way that I came very late, around about ten, you know. I'm so stranded, I don't know what to do.

(female, 50 years old, South Africa, black, D grade)

Contracts

IRNs described poor experiences of negotiating contracts with recruiting agencies. The feeling in the focus groups was that it was a confusing time when they risked a lot to trust the agency to honour their word. On several occasions, their trust in the agency proved mistaken. This caused anger and frustration, and IRNs demanded stricter regulations to safeguard their rights. They also reacted to this situation by blaming themselves and by trying to assist other IRNs not to fall into the same trap.

It was a terrible experience for me personally... the Government has to come up with an agency to safeguard the contracts of all international foreign recruited nurses...BUPA, uhm, promised in the contract, first contract said that they were going to pay five pounds something. In the second contract when I came over and the stupid thing is I signed them all because I wasn't, I must really humbly hang my head and say because I signed because it was an opportunity to go abroad and you're young and you want to travel abroad.

(male, 27 years old, Philippines, South Asian, D grade)

I think that the agencies are very much to blame here because I think that the agency owe it to the nurse to have got the right contract. I mean I cannot understand why they put them in a nursing home when they come if they've come as qualified people. They get their pin number, they need qualified people, we're brought into the country to be qualified, so therefore that's what we must be. But because they're so short in the nursing homes it's exactly what you said, it's like they use our ignorance to fill their gaps. But it's really our fault because we should do the research before we come. That's right.

(male, 39 years old, Nigeria, black, D grade)

And we should make sure that we know exactly where we're going, what we're going to do and how much we're going to get paid and all the rest of it.

(female, 55 years old, Zimbabwe, white, E grade)

There were examples of illegal employment practice such as signing contracts with penalty clauses (paying back flights) and employers confiscating passports and documents as these quotes illustrate:

At the end of the day, you have to sign this for three years or else pay back such a large amount of money to compensate them for it.

(female, 39 years old, Nigeria, black, D grade)

When I came here I was forced to do 50 hours a week on £12,000 ...this is what I earned for more than 1 year and I was policed by care assistants... It was only when I joined the RCN that I learnt the truth. At the time they [the managers] had collected my passport, my card and my certificates...he told me people are coming for an inspection and he held onto them for three months [inaudible]... he told me I couldn't leave the job for two years.

(male, 49 years old, Nigeria, black, E grade)

Strategies for managing exploitation

IRNs described strategies for managing these exploitative conditions. One nurse decided to "play" his colleagues and managers at their own game by refusing to do extra shifts:

Now the manager says he got a new nurse, he want to make a place for the new nurses. He said: "Okay, I can't give you more extra hours now, you're doing limited contract hours." So I say: "Okay, fair enough." But they try to encase my need, so now they give me the calls, now when the white people get called off sick shortage they say: "Would you like to come for a shift?" Now I'm saying: "No, I don't want to come ..." Now they come to me like yesterday: "You like to do some extra

hours?” I say: “No, I’m happy with the limited hours now.” I think we have to be make them scared what they want to do ...
(male, 35 years old, Pakistan, South Asian, D grade)

This strategy of avoiding feeling exploited had a lot to do with getting respect and being appreciated, as we will discuss in more depth below. IRNs described moving to the NHS and moving between care homes to cope with poor adaptation courses and non-registration (see also RCN 2003: 13). This strategy proved the most common and it was a goal for many of the younger IRNs to work in the NHS where conditions were reported to be better for IRNs once their adaptation course was successfully completed. One of the reasons for moving to the NHS was that support and systems were seen to be better as this quote shows:

You are expected to work under supervision and you have this booklet...you set your learning outcomes and your competencies and you have a tutor who comes to check up on you and you have a mentor who is responsible for filling in the booklet.
(female, 41 years old, South Africa, E grade)

Only one IRN described overtly challenging her employer to honour their agreement before arrival in the UK. This IRN described how challenging her employer had led to an improvement in her grade but that it had been an uncomfortable experience:

Anyway, so I went to the sister in charge, who had hired me on the telephone, and I said: “Do you remember that conversation?” And I brought out a piece of paper where I’d signed it and they’d signed it and everything and she said: “Yes.” So I said “well, you said after three months that I would be reviewed and secondly you said that I would start on” such and such. And she actually thought that I had such a cheek ...she thought that I had such a cheek to remind her that she had promised and it was written and signed that they would review it. I said: “But tell me, is there anything in these three months where I’ve been working here that you can honestly say, is there anything that I need to sort out?” “Because if there is then here I am and I need to sort it out.” Well she couldn’t, there was nothing, everything that I was meant to do according to my criteria on the ward I was able to do, because our standard in many respects in Africa is much higher. I thought I was coming to first world nursing.
(female, 55 years old, Zimbabwe, white, E grade)

Other strategies included:

- joining the RCN and becoming aware of their rights as employees
- coming over on holiday visas beforehand and negotiating NHS employment and if necessary adaptation in the NHS
- networking with other IRNs
- leaving the UK to go to another country where conditions were perceived to be better.

These have also been discussed in chapter 6 in relation to IRNs’ experiences of support.

Lack of appreciation

Throughout the focus group discussions a strong theme was IRNs' desire to be appreciated in their job. Apart from *appreciation*, key words often repeated were *respect* and *trust*. We have mentioned above how some IRNs adopted strategies to avoid feeling exploited by their managers and their UK colleagues: demonstrating their value, self-respect and that they could not be expected always to be available. IRNs described how they were treated as "just another hand". This impression was strengthened by the fact that their nursing experiences and qualifications from overseas were not being recognised in the UK and the fact that they were working as care assistants in the independent sector. Also, the IRNs felt that the lack of appreciation was reflected in their pay.

If you're not paid what you think you're worth, if you're a good nurse and you think you're worth more than what you're paid for it's demoralising. If you're a nurse who thinks "oh, this is alright" then maybe it doesn't affect you. It affects the people around you and therefore then it ripples on and it affects you because it creates a very demoralising work area.

(female, 33 years old, Canadian, white, E grade)

[British nurses] do work hard and they're expected to do a lot out of a culture which is fairly unsatisfied, un-contented most of the time.

(female, 47 years old, Zimbabwean, black, D grade)

As discussed earlier in this chapter, some IRNs experienced how their basic needs of rest and having access to food were not appreciated in the workplace. They were expected to provide professional care in an environment which was, basically, uncaring.

You're working for so many hours like eight hours and you are not even offered a cup of tea because, I'm talking like where I work, you bring your own tea bag or your own teaspoon of coffee or you buy the tea at the tea machine ... It's alright, but you give so much you can't even be given, I'm sure two people can share a tea bag if it comes to it.

(female, 52 years old, South African, black, E grade)

Some IRNs described how they felt that the lack of appreciation permeated the whole working situation.

"Thank you very much, you've done a good job." I've been here five years, I've yet to hear that come out of anybody's mouth. I don't think that the medical profession, i.e. the nurses or the HCAs are really and truly appreciated for what they do, whether it be a verbal appreciation, a financial appreciation or a tea bag appreciation, they just don't. You know, and you fell like saying: "Okay, if everybody just decided one day not to show up let's just see how far you all would

get.” You know, they just don’t show any sign of appreciation, they don’t do anything to make you feel it’s worth coming every morning to come in and be faced with whatever you’re faced with wherever you’re working, nothing.
(female, 61 years old, USA, white, F grade)

And that’s the thing which contributes to the shortage of staff, you are not appreciated, why bother going to work, you just take the phone: “Oh, I’m not well, I’m not coming to work.” Because you are not really emotionally, that’s why some people are always upset, that’s because they can’t tell the truth, that’s why, we are not happy.
(female, 52 years old, South African, black, E grade)

Apart from the lack of day-to-day appreciation while working as a nurse, IRNs felt that their public image in the media and political discussions was predominantly negative in the UK (see also the discussion of others’ perceptions in chapter 9).

... it would be very nice to just get somebody, someone to say, you know, “thank you for what you have done”. You know, we don’t know where it would come from, but maybe research people like you, you know ... But even though I still would like somebody to just appreciate what I’m doing, the problems I’ve had, you know, what good things [inaudible]...otherwise I’m just there in my own little flat or my own little, you know.
(female, 57 years old, Zimbabwean, black, D grade)

And, as illustrated in this exchange in one of the Leeds focus groups:¹⁴

... we need to have support in order to be motivated to work. We need enhancement and continued education and compensation as well.

We need representation ... so that we know we’ve got somebody who we can always call up if we’ve got a problem.

And respect ...we need respect from our colleagues or whoever.

Basic human emotional needs, that you need to be appreciated in your job. You come all the way from a third world country and you don’t have to do extra struggle to work here. It’s hard enough to work where you come from and how to be appreciated. The Government rarely does that, all they talk about twenty thousand nurses are needed at the moment, but what about the three thousand, five thousand nurses from Africa, what the hell are they doing here? What are they doing? What are they contributing? And there’s not been enough emphasis on that and I think that would help, boost the morale of everyone.

One IRN contrasted her feeling of not being appreciated in the UK with the general attitude to foreigners in her home country:

¹⁴ Unfortunately it is not possible to attribute these quotes to individual IRNs taking part in the exchange.

A foreigner in our culture ... it's somebody who is to be treated with caution and love and support because he's far away from home. ...you know, you are somebody special who has come in to help us.
(female, 47 years old, Zimbabwean, black, D grade)

Conclusion

The data presented in this chapter show that IRNs experienced the UK as an ambivalent place to work. They experienced British nursing as an IRN as an entirely different experience to nursing in their home countries. They also felt their competencies at communication (a fundamental nursing skill) were compromised in their relationships with colleagues and patients. Being an IRN did give them opportunities for work and to improve their lifestyle in the longer term, but at a cost of poor employment conditions, exploitative contracts and racism from their colleagues and managers. In addition, they risked leaving the relative stability of daily life in their home country:

I cannot go back home now because I spent a lot of money to come here, I spent all the savings that I had to come here and I cannot just go home, but if I had to go I can even go today, but I cannot go because I have to achieve what I came here for. I came here for international experience, I came here because I think going to the UK I'll have better money than the way it is back home and you find yourself just being frustrated. You have nowhere to run to.
(female, 35 Years old, Zambia, black, D grade)

In the next chapter we will discuss the cultural and system differences which affected IRNs working in the UK as nurses.

8. Comparing health care systems and culture

In this chapter, we present the influences of culture and systems of health care on IRNs' experiences of working in the UK. IRNs' experiences are discussed in relation to comparisons between cultural practices between IRNs' home countries and the UK and comparisons between the nurse's role and the health care system in the UK and the IRNs' home country. These influences of culture and systems emerged as a central feature of the IRNs' professional experiences of nursing in the UK. However, we go on to argue that the individual IRNs' experiences of cultural and professional issues are also framed by their experiences of discrimination (chapter 9) as well as their personal coping strategies, the career strategies they adopt and their motives to stay and continue working in the UK (chapter 10).

Cultural practices: UK and overseas

The advantage of the focus groups was that they allowed the generalisation of personal experiences to be challenged by individuals with the same ethnic background while at the same time valuing individual experiences. This was particularly important when discussing cultural practices of both the UK and overseas as it enabled the development of a broader collective understanding which exceeded individual generalisations or cultural stereotypes. IRNs included in their discussion of cultural practices aspects of their professional life which they had found differed to their home country and aspects of British social life more generally. These included central heating, plumbing and:

Lots of silly things that, actually, when time goes by, you learn to cope.
(female, 30 years old, Finland, white, F grade)

When I came, the sister had to keep telling me to "stop calling me sister, call me Jane. I'm just Jane".
(female, 37 years old, Nigeria, black, D grade)

There are many cultural things you need to know before you go into Britain, as opposed to anything else. You need to wear tights and you need to do things a certain way. Initially when I came in there were hats in those days. You need to make a bed in a certain way, it was to say to patients who were able to make their own beds, try to make it, if you can make it, then I come back and it's OK, then that's fine. It was sort of "you have not made such-and-such a bed and that's bad practice". There was never waiting for an explanation, it was "I tell you and you will learn" as opposed to "how come you didn't make those beds?", you know.
(female, 36 years old, Sweden, white, E grade)

However, “silly” things could be frustrating and lead to discrimination and abuse. One IRN recalled observing another IRN make a mistake:

There was a student nurse from Ghana who, it was summer time, he gave a patient a bowl of water. He didn't mix it with warm water, he just, oh, come and see the insults. Fine, he made a mistake, but I can see why he made that mistake, we don't have this winter and it's only a few places you will see hot and cold water, the water is warm, it's tepid water, you can bath even without warming it.
(female, 46 years old, Ghana, black, G grade)

Other cultural differences that made an impact on IRNs were whether they found the British friendly. This aspect of their experience proved to be an important theme as IRNs had to negotiate their lives outside the relative safety of the health care setting. While a minimum of support was expected in work, none was expected outside and relationships with the outside world were often difficult or unrewarding:

I think the Yorkshire people are very conservative. Uhm, I found them friendly but at a distance. I've lived here a long time now [30 years] and it's taken me ages to get close to people.
(female, 56 years old, South African white, D grade)

I think something that I found hard when I came here was the fact that everybody met in the pub and I'd never been into a pub. It was such a difficult thing walking into, to walk into a big crowd by myself I was terribly daunted and I never really overcame that.
(female, 56 years old, South African white, D grade)

I haven't gone around England much, so I don't know, so I like comparing this place to America and Canada. It's not right. So maybe I shouldn't do that. But I've found Canadians friendlier.
(female, 44 years old, Ghana, black, G grade)

Really we cannot socialise because coming from Asian origin or India or Pakistan or whatever most of us we don't smoke, that's not our culture, you know, we don't drink, that's not our culture. But having said that, we don't disrespect because this is your culture in England. We can mingle only if we have the same interest, but here ...I can have my tea or coffee or soft drink, I'm used to that perhaps because I have worked always abroad and I am trained with missionaries, you know, people from all over the world were there in India.
(female, 47 years old, India, South Asian, D grade)

It was really difficult to start with because in Ukraine people are very friendly, goes to each other's houses, doing parties in the end of the work, you know, if there is something, coming here it's different. Three years I work and I have only one friend with whom we can sometimes go out. People really keeps for themselves and they don't speak to you, they don't want to know nothing about you and they don't want to invite you as well to become part of their life.
(female, 32 years old, Ukraine, white, E grade)

IRNs also pointed out that structural arrangements such as social services and care homes could be very different to what they had previously experienced as this quote suggests:

I was just thrown in and so many things different. You have social services, we never had social services there and the only thing we had like public health and you [in the UK] go to visit homes and things...
(female, 44 years old, Ghana, black, grade not given)

IRNs' expectations of British taxation also proved frustrating and a source of anger in the focus groups. There were obvious differences between structural arrangements for paying tax in the UK and elsewhere as this quote shows:

This country, if they can just maybe reduce the tax and maybe the council tax. I suppose whatever we get if I worked 37 hours per week, that money [inaudible]... tax, tax, everything gone with that money. You know we are Africans ...where we come from they expect us to give them a little bit ... why are we working? We need to save...
(male, 35 years old, Zambia, black, E grade)

And this income tax when we bring extra hours there's a lot of tax on our pay.
(male, 36 years old, Pakistan, South Asian, D grade)

And then also I expected a salary, something to really live on that, you know, get good, but then in the long run you find out that the tax has, you know, taken most of it and the pay pack is not really much to write home about.
(female, 37 years old, Nigeria, black, D grade)

One cultural practice that has already been discussed is language (see chapter 7). There were facets to language, which are also pertinent to the discussion of cultural practices. IRNs commented that their experience meant that they were more aware of cultural difference and tolerated it more than their British colleagues (see chapter 9). As these quotes show, IRNs also explained cultural difference to their colleagues because such perceptions could lead to stereotyping as we have seen:

Where I've worked before I worked with a Nigerian nurse and she had this very loud voice and one of the care sisters asked me, she said: "She always speaks in that voice." I said: "You know why? Because most of the African culture", I'm notwith the African culture, but "most of this is it's quite a polite way, they speak in that rich voice."
(male, 27 years old, Philippines, South Asian, E grade)

Exactly.
(female, 46 years old, Zimbabwe, black, D grade)

And it's a cultural difference, a cultural thing and I think each time, each time I see a person making comments like that I'd always say, I'd always make it a point like, you know: "This is a different culture and the least you could do is appreciate that this is this person's culture, that they speak in this voice." And I know it's like talking to a brick wall at times, but...

(male, 27 years old, Philippines, South Asian, E grade)

However, IRNs clearly felt there was cultural stereotyping:

And with Asian people, ... we're always accused of not having a lot of assertiveness and we're laid back people and we don't take things forward and [inaudible]... all the time, which can be annoying because it's a struggle and the first thing they see with you is your colour and the way you speak and not...that you are trying to speak in their own language and assimilate.

(male, 27 years old, Philippines, South Asian, E grade)

Challenging cultural stereotypes in relation to both practices and social structures was important to some IRNs because they felt such stereotyping devalued the IRNs' culture in comparison to the UK. Other IRNs felt that recognising difference helped them negotiate working with colleagues more effectively. These different approaches are conveyed in this quote which shows how different IRNs' personal coping strategies could make a difference in how they reacted to and interpreted colleagues' reactions as racist (see chapter 9). This IRN had continued to work in a care home where her first experiences had been difficult and negative.

There are cultural differences... so most of what he listed [previous discussion of language] are like ignorance, what you don't know, don't understand and I used to be angry with this but now it doesn't bother me because I've learned that we do things differently. Like when I first came to this country I wouldn't look at you talking to you like I'm doing now, you see my head like this [look down]. And for one-and-a-half to two years it was tak[en] against me, I was rude, I was all sorts of names and one day, I was getting into my second year, [an] auxiliary nurse had the courage [and] called me aside and said: "Right, I need to tell you something, I hope you wouldn't be offended, I don't think you are like, you know, the way some people portray you" I said: "Oh, I can't do that in my country." [look people in the eyes] I mean as a sign of respect for an adult my leader is my senior members of staff on the ward, I don't look them in the eyes. So it was how I begin to learn that and the body language, your intonation.

(female, 44 years old, Ghana, black, grade not given)

Cultural practices also shaped their experience of nursing in ways that might seem small but have a significant effect as this Canadian nurse explained:

Uhm, the information accessible for training, so and so forth if you're not on the inside [cultural] track, then you have to work a little bit harder.
(female, 30 years old, Canadian, white, E grade)

This discussion has covered those aspects that IRNs specifically identified as being different to cultural practices at home. We will now discuss IRNs' experiences of being a nurse in the UK and the comparisons they made between the UK and their home countries. Cultural practices and values at a fundamental level also shape these experiences. For example, different values about patients' rights give rise to different ways of being a nurse, as we will see.

Experiences of being a nurse: UK and overseas

These comparisons emerged in the data as frustrations with the organisation of British nursing, their frustrated expectations of *first world nursing* in the UK and IRNs' coping strategies to deal with these disappointments and frustrations. There were some more general reflections on service organisation in the UK that are interesting in the context of current debates over the modernisation of the NHS.

The frustrations of IRNs with British nursing reflected debates in the British literature around changes to nursing over the last 20 years (Salvage 1990; Savage 1995; *Making a difference* DH 1999; *Fitness for practice* DH 1999; *NHS plan* DH 2000). These frustrations involved firstly, the organisation of British nursing and were shared, perhaps surprisingly, by IRNs from developed and developing countries. When comparing their hours of work and pay, IRNs generally agreed that British nurses worked too hard and were underpaid (see also chapter 5):

I was only used to working eight hour shifts. Uhm, quite a shock when I saw my night duty roster and found out I was doing a 12-hour shift, uhm, for seven nights. Uhm, I was given a week off afterwards, but I found that very tiring in terms of doing that, especially over the winter months when you don't get to see the light of day.
(male, 35 years old, Australia, white, F grade)

I didn't realise the struggles nurses have had financially to get fair pay, uhm, and how that is so demoralising on the ward.
(female, 32 years old, Canada, white, E grade)

When I got to the UK to work as a nurse and my pay should be sufficient for me without having to join the agency but I discovered I have to work around the clock if I want to live in the UK as a nurse because the pay is not...
(female, 36 years old, Nigeria, black, D grade)

And you're working for so many hours like eight hours and you are not even offered a cup of tea because, I'm talking like where I work, you bring your own tea bag or your own teaspoon of coffee or you buy the tea at the tea machine and ... It's all right, but you give so much you can't even be given [a cup of tea].

(female, 61 years old, American, white, F grade)

Discussion in the groups revealed that some IRNs experienced British nursing as hierarchical and old-fashioned whereas others thought British nursing was dynamic and less formal than their home country. This related to their country of origin.

I find it very formal over here as well, uhm, everyone is called sister or staff nurse very rarely are people spoken to on a first name basis, uhm, especially working with doctors as well, uhm, especially seeing your doctors want to be called Mr and all this sort of stuff, whereas I was quite used to being, uhm, speaking to people on a first name basis. Certainly in front of patients speaking to them by their titles, that's what they would prefer, but actually when you're in a team meeting it was doctor this or sister that and I'm just not used to be called sister.

(male, 35 years old, Australia, white, F grade)

However, this IRN had returned to the UK and on his second visit found things had changed:

However, on this time coming over I've found that it is changing, that there's a bit more of a dynamic type team approach coming from all the sectors, from the doctor, the nurses, the social services, the physiotherapy to try and get a bit more of a centred focus care going there. Uhm, so in the first instances I found it wasn't very dynamic, uhm, but on this trip back I've found just being a different hospital it, uhm, is feeling a little bit more dynamic where I'm working at the moment.

This was not how other participants experienced the NHS:

I felt there was a big hierarchy in, a much more hierarchy feeling in Britain compared to Sweden. ... You advocate what the doctor says not what the patient says.

(female, 36 years old, Sweden, white, F grade)

I think it's very hierarchical and people who are highly graded throw their weight around.

(female, 30 years old, Australia, mixed race, G grade)

I was going to say about leadership and management. It seems that to solve your problem it's always the sister, it's always the line managers who's doing it. How can those D grade, can (they) learn if it's always from there? So I have so many friends in my wards, same with my race, they're always asking me: "How we can learn more than what we learn now?" It seems that everything, patients always asking for sisters, it seems they don't believe you. But here it seems it's all the ... sister and line manager, so you're not like, uhm, contributing.

(female, 30 years old, South Asian, Philippines, D grade)

...it's very much a blame culture, no one wants to look at the fact that someone might actually make a mistake and if they were shown the right way to do it, then it wouldn't happen again. [It's] a major difference between the culture in Australia and here.

(female, 28 years old, New Zealand, white, H grade)

This view of British nursing being hierarchical was challenged in the groups and forms of clinical leadership encountered in the NHS were compared positively by African nurses to more traditional models of *hands-off* nursing management that they had experienced in Africa as illustrated in these quotes:

Back [home] the nurses, the kind of respect and everything we are trained with is sort of getting through ...which I don't quite really, you know, agree with and here what I've seen so far the society here though they have their own type of respect but not that you have to be subservient to anybody. I quite cherish the kind of the way the senior colleagues do work in the wards.

HERE?¹⁵

Yes, here. Back home as long as you are a matron you are put in a certain class, maybe you are not supposed to do certain things on the ward. You don't work.

SORRY?

You don't work as a matron.

(female, 37 years old, Nigeria, black, D grade)

Plaster nurses, as I call them, they just get a seat and plaster themselves to it and don't move.

(female, 31 year old, Kenya, black, F grade)

See, you're different from us¹⁶. Back home, you just do what the doctor says you should do, you just do what they think you should do. They write the drugs and they give them. You don't question much. If you try to, it's more like you're just a nurse and you don't have to question the medical officer.

(female, 25 years old, Nigeria, black, D grade)

I think it's the discipline. We're still so many years behind in Africa where the person in charge is in charge of the ward and she has the right to say, "you're not practising correctly". But here everything is so politically correct that actually we're not allowed to say anything to anybody...everybody is so scared of offending everybody that management doesn't take a leadership role

(female, 55 years old, Zimbabwe, white, E grade)

I felt very strongly that the reason I was happy working here I found people very friendly, I found people very accessible. If there was anything going wrong, not necessarily that anything was done about it at that time, now there would be, but, uhm, at that time I felt very strongly that, uhm, there was nobody to share a problem

¹⁵ Interviewer Helen Allan.

¹⁶ Sometimes, knowing Helen was a nurse, the participants would refer directly to her when talking about British nursing.

with when I worked back in Cape Town. When I worked here I felt more supported and I felt it was more, uhm, everything was more transparent here the way it was and I likedgenerally.

(female, 56 years old, South Africa, white, D grade)

Another frustration of nursing in the UK was felt to be the amount of documentation that formed part of their clinical experience. While the level of documentation generally was acknowledged, like leadership, to be a necessary aspect of modern nursing some criticised it for moving attention away from actually nursing the patients. They felt that the systemic demands were colonising the nursing practice. These quotes reflect IRNs' ambivalent feelings about documentation:

Yes and then there's this thing that I have to cover my back all the timedocumented it, I've done it, but I forgot to document it. "Oh, you have not documented it, what is going to happen to you if the client turn around and sues you?" So I have to be conscious all the time that I must document things, not to care for the client, to cover my back. That frustrates me because I'm soon to realise that now there's a difference with me at home, I'm more hands on to care for the client. The nurse that is trained in England is more to write the care, to write the document so that it is brilliant for the court or for whoever people to read it when she has not in fact actually cared for the client.

(female, 52 years old, South Africa, black, D grade)

The role of the nurse is much less here, there's a lot more on paperwork, rather than doing.

(female, 33 years old, Philippines, South Asian, E grade)

And another thing, this culture of filling in forms and protocols and when you start, you don't know about this culture.

(female, 52 years old, South Africa, black, E grade)

This last quote suggests that documentation and protocols are linked in current British nursing practice. There was another feature of British nursing and protocols that frustrated IRNs. The legal framework within which UK nurses worked was different to the experiences of IRNs in their home countries or overseas. The participants felt that the scope of practice in the UK was narrower than in home countries and explained this situation through a complex model of behaviour, inter-professional relationships and the rights of clients restricting the nurse's actions.

IRNs were aware of the scope of practice because it affected their ability to use their skills to their full. Many of the participants felt that the scope was restrictive to them personally because often they could see something needed doing for a client but that they were prevented from performing a task as the following quote suggests:

I think it's because the protocols are in force here, that actually there is a protocol that says that you do not have to do anything that you do not feel comfortable doing. That's a cop-out! When I worked at the dental hospital, I was working in theatre. One afternoon we were responsible for the facial suture removing - there was lots of facial suturing. I walked into the waiting room and there must have been about 40 people waiting to have sutures taken out and we didn't have any patients and we were sitting, drinking tea in the theatre. I walked in, I saw this, I went in and I said: "There's all these patients, they need their sutures taking out." Do you know, those girls were able to, by law, say: "We will not do it." So I said: "But why not?" "Oh, because we do not feel comfortable doing that. It's not within our scope of practice." That's right, because they were theatre nurses. But where we qualify [overseas], we nurse the patient from the head to the toe, if something needed to be done, you actually looked at your patient in the bed, and if their hair needed cleaning or their toe nails needed cutting or anything in between, you just did it, because that was your patient. But it's because they've brought up all of these protocols and it actually aids and abets them to be so idle. They could see that the waiting room was just piling up and piling up. And that's a loss for that patient, the skills.

(female, 55 year old, Zimbabwe, white, E grade)

Some IRNs criticised British nurses' attitudes and behaviours by suggesting that they had a narrower scope of practice because they were lazy and unprofessional:

They are usually to "blah blah blah blah".

(male, 46 years old, South Asian, Philippines, E grade)

Yeah, they all sit around talking.

(female, 30 years old, South Asian, Philippines, E grade)

Exactly at the nursing station.

(male, 46 years old, South Asian, Philippines, E grade)

And they have a cup of coffee.

(female, 30 years old, South Asian, Philippines, E grade)

"Blah blah blah blah blah blah." Sometimes patient needsor to take their observations, little things sometimesnurses, nurses stationblah blah blah blah blah.

(male, 46 years old, South Asian, Philippines, E grade)

...

I don't want to say, but most of those white people it seems that they just sit in the stations and rather than doing the job and sometimes you can do the job very fast. It seems that theyjust talking and even the patient said: "You can do your job while you're talking." So I think so. I don't know, but on the past I have like a confidential talk with the line manager about it, butalso because the line manager thinks it's just also foreigners.

(female, 30 years old, South Asian, Philippines, E grade)

Like on the attitude in practice whereby eating habits, someone could eat an apple and leave it on the side. They leave the specimen there ... continue with the report,

go and handle something else, you know, and I think (you) expect, when you come to the UK, that environment, you expect to learn high standards of medicine care. Or, nurses come, they sit on the floor, they squat on the floor, just get a piece of paper, sit down and they get their reports, with their handbags just on the floor. We are told, floors - infection control, or bed making, we are told to make the bed nicely. We find, just the basics of nursing might be given away somehow, somehow. I don't know who needs to report it. Cleanliness. I think cleaning of the wards has been very much cleaning up and so on. So you find you have to ... maybe do certain jobs, but you have to put up with people who have dirty sinks and the floor can be dirty, but no-one bothers, like it has been there for the past two days.
(female, 53 years old, India, South Asian, E grade)

However, attitudes to the scope of practice were mixed.¹⁷ Some IRNs felt that the UK scope of practice had benefits and drawbacks:

I mean you have a very high level of independence and scope of practice but here you've got so many restrictions, you just can't do so many things except you've got the licence to practice such things.
(female, 30 years old, Nigeria, black, D grade)

Actually it's the client who suffers because so much depends on the district nurse coming to do the bloods or sending the patient to the hospital. But often the nurse on duty hasn't had the training and is incompetent.
(female, 30 years old, Nigeria, black, D grade)

What I would say is that nurses here are more accountable and responsible than in my country. A lot of people in my country are not aware of their rights. So nurses and doctors get away... which they wouldn't do if they were working here.
(female, 46 years old, Ghana, black, G grade)

I was in South Africa in August and my husband was ill. I was reminded by the nurses of the ease with which they operate, they do what they like and things can be swept under the carpet.
(female, 56 years old, South Africa, white, D grade)

The scope of practice was understood by participants to be shaped by the relationship with and numbers of doctors available in the health care system:

Our practice in Africa is so much vaster, a) because we are so short staffed and b) because the doctors haven't got time to do all the things that we do, so we do a lot that what the junior doctors would do here, we would do.
(male, 39 years old, Nigeria, black, D grade)

¹⁷ One IRN explained the narrowness of the scope of practice through a British acceptance of a lack of service. Her argument was that conforming to a narrow scope of practice meant poor service which she experienced throughout British culture: "Yes, manners, you've got very good manners and no service at all." (female, 49 years old, South Africa, black)

I don't know whether it's because our doctors we have not had sufficient doctors. You are expected to cope with emergencies.
(female, 54 years old, South Africa, black, D grade)

Back home the doctors listen to you. We work so much nearer to the doctor and the doctor pays respect to the nurse. Here they won't listen to you. We don't discuss the patient.
(male, 49 years old, Nigeria, black, E grade)

It's again the hierarchy. It's the doctor and all the way down. Fortunately, in the States, it evolved over 40 years of my nursing and we've become equals and worked in a team... But here it's still the doctor.
(female, 61 years old, American, white, F grade)

IRNs commented that restricting the scope of nursing, whether it was morally or legally right to do so, led to delays and longer waits for patients. Their perception was that if the patient was to be treated, then they should be treated by the person best suited for the job and this could be the trained IRN, UK nurse or doctor if there was one. As this quote suggest, participants seemed bemused by the lack of awareness of this potential solution to waiting lists in the UK:

I think the problem is because the nurses are not empowered to do anything, it's got to be a doctor. They don't do anything, they just wait for the doctor.
(male, 35 years old, Zambia, black, E grade)

In my country, when you qualify, you are there to save lives and you find yourself in an environment where you do everything. You are a qualified nurse and they expect you to do it all, and there are no doctors.
(female, 40 years old, Zambia, black, E grade)

But look at the set-up in this country, nurses could be there and do the primary care. Instead of people having to go and wait for doctors. They have long queues in A&E. But it can't happen because of this suing business. People will sue nurses. "Why wasn't the doctor called?" But it works in our country.
(female, 65 years old, South Africa, black, D grade)

We use the same curriculum, we have been taught the same way, but here you have to actually "act" according to what have been taught to do. You cannot use your own discretion to do things.
(female, 36 years old, Sweden, white, E grade)

IRNs also explained the narrow scope of practice by the rights of British clients to question nursing practice and argued that while this fitted with British law, it restricted the role of the nurse:

It frustrates me. The right of the clientI would know what is right for a client to be done, the client doesn't want to do it. Then where do I stand? I need to protect the client. I know at home I have to protect the client, but the client here has got a right to do something even if it is detrimental to his life or health, then I got frustrated.

(female, 52 years old, South Africa, black, D grade)

The role of the nurse here is a facilitator of care. The client leads the care. We talk of individual care at home but the extent to which it is here is greater than at home. At home we tell the client what he needs.

(female, 30 years old, Nigeria, black, D grade)

Expectations of first world nursing

The second key frustration of British nursing for IRNs was the expectation of *first world nursing* and meeting the reality of *third world nursing*. One of the motivating factors for IRNs coming to the UK was the colonial relationship between Britain and the home country (see chapter 4). Many of the participants stressed how British curricula, books and values had shaped the nurse training in their home country. However, this relationship also led to an experience of frustration, as the UK experience did not measure up to their expectations as the following quotes show:

I thought I was coming to first world nursing. People asked me why I was coming. I said first of all to travel and secondly to experience first world nursing whereas that hospital in XXX I could not believe it was first world medicine because even the mission hospitals back in Zimbabwe were cleaner and better run.

(female, 55 years old, Zimbabwe, white, E grade)

I cannot fault the standard of nursing that the, the knowledge of the nurses here, they, it really is good. In many respects I think it's wonderful, but the basics are nowhere near our basics in Africa, nowhere near. The cleanliness and the basic understanding of cleanliness andis nowhere near and we learnt it all from the British because the British came to Africa, taught us how to do it, our whole hospitals are run on British standards with the cleanliness and the nurses themselves, the cleanliness of the nurses themselves and the cleanliness of our uniforms and our antiseptic techniques, we learnt it all from you and then when we came here we expected that that's what we would see and actually I've made it my three years I've been here I've done a lot of talking to the nurses telling them: "Actually we learnt it from you but we don't see you doing it but we're still doing it back in Africa."

(female, 34 years old, Zambia, black, D grade)

The nursing I experienced in South Africa was definitely third world and coming I feel like there was not the resources you should have in a first world country.

(female, 52 years old, South Africa, black, E grade)

I have to admit that I was disappointed, I was expecting it to be more progressive and modern and it's started becoming quite ...and I was thinking: "Oh, this is where

we learn everything from.” And so I expected to learn a lot and be able to take back something to South Africa. Well I was very disappointed, management staff, everything to me is very archaic and even equipment and I felt like I actually really felt like I came, I came from a third world country but I came to a third world nursing experience here in this country, really I did and that was disappointing.
(female, 50 years old, South Africa, white, D grade)

I found really shocking the discrepancy between the standards which you read and the history all around us and entering a British hospital and I had the impression I was in a museum.
(female, 32 years old, Ukraine, white, E grade)

When I came in I was a bit disappointed maybe because I’ve travelled to Canada and America. I went to MIT and compared to there, the technology here is a disappointment ...I’m coming from a third world country and, well, am I in the right place?
(female, 46 years old, Ghana, black, G grade)

And I’m a tutor so the books we were getting from Britain to teach had many of the pictures and I was expecting to see...I was told you get that in a private hospital. But they should de-colonise the books. The technology is very different
(female, 46 years old, Ghana, black, G grade)

The IRNs seemed to feel that they were able to appreciate the differences between a first world and third world country because they had travelled, something that they felt their British colleagues had not often had the opportunity to do. These quotes show some of this feeling:

In Saudi, some of our surgeons came from Germany and brought their equipment with them and we were introduced to new things.
(female, 33 years old, Philippines, South Asian, E grade)

I think like you say, we came from a classified third world country but for us we’re working in a first world environment where we’re seen as professionals and we got here and you back in the third world.
(female, 40 years old, black, Ethiopia, D grade)

I think the saddest part is that the nurses in the UK don’t even realise that this is, this is third world and you talk to them about what you’d get [better treatment as a nurse] in South Africa and it’s just like: “Oh, you’ll never get it in the UK.”
(female, 52 years old, South Africa, white, E grade)

It’s like they don’t believe you [when I tell them standards are better in my country].
(female, 30 years old, South Africa, white, E grade)

Coping strategies

These frustrations led to coping strategies that involved *doing as the Romans do*, that is: behaving as the British nurses do. One exchange in a Cardiff group described this process of acclimatisation as conscience killing:

You mustn't do it, you have to walk away. Your conscience is telling you "let me do this" but you are not permitted to do it.
(male, 39 years old, Nigeria, black, D grade)

I think it takes the joy of nursing away.....there's no joy in it any more because you're not allowed to work and get things done.....When in Rome, do as the Romans do, so we've become complacent and instead of trying to bring them up with the standard, with the norm, with the Commonwealth, we are now in danger of going down to their standards. I don't really know what to do about it because you're reminded all the time that you're an immigrant.
(female, 55 years old, Zimbabwe, white, E grade)

Yes, it's conscience killing. That is if you have a conscience. Not to exhibit what you know. You feel, what are you? You feel bad....
(female, 36 years old, Nigeria, black, D grade)

Those small things which a nurse can do waiting for a doctor like putting up a drip and a patient waits for ...and you feel bad because we know how to do them...at the end of it, I say: 'There's nothing I can do, let me wait and get paid.'
(male, 27 years old, Philippines, South Asian, D grade)

But I came here, I discovered if you want to survive in the UK, you work alone and you protect yourself because you will lose your PIN....if you do anything here you don't have anyone to fall back on. You want to do things, you want to help a client you want to give (care) but not lose your PIN. The patient doesn't get the best care from youI don't want to lose my PIN.
(female, 36 years old, Nigeria, black, D grade)

Another strategy to cope with these frustrations was to become deskilled or retrain to do tasks that the IRNs felt they were perfectly capable of on arrival. Some participants expressed this feeling of deskilling quite graphically:

So you come here, and whatever experience you have is just cut off.
(female, 40 years old, Zambian, black, E grade)

I felt really demoralised when I first arrived [I'm not allowed to give] one tablet or anything and I've been nursing for so many years and I felt as though my hands were chopped off.
(female, 50 years old, South Africa, white, D grade)

I think one of the things that I've noticed so much here is that they have all the policies, everything is a policy, and when I first arrived I took the medicine trolley to give the medicine, and one of the nurses said to me: "Have you been assessed in giving out medicine?" I said: "Well, I've been doing this." Anyway, that was fine, I had to get assessed. It was the same for injections, the same for everything, so I spent the first six months doing every single precaution, for something that I had been doing for the last 15 years.

(male, 39 years old, Nigeria, black, D grade)

I immediately realised there was a limited scope here. When I came from home, I was an experienced nurse with lots of years of experience and I have to throw away certain things.

(female, 52 year old, South Africa, black, D grade)

Some participants tried to raise what they perceived as low standards especially in the privately owned care homes by modelling and, in some cases, teaching care assistants the *proper* standards of care. These quotes suggest the frustrated feelings this situation produced for IRNs:

When you come with a basin to say or there is a hand-wash basin there and you take the flannel, the flannels are there, all the equipment is there, but now it's not in practice that people are cleaned like the eyes and other things and you'll find the old lady with dirty eyes and sitting there going to have breakfast, then you'll just wonder how can you really go and help give something for somebody to eat, something to eat without washing first....They can't even wipe the glasses. Then they just sit there and you just think, and when you are there they think you are taking too long because you are trying to clean this person and like especially with the rest of the nurses the eye treatment they don't want to do that because they don't like to clean these eyes, so now I don't know what is behind cleaning, whether during their training they are not taught how to clean.

(female, 54 year old, South Africa, black, D grade)

I think that a nurse in charge, as a staff nurse, you've got the responsibility to teach the carers what to do. That's what our job description is. Yes. To supervise them, to tell them what to do and things like that, and to put everything in writing. If they don't argue or follow, go to the manager and tell them "this has been our care", but I guess, the standard of caring is getting poorer, so you have to do about it, isn't it?

(female, 53 years old, Nigeria, black, D grade)

With the care assistants at the homes, I don't know about hospitals, I don't know what they do there, but at the homes they are the most respected. People are taken to be knowing everything ... even if you say the care assistants are not cleaning the patients, you leave the patient alone when you are there, but they don't ask for that most of the time. They don't care, because once you report something that has been done by the care assistant, the care assistant, before you know it says: "She's wasting time, she's only done one patient and we have done five." But when you are trying to do the correct thing, then you are told you are wasting time.

(female, 54 year old, South Africa, black, D grade)

While coping with their frustrations, IRNs also tried to explain their experiences by arguing that British nurse training did not prepare student nurses for clinical practice. This was surprising for them because their training and education was based on a British model (often because of colonial ties) and emphasised traditional values of practical skills above academic skills:

Probably it's the curriculum, you know because some of my (British) colleagues have not been given any training in medicine....they just observe. They don't get any experience. They just observe.

(female, 49 years old, South Africa, black, grade not given)

I don't think the education system in this country is up to snuff. I think there are too many students in their third year who are falling through the cracks.

(female, 33 years old, Canada, white, E grade)

It's true. We had to get a nurse out of the toilet because she'd locked herself in the toilet at the thought of taking the ward over.

(female, 56 years old, South Africa, white, D grade)

Yes, because, you know, in caring standards that we have set at home I think it's just the same as in here because I see a lot that the standards, thestandards that they have in herejust the same asThe other, just one thing, I don't know whether I'm out of the point maybe, but what worries me a bit here is that like with the nursing care just the ordinary nursing care of the patient I don't know whether people, maybe they just concentrate on both or the practical part is not quite, I'm not really impressed with the practical part that I come across, you know, especially with the members (registered nurses).

(female, 54 years old, South Africa, black, D grade)

They don't know basic stuff and I'm thinking, why they spend three years studying and practising when they come and the next day after they qualified, they look as if they never been to hospital at all....

(female, 32 year old, Ukraine, white, E grade)

One of the key differences experienced by IRNs between nursing in their home countries and the UK are summed up in this exchange in a London group:

In our country, the patients respect nurses, you know they treat us with respect.

(female, 39 years old, Nigeria, black, D grade)

Dignity with dignity.

(female, 32 years old, Nigeria, black, E grade)

With dignity. You are happy being a nurse in the hospital. Well, here the patients, they treat us, they are the lords and you are the servants.

(female, 39 years old, Nigeria, black, D grade)

IRNs clearly felt that these values underpinned the health care system in their home country. We will now discuss their more general thoughts of working in the British health care system.

Experiences of the health care systems: UK and overseas

There were three main differences that IRNs commented on between the UK system of health care and those of their home countries. The first was the level of bureaucracy that IRNs experienced as intrusive and demoralising (this is explored in greater detail in chapter 9). The level of bureaucracy related to the experiences presented above where IRNs felt that British nursing was more restricted in its scope of practice and by its legal framework. It also reflects their perception that British nurses did not focus on the patient and the following quote is another example of how IRNs understood this as a concern with the system rather than the patient:

My whole thing with nursing here, that the person that they've forgotten in the whole thing is the patient. They are so busy worrying about whether they've got the qualifications or whether you should do it, or whether you shouldn't do it, that they've forgotten about the patient who could have been waiting for two days to have a cannula put in so that they can have antibiotics, and so they lose sight of the sense of it all. I mean, I just feel that they need to be refreshed in that area because they built up the Commonwealth on common sense and it's gone in professional jealousy. We wouldn't be here if they didn't need us, but we are also here because we want to be here, you know what I mean, and we want to add, like you said, we also want to share our wealth of experience.

(female, 40 years old, Zambia, black, E grade)

The second difference was in care of the elderly and the different types of disease profile of patients encountered in the UK. It appears that for the African and Philippine IRNs, there is no tradition of caring for the elderly in care homes and IRNs were unaware of this form of care before coming to the UK. Often they were not clear before arriving in the UK that this group of people would be the focus of their care:

Yes, there are some of the things that I did not know, but I have experience, for an example we are not working in the old age home in South Africa, most of the time we are working in the hospitals, but here I started working in the nursing homes nursing the old people. What I experienced there it's just exactly like in the book, you know, you must be patient when you are dealing with these people because they are old and they are, their movement is very slowly and you have to be very patient with them and most ofthey fall and then we are to, we have to use the hoist.

(female, 53 years old, Nigeria, black, D grade)

We don't have nursing homes, so I don't know about (these). I wanted to work with the elderly though
(female, 46 years old, Ghana, black, G grade)

One IRN commented that learning about diseases previously only studied in textbooks was a challenge that she had coped with:

Even if you think about the illnesses, the common illness back home and in developed countries are different. I had to face a lot of problems in this country even ...like back home we don't do ECGs. These are the basic things in this country.
(female, 40 years old, Ethiopia, black, D grade)

The third difference was resources. Some IRNs were used to nursing with fewer resources in their home countries than in the UK while others had experiences with better equipped nursing environments. African IRNs were not used to having the resources which were available in the UK, as these quotes suggest:

But I must say there are a lot of other that are not available at home like supplies and equipment that I'm exposed to that I'm learning to use, which I wish I could have had. My patients at home need those things. I'm getting experience as far as that is concerned and I wonder whether when I go back home will my government supplyback home?
(female, 52 years old, South African, black, D grade)

If somebody needs urgent treatment it's there, if they need urgent transport to hospital it's there, if they need whatever, they need to be transferred to another hospital it's there, if they need, you know, the cardiac monitor, is there. That gives me contentment, I really love nursing and I'm really loving it
(female, 47 years old, Zimbabwe, black, D grade)

I'm from South Africa and worked in you know the rural hospital and in black rural areas, the equipment is not adequate
(female, 53 years old, South Africa, black, D grade)

For the Australians, Europeans, Canadian IRNs and those IRNs who had experience of working in Saudi Arabia and the USA, it was the distribution of relatively restricted resources in the UK compared to their home countries, and the amount of resources combined with perceived poor standards, which was surprising.

I come from the Ukraine and our system is 60 years back from what it is here ...very old-fashioned and how old the equipment is and educational needs...I was just shocked, I think Sainsbury's is cleaner than any hospital you have and it's absolutely shocking
(female, 32 years old, Ukraine, white, E grade)

You try and save everybody in a country where there's not a lot of money. You save the ones you can and the rest you treat with dignity and just let them die.....there are not unlimited resources. When I got here and money was spent on patients who were never going to survive, it was like money was being poured in and you knew it was never going to be And the waste, the general waste
(female, 30 years old, South Africa, white, E grade)

A place which has an NHS and all the resources I don't know why people wait for 6 months...It's frustrating because there are the resources it's not as if you have got to negotiate that money
(female, 52 years old, South Africa, white, E grade)

Conclusion

IRNs' frustrations with nursing in the British system of health care were a complex mixture of prior expectations of the UK which were unmet by their experiences. Rather than contributing their experience and feeling valued for that contribution IRNs were surviving in an unsympathetic environment. IRNs' feelings of their treatment in Britain are summed up in the following quote that illustrates the frustrations many IRNs felt:

And fair enough, we've got a lot to learn but we've also got a lot to give. If they give us credit for what we do now, instead of being threatened by us and of just saying 'Well, what would you know, you're just Africans?' Because they think we've got lions prowling around outside the theatre
(female, 55 years old, Zimbabwe, white, E grade)

The next chapter further explores how IRNs interpreted the experiences described in this chapter by presenting IRNs' feelings of discrimination in the context of British health care and British nursing.

9. Discrimination – colour or culture

In chapter 8, we presented a picture of IRNs surviving in an unsympathetic environment rather than contributing their experience and feeling valued for that contribution. In this chapter, we discuss how IRNs interpreted these experiences as discrimination and racism and many IRNs expressed anger over how they had been treated in the UK. However, as discussed in chapter 7, these experiences were balanced by IRNs' desire for recognition as trained nurses, appreciation by British nurses and the wider health care system and a desire for trust to develop between UK nurses and IRNs. While this might seem an optimistic conclusion, we do not mean to diminish IRNs' wishes for their racist treatment to be shared with the wider nursing and general public and for this to lead to better treatment of IRNs.

Discrimination

Racism, a form of discrimination, has been described as 'a fluid, transforming, historically specific concept parasitic on theoretic and social discourses for the meaning it assumes at any historical moment' (Goldberg 1993 cited by Anthias 1999; Miles 1989). Racism has been discussed widely in the literature since the Stephen Lawrence Inquiry (MacPherson of Cluny 1999) and debates around defining institutional racism continue in British life (Yuval-Davies 1999; Anthias 1999) and will be discussed further in the recommendations in Chapter 11. Academic or political understandings of racism were not always shared by the IRNs we interviewed; IRNs discussed discrimination in terms of colour and cultural difference rather than race. Their discussions of the *meaning* of racism became a sharing of experiences of discrimination.

Many of the ethnically mixed groups were able to challenge each other's interpretations of their discrimination as racism and this gave rise to fruitful explorations of colour or culture as competing explanations for discrimination. Although this was a difficult area for the discussions, it also provoked laughter and empathy between IRNs as they discussed the British attitudes to colour and difference in the context of their own experiences.

An analytical theme that was evident in some of the data is the sociological concept of *stigma* (Whiteford & Gonzalez 1995). We have already shown that stigma was used by one IRN to explain how communication was used as a mechanism for highlighting differences between IRNs and British nurses (see Chapter 7). There were other examples that showed how the process of stigma had emerged during social interactions between IRNs and British nurses:

You find yourself just being frustrated. You have nowhere to run to, you are like [inaudible]... you cannot go to the manager because the manager listen to the carers, the carers will go and report you to the managers. You cannot go to your fellow nurses because the nurses also are listening to the carers. You are left on your own to do things your own way and by the end of the day they say "She's very rude" because you are trained to defend yourself. If you are calm they'll be on you, but you just end up also throwing things back to them. If they are rude you are also rude, if they are kind you [inaudible]... kind to you then you are also kind. If you [inaudible]... being rude, you hit back just to defend yourself. But by the end of the day they say "Oh, she's very rude. Have you seen her? She's got an attitude." But it's not an attitude, it's the reception that you get
(female, 35 years old, Zambia, black, D grade)

In this example, there are complex social processes at work which result in the IRN being seen (stigmatised) as different (an IRN), being isolated by her colleagues, reacting to her treatment and her reaction being interpreted as rude and having an attitude. This process could be a useful tool in understanding how *being different* effects professional interactions between *supposed* colleagues and patients. Another white IRN summed up her attitude to other IRNs she worked with which shows again how attitudes to difference are socially constructed through daily interactions:

But I think it's preconceptions of what kind of, she's from this country, what kind of, because I have preconceptions of, and have worked with, uhm, nurses from China, the Philippines and that and I don't like their style of nursing, so therefore do I go out and make friends with them socially? No. Like at work it's like a social, that social atmosphere, I get on with them but I don't, there's no sense of "You're the same as me" even though they are the same as me in the basis of their nursing
(female, 30 years old, Canadian, white, E grade)

Most IRNs did not describe their experiences in such detail and the data on discrimination falls into the following four broad themes:

- recognising difference before other attributes
- explaining discrimination through racism
- attitudes to difference
- colour or culture.

Recognising difference before anything else

IRNs explained that they felt their 'difference' was seen as a social marker (Banton 1994) which affected their relationships with British nurses before their personal attributes could be judged. Their 'difference' could be either colour, culture or foreignness and, at times, it made them question whether they were viewed empathetically as fellow human beings:

When I came here I have to make them realise in my environment that ‘put yourself in my position, I want empathy, I don’t want sympathy. Put yourself in my position, if you go back to my country today, go to Africa, it will take you one month to pronounce the words and before you can get it right people will laugh at you’
(female, 46 years old, South Africa, black, D grade)

No matter if they know you are an overseas qualified nurse the way you are being approached or addressed is quite different completely from the so called UK trained nurses because they look at you as if you don’t have anything upstairs at all. They look at you as if you don’t know anything relating to nursing. So such attitude actually demoralise human being
(male, 39 years old, Nigeria, black, D grade)

Some IRNs were not surprised by their treatment and the impact their skin colour would have on relationships with British people and how they would be treated. They expected racism:

I’ve always thought that wherever you go in western countries you’d always be treated differently because of your colour and with that pre-set, with that frame of mind I came over thinking it’s going to be a struggle, it’s going to be one big hurdle for me to try and prove “Look, if you can do that I can do that.” You know regardless of the colour and it’s always been a struggle. In the NHS now it’s still a struggle for me. I’ve been trying to get into a lot of things and I’m held back because I haven’t been trained in intensive care, I haven’t done ...but I know what the bottom line is, it’s because I come from a different country. And my colour is different, so I’m held back by the very idea that I’m different
(male, 27 years old, Philippines, South Asian, E grade)

However, for other IRNs, the impact that colour made on their experience and relationships was unexpected and shocking:

But here I think you are made to realise what colour you are, something that you never thought about at home, but here you know I’m black. Even my son who is eight-years-old knows that he’s black and he ...we are slaves. I don’t know where he got that from but he knows. So I think it’s not good for me, even for my children who are growing up to grow up in certain environment
(female, 35 years old, Zambia, black, D grade)

It’s a shame you had to leave your own countries to realise you were black...In your own country and then to be over here and to be labelled the way you have been. I think it’s disgusting as us as nurses [to do that]
(male, 35 years old, Australian, white, F grade)

I expected racism to be better in this country than where I was coming from, but instead I found there was, I was made to be more timid, more frightened about, you know, the profession ...this is what I know. I’m not good at anything else other than my nursing profession, so it really made me feel unhappy to find that there was this much racism and all ...It took me time to actually feel more comfortable and not ...and in the end I ended up teaching other people and I had to tell them that never mind the skin, now just look at the client or the patient, as we used to call them. But there was a shock in the racism that I came across
(female, 54 years old, Nigeria, black, D grade)

The shock was particularly striking if these attitudes had not improved over a lifetime of working as an IRN in the UK. While most IRNs expressed anger and frustration over the discrimination and racism they met, this IRN explained how she had been able to deal with overt racism by understanding them:

... we had problems with the care assistants, not with management, not with them but with the carers and, uhm, it was, it was tough for some of my colleagues, but I'm the [inaudible]...type and the type who likes to find out why people behave the way they behave. If someone behave nasty I want to find out why the person is being nasty to me. So I think I got on quickly with a lot of the care assistants as opposed to my colleagues, they didn't like it. ... I didn't have any resentment at all because I just got on. First of all I remember my [IRN] colleagues [they asked:] "Why do you get on so well with them when they are nasty to you?" So I said "Have you considered that maybe they have never worked with black people before?" So I said "Well that's what I thought." And so they are not sure how to relate to us and, uhm, we have to help them. ... I was thinking of back home in the village when a white person comes they way the children will run away. I don't know why they run but the children will all run away so scared because they've never seen ... a white and then when they come closer they will come close and touch, you know, touch. So I put it in that situation that maybe [inaudible]...black because we're five sent to that nursing home and all black faces. That's a lot of black people around.

(female, 46 years old, Ghanaian, black, G grade)

The ethnic mix of the focus groups allowed IRNs to share experiences across colour; and this white IRN, married to a British man, explained how her *foreignness* still stigmatised her:

I find this so interesting because having been here a long time ... because for quite a while I went to work in a country hospital and the fact I was foreign trained, although I'd worked here and had a midwifery qualification from here it was still more important the fact that I was foreign and people just treated me in such an odd way. I found it very difficult to adjust and in fact I really didn't like the place at all in, uhm, I found it quite oppressive...But when I went back into nursing after having had my family and the first thing they asked me about [was] my training and when I told them that I was trained abroad, my general training was from abroad, they said "Well then there's no way that we're even interested in interviewing" and not discussing it with me because their hospital was for local nurses and they weren't interested, they didn't pursue it at all

(female, 56 years old, South African, white, D grade)

Explaining discrimination through racism

Many of the experiences describing discrimination shared in the focus groups were explained by racism, that is, their colour as Black and Asian nurses affected how they had been treated in job selection, within ward teams and on adaptation courses¹⁸. They clearly felt that this explanation would be accepted in the focus groups but had not shared their feelings about discrimination with their white work colleagues as this quote demonstrates:

Yeah, back home we have our own tradition, which is respect, that respect is there in Nigeria. The nurse rank over you, you have to respect, we call it ethics of nursing, so I don't know why it's not practised here and British used to be [inaudible]... they enslaved us and they came up with all the things we were doing as regarding nursing and there's no ethics of nursing here. The respect is not just there and the racism, as I recall it, it's existing because they have no choice, that's why they accept us. If not for the parliament that passed that issue allowing nurses to come to UK and be working so, they wouldn't have accepted us. So the racism is there, we are just fooling ourselves. We know it is there and they are not accepting us
(female, 54 years old, Nigeria, black, D grade)

Indeed, racism was not being discussed at all in the workplace as one IRN explained:

It's an issue which is not being discussed, people don't like talking about it.
(female, 25 years old, Nigerian, black, D grade)

The difficulty of talking openly about racial discrimination gave this South African woman the feeling that racism was worse in the UK than in her home country. At the same time she found it paradoxical that, whereas in the nursing practice everything is documented, the racism is silent, in the hearts and minds.

I even said "Oh, in South Africa it was better." This thing was documented, everybody was aware that I can't mix with [white people]...because it was illegal. Here it's not legalised but it's deep down in the hearts or in the mind. I don't know where things are presently.
(female, 52 years old, South African, black, E grade)

SO IT'S THE INFORMAL NON-SPOKEN?¹⁹

Yeah, it's been worse than the written one. In South Africa it was written, not read or I wouldn't go there, I wouldn't bother, but if nothing is there because especially because everything here is documented, they document A to Z, but this non-documented thing it's more practised, so it doesn't go now with the protocol of writing everything down so that you know it's there.
(female, 52 years old, South African, black, E grade)

¹⁸ See Chapter 7 for discussion about how their status as IRNs affected their relationships with colleagues.

¹⁹ Interviewer Helen Allan.

Although there was challenge to some interpretations of racism, generally IRNs agreed that discrimination existed and that it could be based on colour, foreignness or culture. Their understandings of racism as potentially being caused by more than a person's racial origin were consistent with more recent definitions of racism which include ethnicity and social class (Anthias 1999). As Goldberg's definition of racism suggests (1993), racism is difficult to prove from the oppressed's viewpoint because of its historical and social nature. However, the following quotes show how pervasive IRNs' feelings of racism and oppression were and the focus group data shows that many individual experiences were shared and therefore socially accepted as racist:

But you find that somebody who is lower than you in qualifications they respect that person more than you because she's from England
(female, 46 years old, South Africa, black, D grade)

The job description was there. I felt I qualified for it and then, after the job was advertised, there were two of us shortlisted and we went for interviews and then later they said I did very well, my presentation was very good and I'm highly qualified, but they were sort of degrading the post, they wanted somebody sort of junior than me [inaudible]... I was too overqualified for the job... So I don't know whether I wasn't given that job because I come from Africa ... So I don't know where to go, whether it's me as a black African or it's me too overqualified. So you can have the experience and maybe the knowledge, you have some input you could give in this country, but you're not given the chance
(female, 40 years old, Zambia, black, E grade)

When I realise people aren't understanding me [I say] 'Oh this African accent'. They will laugh and then you realise that the eyes have spoken. But I think it's ignorance, honestly
(female, 46 years old, Ghana, black, G grade)

Actually I experienced that, I even get this resentment from some of the managers and some of the unit managers who are English. They don't see why they should give me the position [the only black G grade in the independent home] they've given me now. Number one I'm a foreigner
(female, 46 years old, Ghana, black, G grade)

In fact if you enter a ward all the, some of the managers when they see you you're a black maybe from an agency they will start ... I have the experience at one of the hospitals, I wouldn't want to mention it, they gave me fourteen patients, only me, and they are all at least about six of them are quarterly-hourly observation. I had to go to the manager and say "How on earth you expect somebody, one person to do this kind of job, even if I'm from the agency and I'm black?" ... A lot of us experience a kind of discrimination and once you ask them any question they won't answer, they won't even, the last thing they will do is to give you a good guideline, they want you to make mistake and then they will write to UKCC that you're making a mistake
(female, 43 years old, Nigeria, black, G grade)

The significance of many of the examples given by IRNs to illustrate their feelings of racism can often only be meaningful if the complexities of nursing hierarchies are understood. The two quotes which follow, use the ward keys and the duty rota to draw such examples: both the ward keys and the rota are powerful ways in which authority is conveyed to colleagues (Ford & Walsh 1994; Savage 1995).

Discrimination still exists in the NHS though. So generally in the nursing profession you are put on the rota according to your seniority isn't it? So they [white, return to practice nurses] were still doing adaptation, hence, by the time they finish I've already started on the ward as a D grade staff nurse [inaudible]... but when they completed they shifted my name from below them on to the rota
(female, 36 years old, Nigeria, black, E grade)

There is me and another person on duty who is the junior nurse. They prefer to give the key to the junior nurse on duty. [On the rota] There is E grade, D grade and if there are two D grades on duty there is one who has come before the other, they give the key to whoever has been there before the other D and when you are E they have to give the key to you before they give to the other. So I noticed that whenever I'm on duty they prefer to give the key to the other lady, who is the D grade. I didn't say anything. It happened twice, the second time she gave the key to the D grade and the D grade handed over the key and give it back to me. I said "No, hold the key. She told you to hold the key so keep it with you." So she said "Oh no, I can give the key to anyone I want to give it tothey key between ourselves." She and whoever did the shift, that so the key doesn't matter. And I said "Well, if that is the case no, I'm not fussy about holding the key." And the key means once you are in charge of the ward you keep the key with you
(female, 54 years old, Nigeria, black, E grade)

Attitudes to difference

The IRNs' experiences also highlight British attitudes to difference. These examples of IRNs' experiences are, of course, their responses to attitudes and, therefore, an interpretation.

However, they clearly show that being a foreigner in the UK is not always a pleasant experience. In the first quote, it seems that difference such as accent is commented upon rather than accepted. As the next quotes suggest, this arises because of the lack of education among British people IRNs have worked with:

Where I've worked before I worked with a Nigerian nurse and she had this very loud voice and one of the sisters asked me, she said "She always speaks in that voice." I said "You know why? Because most of the African culture.... it's quite a polite way, they speak in that rich voice."

Exactly
(female, 46 years old, Nigeria, black, D grade)

And it's a cultural difference, a cultural thing and I think each time, each time I see a person making comments like that I'd always say, I'd always make it a point like,

you know “this is a different culture and the least you could do is appreciate that this is this person’s culture, that they speak in this voice”. And I know it’s like talking to a brick wall at times.

(male, 27 years old, Philippines, South Asian, E grade)

The next thing is the culture, the culture and communication thing I think the assimilation, the culture or assimilation of foreigners is made all the more difficult about the general attitude of British general environment if you come over here, about the ignorance and I think a way to attack it is just education.

(male, 35 years old, Zambia, black, E grade)

Maybe patients who’ve never been looked after by qualified [black] nurses because in London you have a lot of carers, I was the only black qualified RGN...mainly carers were back and qualified nurses white.

(female, 40 years old, Zambia, black, E grade)

I was looking after one gentleman who’s ninety-one years old and he was telling about world war and he met some Russian and everything. When he was going home he walked up to me and he said he admitted that when he first saw me and he said: “What can this stupid Russian do?” And he said that he thought in his mind how desperate NHS should be to employ me. It’s what he thought, but by the end of four months he said: “You’re most efficient nurse I met, I ever met.” And it’s what he wrote in a card. But it’s a theory, it’s exactly what he was thinking when he saw me first time and when he told me this I was like, you know, after what good he said about me I couldn’t hear anymore.

(female, 32 years old, Ukraine, white, E grade)

More overt examples of racist attitudes are conveyed in the following descriptions of IRN and patient exchanges:

They [patients] can make your life miserable. They can easily “no, I don’t want you to care for me” and you feel bad. One or two got this black thing, but ...

(female, 46 years old, Zimbabwe, black, D grade)

I remember an incident when somebody said: “Why do you have black faces?”

(male, 35 years old, Zambia, black, E grade)

[LAUGHTER]

I said: “Look at it, touch it, it’s natural.”

(male, 35 years old, Zambia, black, E grade)

Is there an anatomical difference between white [and black]?

(female, 46 years old, South Africa, black, D grade)

Equally, IRNs experienced these negative experiences from staff they worked with:

When you do your work and you can see you’re doing it better than they they’re doing. But because you’re from another country, you are not from here, they don’t take it as anything they recognise.

(female, 54 years old, South Africa, black, D grade)

However, difference was not always colour as the following quote shows:

Well I've had someone say to me: "Another Australian taking one of our English nurse's jobs." Well it's just the fact that, you know, well if I wasn't here no-one would be here looking after you, you would have to wait a bit longer to get somebody else to come, you know. It's the same as like they sort of forget that you actually have the same qualifications, we are all here as a nurse. You know, none of them will ask you what you've done previously. I worked in London for six months before somebody asked me what I did back home.

(male, 35 years old, Australian, white, F grade)

Colour or culture

IRNs' discussion of whether their experiences were caused by race was the fourth theme of IRNs' experiences of discrimination. While the mixed nature of the groups meant that the topic could be explored, IRNs obviously felt that it was a sensitive issue and the degree to which they were able to be honest is unknown. What the following quotes illustrate is their wish to arrive at some explanation for their experiences. The first quote shows the degree to which a white Zimbabwean IRN experienced some sense of discrimination while at the same time being aware of her black colleagues' more difficult situation:

But when I got here I know exactly what all you people are saying because I was the only white one to come from Africa, I was also much older than everybody else, I qualified in the era of the Commonwealth when Africa was very much in the commonwealth so I didn't have to do any extra training because our training was automatically accredited. I also had a British passport, which I had got before I came, and that also helped such a lot. But I lived in a nursing home where all the immigrant nurses went and I was the only, I'm being racialistic here, but you people understand because we come from Africa, I was the only white and I listened to the stories of what these girls had to go through and, you know, I just thought I've lived in a continent where I've been privileged all my life just by being English speaking and white and now I come back to Britain, which is meant to be so emancipated and so progressive, and yet I saw exactly what was happening. I was put into the ward where I chose to be, they were put into the ward where they [employers] wanted them to be, so it was, it was very different, it was, and it was a strange thing because I wasn't accepted by the English people because of my accent and because they also didn't know whether I was what I said I was, you know? I came from Africa: "How come? What are you doing? Why are you coming from Africa? How can you say that you know all that you know?" Even though my CV is sitting there with all my qualifications. But then I wasn't accepted really by immigrants either because they could see that, that my contract was more cut and dry.

(female, 55 years old, Zimbabwe, white, E grade)

Others argued that IRNs experienced discrimination because of the hierarchical nature of British nursing and the grading system. Their argument was that there may be racism but that British nurses are also uncaring and unsupportive to each other whatever their colour.

I think nursing is very hierarchical and I think people who are highly graded like to throw their weight around and I see that all the time and I think it, you know, I think it's personalities sometimes, it's not just racism. It could be racism, it could just be

that that person is a nasty person. I think my experience as well is that because I started off doing agency work, people aren't very friendly or helpful and I mean I come from an English speaking country, I am Australian and they were my experiences as well and I was lied to by my agency. I was recruited via another agency back home, but when I got here things weren't as they were meant to be either.

(female, 30 years old, Australia, mixed race, G grade)

It's funny because I found there's a lot of bullying in London and if you're a D grade the E grades are very [inaudible], the E grades are fine, but the F grades are just, they can't [inaudible]... I think it's aggression because nobody cares to know what you know, like you are supposed to just listen. I told colleagues about it and I talked to my mentor about it, but it's getting better now. Yeah, it's getting better now and just yesterday we had a study day, oh dear, the D grades and I was just going to discuss with them their experience and I wouldn't say that it is a racist thing, some of the D grades are English, they are from different nationalities, so I would just say it's bullying by the F grade, yeah.

(female, 31 years old, Kenya, black, D grade)

I have a feeling there's a lot of bullying going on, especially in the NHS. When I had my adaptation to me it was okay, the relationship was fine. I mean if you disregard the attitude of the health care assistant toward the nurses every other thing is okay. You know, what I mean, you know, the relationship between the health care assistants and the nurses are quite, it's a bit sour. In the NHS I happened to work there as an agency nurse and like if you're introduced into the ward even if it's your first time there I mean it's surprising to leave you alone along to a place where you're not even familiar with the environment, with even the patients [inaudible]... even if you're trying to ask about other things you met with stiff opposition, you know, something like they shrug you off like that. You're supposed to know it, you are a qualified nurse. I mean it could wear one down at times, you know. But then I mean when you do something and certain things you just try and look at your back. You discover that you are being talked about. It really was, you know, psychology, psychologically and there's a lot of bullying going on there with that.

(female, 37 years old, Nigeria, black, D grade)

The following exchange in one of the London focus groups is a good example of how IRNs explored the issue of racism, colour or culture. In the first quote, the black nurse interprets her negative experience as reflecting racism whereas in the second quote, the mixed race IRN suggests that such experiences can be caused by the traditional form of British nursing:

It's like you're not considered as the primary nurse. The doctor will discuss about the transfer with the nurse in charge, the nurse then you get a phone call from HDU "give me the details" and you go "details of what?" And, "oh, the patient is going out in half-an-hour, we're expecting another one, so can you hurry up". It just messes you up. I really don't know, but sometimes I know I'm black, but problems are [I] really love myself the way I am, so that's what I tell my friends, they really, really have to respect themselves for who they are first before they come here. Somebody comes to get the information about a patient, they will just ignore you. If there's a physiotherapist who is white they'd rather talk to that physiotherapist about that patient and then sometimes it's just like [inaudible]... so they go to the white person and try to talk to them.

(female, 31 years old, Kenya, black, D grade)

Because I know like in hospitals I've worked at, the ward manager will get all the information and I thought that quite strange myself because if I'm the primary nurse looking after this patient [I should be consulted]. I think it's my experience again that nursing over here is a little bit old-fashioned compared to what I'm used to and I think, you know, that whole task allocation thing, that's why I was wondering if it was a race, racism thing rather than just, you know, a traditional thing where the nurses in the past, you know, took, went and did the ward rounds with the doctors and then the junior staff would do whatever they did, you know. I don't know, but that's, that's what I thought I may have been, but if you guys think that it's not that I don't know.

(female, 30 years old, Australia, mixed race, G grade)

One black IRN was quite clear that she felt racism was due to colour and not culture:

I think it's the colour because the culture has nothing to do with it [racism]. My culture is my problem, it's nobody's problem because I don't display my culture here so it's got nothing to do with here at all. It's only that I'm black. The black British still experience the same problems anyway.

(female, 32 years old, Nigeria, black, D grade)

IRNs identified two ways in which discrimination affected their experiences of nursing in the UK. Firstly, through others' perceptions of IRNs, which could affect their career prospects and their interactions on a daily basis with work colleagues as we have seen in chapter 7 when presenting IRNs' experiences of working with carers in the independent sector. Secondly, through the lack of recognition of IRNs' qualifications, which affected the length of adaptation, the skills they were allowed to use in the UK, their self-worth and how British nurses viewed them.

Others' perceptions of IRNs

Managing discrimination based on colour, culture or foreignness was a feature of IRNs' experiences in the UK. These discriminatory attitudes were conveyed to them through others' perceptions of IRNs and their *perceived* motivations for coming to work in the UK. These are some of the perceptions that IRNs encountered and expressed in the focus groups.

A common perception of African nurses was that there was such poverty in Africa that IRNs had no choice but to work abroad. While some IRNs agreed that there was poverty and that working in the UK did allow them to increase their earnings, they felt that this perception of Africa was wrong (see also the discussion of IRNs' motives to come to work in the UK in chapter 4). There was more variety in social class and wealth than British people supposed:

What are you doing here with all your qualifications? If I told them what I am at home they say "then why do you come?" So it is believed that we have come

possibly because of poverty or because we should come and make money in England. It's the wrong opinion, it's not everybody that has come to here and you are what you do but it's not fair.

(female, 46 years old, South Africa, black, D grade)

They think that we are, I'm sorry to say it because they think that we're suffering in Africa and that's why we're here for money. That they've forgotten that in Nigeria we [have] the same values and all the nursing curriculum and everything was from here and up until now they [inaudible]... the same thing, they've forgotten about our experience in England. Many people don't even recognise our experiences and they don't even appreciate it that we've got something of wealth.

(female, 37 years old, Nigeria, black, D grade)

Another perception African nurses met was the fear of HIV and black African nurses:

That's the respect which we want as well, you know, that positive kind of, you know, publication instead of having issues like, uhm, those like issues which you really see sometimes in the paper or in whatever "HIV in Africa in NHS [with] black nurses". You know, you feel like, you know, you are stigmatised, you are dealing with the question all the time that you know you are dealing with them they just think of HIV.

(female, 44 years old, Nigeria, black, D grade)

Other perceptions described by IRNs were based on straightforward ignorance about other cultures tinged with discrimination as these quotes illustrate:

I felt that because my language skills, I understood what people were saying to me, but I noticed that people were frustrated that they had to use like sign language to say "would you like to have a cup of coffee?" And, but then after the first three months when it came like easier I think that then, but I think that in the beginning people think that you're thick. People think that everything has to be, that they have to explain to you and then they don't know where you come from and they don't have any knowledge, like that they think that you just come here because of the money and that you don't have like, that where you come from there must be everything. People were asking me when you come from Finland you must "do you eat?" Do you have polar bears?"

(female, 30 years old, Finland, white, F grade)

People always ask why you came and sometimes when you said "I wanted the new experience" and people like things like you said that it's only money or it's only something must be, you know, wrong in your country and even as many times that I think that that I would be, there's so many things that I would be happier in my own country, but also that I met my partner here, he's British and in one way you learn to cope, that you, that if you make the decision that you, sometimes I remember the things that really annoyed me in the beginning, already the hot water and the cold water came from the different tap.

(female, 30 years old, Finland, white, D grade)

I came through an agency and they paid for all of my financial expenses to come to this country and then that's it family. Do you, just as a sort of aside, I don't mean to [inaudible]... but, uhm, do you think that from a family point of view and a British

cultural point of view maybe they might be thinking: “How could you come to this country to work in this kind of environment and leave your family?”
(female, 32 years old, Canada, white, E grade)

Yes, they told us that we’re wicked.
(female, 42 years old, Nigeria, black, G grade)

There’s one thing leaving your family, but how could you leave your children?
(female, 47 years old, Zimbabwe, black, D grade)

Reacting to these perceptions was difficult as they were ingrained in discriminatory actions, which disempowered IRNs and made any response open to interpretation by the British nurse. As one IRN explained when explaining the perception that IRNs were meant to be unambitious:

I don’t think that they appreciate people who think of pushing themselves forward. They don’t want you to have ambition.
(female, 34 years old, Zambia, black, D grade)

“You’re there, you do this, you aren’t expected to know that.”
(female, 55 years old, Zimbabwe, white, E grade)

... are not expected of immigrant nurses. When you try to get higher because of ambition, they think you are cheeky...
(female, 34 years old, Zambia, black, D grade)

We need to be accepted, motivated to stay longer in this country. We just need to be accepted, if only people could see us for who we are, I think that wouldn’t put us off staying longer in this country.
(female, 55 years old, Zimbabwe, white, E grade)

Conclusion

Much of this chapter has presented difficult and discouraging data. Many of the IRNs’ experiences of racism and discrimination are repeated in other spheres of British life (MacPherson of Cluny 1999; Yuval-Davies 1999; Anthias 1999). Some IRNs felt that their experiences had discouraged them:

I mean you feel like you’re not wanted, you’re lost, you start thinking: “Am I supposed to be here or not? Why should I be here?” Like I just put down there on question there “I’m really disappointed tomorrow to be a nurse in this country because you’re not accepted anywhere you go to, especially when you open your mouth to speak.”
(female, 50 years old, Germany, white, F grade midwife)

In the face of these experiences, the IRNs interviewed were both willing and able to suggest ways in which IRNs’ experiences could be more positive in the future and contribute to the NHS and independent sector. Some very important aspects involved the surrounding British

society and related to their demands to being appreciated, as discussed in chapter 7. Other suggestions were more self-directed and can be presented as coping strategies, to be discussed in the next chapter.

10. Coping strategies

This chapter directs attention to how IRNs' experiences in the UK affect them personally: what they feel and how they manage to cope with the situation. Furthermore, the chapter provides an overview of what could motivate IRNs to stay working as nurses in the UK for a longer period.

Self-motivation and self-confidence

IRNs generally were put under considerable strain not only because they were by themselves, separated from family and friends in a foreign country where everything was different: the people, the language, the culture, the landscape, the food and the weather (see chapter 8 on experiences living in the UK). Some had left their husbands and children behind, not knowing for certain when they would see them again and having no idea what was awaiting them in the UK. While some IRNs were welcomed on arrival, others, as described in chapter 6, had a negative first impression of their new home. Experiences with adaptation and induction programmes were also mixed, but they all experienced a fall in professional status and recognition by being placed lowest on the grading scale and by not having their qualifications from back home recognised. To many, it was a degrading and demoralising experience. A Nigerian research participant described the difficulty of having to put aside her skills:

...you just can't put it behind you because if you want to put it behind you can continue with just decide to go back. But well, you put it aside and then continue, provided you know what you're doing is right, you don't give a damn to ... You need to have this self-motivation, self-confidence and self-absorption to be able to absorb some of those things ... because you find most of the nurses coming in and leaving within a very short space of time, some within two weeks, some within four weeks, six weeks. High is one year. You have to go back because it's better at home.

(female, 30 years old, Nigeria, black, D grade)

Many felt that they were not appreciated and trusted in the workplace (see chapter 7). Such feelings were accentuated by experiences with discrimination and racism, as described in chapter 9. Being supervised by care assistants in care homes, the IRNs felt that their professional qualifications were undermined.

...you feel, really feel that you are just nothing because these care assistants they have not been educated, they don't know anything, they're just taken from the street and they can change and do whatever. Then you also go and work with them and they so undermine you [inaudible]...because they are made to undermine you. So that's how I felt.

(female, 54 years old, South African, black, D grade)

Several IRNs told about how they had struggled, and some explained that they used to go home and cry:

You went with the flow so to speak “Okay, that’s the way they do things”. But I think that period of first getting into the hospital situation and getting to the point of understanding that’s the way it’s done I think that was a very difficult, I found it because I guess that after thirty-seven years as a nurse I came over here, okay? And to be told that in order to give a simple medication, okay, that I either had to take a course or, you know, have people supervise me, I think that I found demoralising, insulting, because you had, as Anna said, they had our transcripts, they had what our nursing [inaudible]...I think that was a hard thing to adjust to in my, for me to adjust to the fact that even though they knew my qualifications, what I’ve been doing, years of doing it, I’m still not allowed to do it.
(female, 61 years old, American, white, F grade)

But the fact that they accepted my qualifications as it stood and I got here and I could do less than what I was allowed to do as a student was for me demoralising and it took me nearly a year to stop butting against it because it made my life ten times more difficult to just accept the fact that it is not, I cannot do this without going to ten extra courses. Now if I want to make my life more comfortable in my work environment I have to do this course. ...It’s very much a cultural thing also because the culture, the nursing it’s the whole structure in the UK because I always thought that there wouldn’t be that much of a difference between South Africa and the UK and I’ve come to realise that there is actually a major difference and I think it’s accepting the whole thing. You came here for a purpose so either you’re going to accept it and make peace with it and find you way that you’re comfortable in it or go back. You’ve got a choice, you came here willingly, nobody forced you to come here so you can either accept it or go back.
(female, 30 years old, South African, white, E grade)

But even when they most of all wanted to go back home, this was not always a realistic option. Some had financial obligations binding them, and for others the investment in a new life as a nurse in the UK had meant that returning was not feasible, as these nurses explained:

...a friend of mine told me she just felt she wants to go back because she didn’t know what to do anymore, she wanted to go back, she’s had enough. But you’ve left your position over there to come here and it’s difficult to go back because it’s like “oh, what have you achieved so far?” You know, it’s like something like [inaudible]...so coming here so you just stick to it.
(female, 37 years old, Nigerian, black, D grade)

My confidence was completely shattered, but I cannot express that at home. I could not tell them that this is what I’m going through, except my family “here is not a bed of roses too”.
(female, 46 years old, South African, black, D grade)

Standing up for yourself

Research participants explained that in order to survive the ordeal as an IRN in the UK you had to be strong and have self-control:

I think what I've learnt from working here is that you really have to have self-control because that's the most important thing I've learnt here, self-control. If you don't have self-control you can be struck off the register and go home...
(female, 35 years old, Zambian, black, D grade)

Others talked about how it was important to be self-confident and learn to stand up for "yourself":

I tell my friends who maybe ask me they want to come over I tell them they really have to learn to love themselves before they can come here, because it's not as home, you really have to stand up for yourself. If you don't stand up for yourself nobody really backs you up... I really don't know, but sometimes I know I'm black, but problems are really love myself the way I am, so that's what I tell my friends, they really, really have to respect themselves for who they are first.
(female, 31 years old, Kenyan, black, D grade)

In another group a South African nurse said that for this reason it was an advantage to be a bit older and have professional experience before coming to work in the UK. She was herself working in a care home where she could earn a higher salary but she suggested that for younger IRNs it probably would be a better choice to work in the NHS where they could find better support:

You know, such stress will break you down if you are a young nurse I think, but because I was too old [inaudible]...you just look at your objective "what do I want?" Then stick to it and sit and then you had to go to face the manager.
(female, 47 years old, Zimbabwean, black, D grade)

An IRN described how the stay in the UK had changed her to become more assertive and self-confident, especially when dealing with her UK colleagues. Even if in the beginning it had been very hard for her, in retrospect she believed that it had had a positive influence on her character:

...one thing I've noticed you must really stand yourself. If you're just timid and things you'll be frustrated, you need to, for example in my culture my people would never think it's the same me because I used to be I'm just a timid shy person, but since one year I was timid here, second year you wouldn't believe I was the same person, I just [inaudible]...stand up for myself. I think it's good, it does you good. ...Yeah, survival skills you tend to learn. I didn't know that I can learn them at this

age because I was just [being subservient saying]: “Oh yes, I’m here. Thank you.”
But now, no!
(female, 52 years old, South African, black, E grade)

To some, being an IRN in the UK not only involved professional and cultural challenges but also a challenge to the personality of the individual nurse.

Career strategies

The research participants told about various ways in which they could respond to the pressures, degradation, humiliation, discrimination and exploitation they experienced in the workplaces. Some of these involved self-directed psychological strategies, such as learning to stand up for *yourself* and be self-confident, but they could also involve strategic and complex strategies of *impression management* (Goffman 1971). Perhaps the most eloquent example of such a strategy to improve individual status and regard in relation to colleagues and managers was described by a young male Filipino nurse. Recently, he had started to challenge the way he was treated and perceived, by his manager, as a subservient and always available employee:

You just, the people they try to encase your needs, they think we are poor, they try to encase this emotional thing. I just want to share this thing. Before six months ago I’m working sixteen or eighteen days continuously without any break, so I am doing around sixty-five to sixty-eight hours per week. I’m paying [inaudible]... and I’m earning around twenty-two hundred pounds and I’m paying six hundred or seven hundred pounds for income tax and National Insurance. It’s a big contribution for me I say. It’s a big part. Now the manager says he got a new nurse, he want to make a place for the new nurses. He said: “Okay, I can’t give you more extra hours now, you’re doing limited contract hours.” So I say: “Okay, fair enough.” But they try to encase my need, so now they give me the calls, now when the white people get called off sick shortage they say: “Would you like to come for a shift?” Now I’m saying: “No, I don’t want to come [inaudible]...” They’re paying me two pound extra. But I’m not doing just give the false statement because made them scared so I’m doing, even [inaudible]... before I’m saving big money, now I’m just [saving] nothing. Now they give me the twenty-five hours, thirty hours, thirty-five hours it’s not fit for my requirement. Now they come to me like yesterday: “You like to do some extra hours?” I say: “No, I’m happy with the limited hours now.” I think we have to make them scared ... [LAUGHING] But I sacrifice, I just sacrifice, I’m just struggling with my five, six hundred different pounds per month since last three months. They came to me and said: “You like to do it?” I said: “No, I’m happy, I’m doing extra work with BNA.” I’m not doing anything else, I’m just sitting home and watching telly.
(male, 27 years old, Filipino, South Asian, D grade)

By demonstrating that he is not always available on request, and by – falsely – stating that he is working extra hours for an agency, he is showing the manager that he needs to be appreciated and respected (see also chapter 7). In other cases, however, the claim to be

working for an agency in the free time was not untrue. In a different focus group another male nurse described how he was refusing to do overtime in his regular job in order to work with an agency which awarded a higher pay.

Some older IRNs who came to the UK to make savings explained that, because of the higher pay, they preferred to work in care homes even if the professional standards and career prospects generally were worse than in the NHS. Further, there was an agreement among IRNs that it was generally more stressful to be working in a care home. However, as this South African woman explained, she was old and had long experience with nursing, so she did not care, but she would recommend young IRNs to find work in the NHS:

I'm about to retire, so I just don't bother, even if I want to work in the hospital. Though I miss it, because I worked in the hospital for the whole 20 years old, but now, the young ones, just coming from training, I don't really advise them to go to nursing homes. At least they should go to the hospitals to gain experience, those are the people who will benefit. Back at home, I said I would retire at 55. I am 54 this year, so next year I was going to stop working, but now I said, "OK, if I am still OK here I can do another year" just to make the pension up. ... It's better that they [the young IRNs] go to the hospitals. We will tell them if we write home, that when they recruit you, try to ask them to put you into hospitals. Don't go into nursing homes, because you will go back home not knowing anything. It's good for us because we are old.

(female, 54 years old, south African, black, D grade)

Some IRNs were not fully aware of the type and quality of the workplace they would start work in. In Chapter 6 it was described how IRNs had different experiences with recruitment, and that some had been better positioned to seek out information and negotiate their terms of employment beforehand. For some IRNs the immediate problem when starting work in the UK was to become fully recognised as a qualified nurse and receive a PIN number. Those who first had to undergo an adaptation programme could face considerable problems if it turned out that the care home was not accredited to do the adaptation programme, as this IRN explained:

When we are being brought to this country personally to me I came here to an agency, I was posted to a nursing home where it was not accredited. I first of all wasted three months in that nursing home before I took my own decision out of my own indecision, because financially I was down, to now come down to Cardiff ...and reach out to another nursing home which has been accredited after collecting a huge sum of money from me. And I was fortunate to have got in a nursing home where I had to undergo three months before I've been signed up and collecting my pin number. ... Okay, then I started working, but during the process of this adaptation I realised that it is basically ninety percent carer job, ten percent nursing job. So I've been subjected to stress, psychological warfare and a lot of, a lot of psychological problem [inaudible]...from what you are doing there. But after the

end result pin number came and then we have to start then for some period of time and then fortunately I reach out to look for employment elsewhere, which is now the NHS trust which I am at present.

(male, 39 years old, Nigerian, black, D grade)

Other research participants explained how moving job could be a beneficial career strategy for IRNs. In particular, it could be advantageous to IRNs who effectively had been working as care assistants in their adaptation periods. For some it can be difficult to suddenly change this status and identity in relation to the UK colleagues, as this male nurse from Pakistan explained:

When they're starting the [inaudible]...they work as a carer and the carers... he or she is just a carer. When they apply for pin number and the manager says "Oh, he's a nurse, he's going to take over charge and you'll be work under him" or her, they're not give fully respect... They [the carers] are just thinking: "We can run shift better than he or she." Yeah, some changes job because of this...

(male, 36 years old, Pakistani, South Asian, D grade)

Even if she had not had to undergo an adaptation period working as a care assistant a Canadian nurse described a similar strategy to gain more respect after the initial period working in the UK:

...as you progress in your job if you stay in the job and progress in that job in that department you stay with the... the identity on which you first started, uhm, possibly resentment as you go up the chain of the grading system. If you leave your job and start a new job at a different grading, uhm, then the mistakes in which you made to get you at that level of grade have been left behind and so nobody knows what you had to go through to get to the point you had to get to. So people accept you for what you are at face value because they have no preconceptions of what kind of nurse you were prior to that.

(female, 33 years old, Canadian, white, E grade)

Changing job after an initial period with a low professional status or regard could be a way to start afresh and be recognised as a fully qualified and competent nurse in the new workplace. Another strategy to gain respect from colleagues and managers in the workplace was to show them what they could do, as this South African nurse explained:

There were two ladies that came before me in the three months before me and when I sit with them they tell me their experiences. They say it was hard more than it was hard for me. For me it was a little bit better because I had them to fall back onto, but I had to sit, we had together to sit and say: "Look here, let's look at this thing in another way. These people they don't know us, we don't know them, they are also learning what we are and what we're capable of, let's go out and show them what we can do." And this is what we started doing, to show them what we can do. You

know, it's interesting for me now to find them coming to me and saying: "Mary, so and so is doing this, what do you think we must do?" But it's something that I think we have had a breakthrough to break this wall, right? I'm not saying everything is rosy, we still have problems of administration, policies are not okay. Actually where I am we have been criticised by the National Care Standards in [inaudible]...so the whole unit is just being resent from all sides. The manager is trying to put things into place, we are trying to learn things, it's quite stressful for all of us because a lot of things were wrong, you know, they are being correction from the National Care Standards point of view, so we are all learning.
(female, 52 years old, South African, black, D grade)

Some IRNs explained that they were very motivated to advance and develop professionally:

I would describe myself, and I think that Africans on the whole, we are ambitious people. We want to be ahead, you know what I mean? Because we don't have the infrastructure to fall back on like they do here. Like unemployment pay, and that sort of thing, so we actually know that our future's in our hands. We don't have anybody else to fall back on.
(female, 55 years old, Zimbabwean, white, E grade)

Therefore, some IRNs felt very frustrated and discriminated against if they experienced that they were not allowed further education and promotion. However, the IRNs who took part in this study had different experiences, and others said that their leaders supported that they educated themselves. In one group it was discussed whether it was fair that IRNs were given less opportunities than their UK colleagues:

But I think that's fair enough, if you're only going to stay here for a year why should they send you on a course that's not going to benefit them?
(female, 30 years old, South African, white, E grade)

Yeah.

So why should they pay for you to go and have a course?
(female, 30 years old, South African, white, E grade)

But then again, if you had some, then you might stay though if you were offered something.
(female, 47 years old, Australian, white, E grade)

Incitements to stay

All the focus groups ended with a discussion of what would motivate IRNs to stay and work as nurses in the UK for a longer period. Not surprisingly, the suggestions reflected the various points of criticism detailed in this and previous chapters. Better living conditions and accommodation was often mentioned, whether higher quality nurse flats or help to get a mortgage and buy their own homes. Others would like to have better possibilities to see their

families and either loosen the immigration laws so that adult close relatives could join them, or make it easier for them to come to the UK for visits, as this Nigerian woman explained:

Most of us do suffer, you know, severe stress due to separation from families. If the issue can be addressed where, you know, like some of us come in and stay more than one year, three years without even seeing your family, you know, and that will not [inaudible]...the way you work, you know, when you think mostly about home. Sometimes I spend up to ten pounds a week phoning Nigeria every week. I have to phone them three times, you know, in the house, I had to spend money to put a phone in the house. So if they can make it in a way that they can, you know, make the movement easy so that the husband or the family can come in any time they want to come in, see the person and go back. Because personally I wouldn't want to bring up my children here at this early stage, so I want them to come when they're old enough to know what is good and what is bad. So I wouldn't want them in here at the moment, but at least if they can be given a kind of, you know, permit where they can come in when they want to come during the holidays and then go back because most of us suffer it, you know, and it's so stressful and, you know, it put you in a pickle of a confused mind, you won't even know what you are doing.
(female, 40 years old, Nigerian, black, D grade)

Others said that they had decided that they would stay, since they had settled here with their families, like this Finnish nurse who had married an English man:

I think that for me I'm like at the moment settled in here, so I don't know if would I at the moment go and would there be anything because I have the family, like my own family here even that I miss my family. At the moment I'm settled here.
(female, 30 years old, Finnish, white, F grade)

Some IRNs were determined to stay in the UK for the time being because their children were going to British schools and they did not want to uproot them. One also mentioned the benefits of the British health care system to provide treatment for her chronically ill son. Family issues were clearly central to IRNs' decisions whether they would stay longer in the UK or go back home, but many suggestions were made how to improve conditions around work. Most frequently, IRNs mentioned that a pay rise would be very welcome and could motivate them to stay in the UK. Some had expectations that imminent plans of modernisation of the NHS could improve the work situation, career structures and pay of nurses. In order to attract and retain IRNs, suggestions were also made to set up especially favourable tax regulations and to develop good pension schemes to secure their retirement. As already mentioned, the possibilities of professional development through education and promotion were high on the list. Some had already this prospect in sight, as this IRN from New Zealand explained:

Okay, well I've actually probably just been given the stuff that will motivate me to stay, I've just been, just been accepted into a job, started on Monday where I'm the only nurse in the unit, I already know the people who are working there, so I now call all the doctors, the secretaries first names, none of this, you know... hierarchical rubbish. I'm supported by my manager who has guaranteed me and is already teeing up all the education I will need to expand my role. One of the things that my line manager said when I accept the job was: "You drink, that's good, Thursday nights we go for drinks." So it's kind of "come in, be part of the team, be part of us" kind of thing that I've never experienced anywhere else. I was working in the same hospital, different ward, I left after two years to go to this job and it was "okay, see you around". No goodbye card, no thank you very much for working, none of that. But they'd used all of my extended experience, they'd used that without any acknowledgement, management experience [inaudible]...and nothing. So respect, acknowledging abilities, offering education and welcoming people, that is the stuff. *(female, 28 years old, New Zealand, white, H grade)*

Generally, IRNs expressed a strong wish to be accepted as part of the team: that their voice would be heard and their experiences and competencies respected. As this Indian nurse explained:

I would like to participate in bringing about the change. You know, our ideas from abroad. Our say should be valued. It shouldn't be left, these people should come forward and ask us. ... I would like them to give us chance to participate and tell you our experience, our education, and also I would like to help to bring about the change for certain regions, because now that we have done a lot of research in my masters, I know there is a [inaudible]... practice there, which in general a trained nurse or a new or fresh nurse cannot recognise. They should make use of experience. I am not here to criticise, but there are a lot of people around in this venture who may be having very good experience and lots to give to NHS, but yet there are people sitting in high positions who don't allow you to move or shuffle or to mingle with them. It's like a barrier there. It should be broken, you know? *(female, 53 years old, Indian, South Asian, E grade)*

There was agreement in all the groups that as IRNs they were not really appreciated and respected, as discussed in chapter 7:

...sometimes I think, "I've worked hard for this", and you still think, "people don't actually see this" You just feel used. You feel that they are using you and you are just a fact. Not considering you as a person who really is there for the residents. There is just a worker and a number there. If you feel you don't want to work you can go home at any time and they will get another nurse. There is that, you also get that feeling in yourself, not to waste your time. *(female, 65 years old, South African, black, D grade)*

IRNs hoped for more appreciation from managers, colleagues and patients. They also wanted public appreciation. Instead of just being perceived as a mute and dispensable number in the

workforce they would like to be recognised for their contribution to improve and support the British health service, as this IRN demanded:

Basic human emotional needs that you need to be appreciated in your job. You come all the way from a third world country and you don't have to do extra struggle to work here. It's hard enough to work where you come from and how to be appreciated. The government rarely does that, all they talk about twenty thousand nurses are needed at the moment, but what about the three thousand, five thousand nurses from Africa, what the hell are they doing here? What are they doing? What are they contributing? And there's not been enough emphasis on that and I think that would help, boost the morale of everyone.
(*participant not identified, Leeds group*)

Apart from a wish "just to be treated and respected like any other human being" (*female, 49 years old, South African, black, grade not reported*) they advocated initiatives to improve understanding and support to help IRNs to adapt to UK working practices. For example:

Well if they want us to stay longer, one, they must recognise our, you know, like I said, whatever training we've had they must put that into consideration and from there start to integrate us into their system and then they must recognise, like I said, our culture, you know, that like we said, I find it difficult to call somebody their first name. When I came the sister had to me "stop calling me. Call me Jane, I'm just Jane. Don't call me sister". So I eventually learned to do that. Anyway, all those things must be taught because it might take a while for someone to integrate, but we should be taught. And then they should provide the accommodation. Many NHS hospitals I don't think they've got accommodation and because when I wanted to move from [inaudible]...to Sheffield I was cut out for so many accommodation before I could get one and I was to resume on Monday. The weekend I had to get one by all means and that cost me quite a lot of money because I was moving from one town to another, so all those things must be put into consideration as well and, uhm, regarding training as well whatever they can do to help us with training to get adapted into the system should we need them, you know.
(*female, 37 years old, Nigerian, black, D grade*)

Some recommended that there should be established networks of IRNs to support each other. No matter if they were planning to save money for retiring in their home country or settling in the UK, the IRNs who took part in this study wanted to help their IRN colleagues, and they welcomed initiatives to improve the experiences of IRNs in the UK. For example:

I'm settled here, so I just wanted to feel better really and it helps when I see some people coming from where I came from and I can relate to their experiences and see them being treated. I try to help those that my hands can reach, but there are a lot out there that my hands cannot reach, so if in the long run something is done where our white colleagues here are taught a bit about us and we to get a good induction about, you know, what things are like here then it will be better I think because as for conflict and things like that I believe where two people are there is bound to be that, so there should be some sort of solution.
(*female, 44 years old, Ghanaian, black, grade not reported*)

Conclusion

In this chapter, we have presented IRNs' coping strategies to deal with their experiences of working as an IRN in the UK. These coping strategies must be seen in the light of their experiences but also in the context of immigrant workers more generally. As Mohan & Williams (2002) argue in relation to the African Diaspora, such movements of skilled workers need to be seen in the context of wider Diaspora and globalisation. Without such integrated analyses of immigration of skilled workers (Muschkin 1993), IRNs' motivations to stay and work in the UK will be understood to a limited extent. The last chapter presents the recommendations that can be made from the data.

11. Recommendations

This report has presented the data from the focus groups and suggested a model for understanding the experiences of IRNs working in the UK in relation to:

- individual motives to come to work as IRNs in the UK
- personal experiences of IRNs when living in the UK
- issues surrounding recruitment, reception and support on first arriving in the UK
- experiences of working as a nurse in the UK
- structural differences IRNs experience between nursing in the UK and their home countries
- their experiences of discrimination
- their coping strategies to manage their experiences and their wish for appreciation and trust from British nurses and employers.

The findings form the basis for professional organisations to inform the development of standards to support the working situation of IRNs in the UK. Further, the findings will assist both independent sector and NHS recruitment officers and managers to prepare targeted interventions and training materials for staff development. Such initiatives will aim to increase inter-cultural sensitivity, improve communication and reduce discrimination at work.

The following recommendations are developed from the data expressed in the interviews and in some cases were identified by the IRNs themselves.

We suggest eight interrelated areas of recommendations. These generalised recommendations are grounded in the experiences and suggestions of individual IRNs who took part in the research and let their voices be heard.

Recommendation 1

Better pre-recruitment information material for future and potential IRNs informing them about life in the UK, differences of culture and local dialects and which types of work they may encounter (in particular describing work in the NHS as well as in care homes).

...when you apply to come over here we said like back at home we don't have nursing homes, now when you come here the first thing you're sent to is a nursing home. We've never had experiences back at home whatsoever. We come here, we don't know what to do, we're exposed, you know, to such an environment. ...

Basically, I feel the first and foremost thing really that should be done is all these agencies that recruit the nurses from back home they should be able to tell us what sort of areas they're going to send us to so that we are aware in advance aware of to where we're being sent, other than just coming blindly and then in the end you end up working as a tea maker in a nursing home.

(female, 34 years old, Zambian, black, D grade)

Recommendation 2

Better matching between employers' needs and IRNs' professional qualifications as well as personal expectations about life in the UK. For example, are they coming for a temporary working holiday, to make savings while working for back home, or are they planning a permanent move?

I think that the agencies are very much to blame here because I think that the agency owe it to the nurse to have got the right contract. I mean I cannot understand why they put them in a nursing home when they come if they've come as qualified people. They get their pin number, they need qualified people, we're brought into the country to be qualified, so therefore that's what we must be. But because they're so short in the nursing homes it's exactly what you said, it's like they use our ignorance to fill their gaps. But it's really our fault because we should do the research before we come...

(female, 55 years old, Zimbabwean, white, E grade)

Recommendation 3

Improving and regulating induction and adaptation courses for IRNs and, where possible, use of experienced IRNs as support (supervisors/mentors) for new IRNs.

...the recruits from other countries need to be moulded into the culture here, even the language, you know, like where I come from now they call a bus a "boos" you know. When somebody say they're going to a "boos" stop you don't understand what they are talking about. You know, things like that if you get into the area and then you're moulded into that culture it will remove all these problems because you would know what is expected of you. So if there could be some form of induction of some sort, I don't know how they could do that, but since we have a department is the one that especially recruiting, initiating this recruitment they should be able to initiate these programmes.

(female, 49 years old, South Africa, black, grade not given)

Recommendation 4

Establish induction-programmes for UK staff, who are working with IRNs. Induction programmes should aim to provide UK nurses with greater understanding and *acceptance* of professional and cultural difference (both professional and social) so that they are better able to support IRNs to integrate into UK nursing teams and to reach their full potential. The programmes should include information/discussion on:

- behavioural norms relating to the health care environment in the countries from which the IRNs come from and how this may differ from the UK setting. For example, how different forms of respect are shown to senior staff i.e. eye contact
- professional qualifications and nursing practice in source countries
- IRNs' previous professional experiences and how these may inform clinical practice in the UK health care setting.

Yeah, and then I think in the long run NHS will probably need, now that they are recruiting a lot of people from outside, somebody, you know, who could study different people's cultures and how do you relate to each other and then give talk to, you know, people like the centres for study days for those things. Staff on the ward could be sent for such study days and, you know, somebody just lecture them. Because it was very bad, it was really, I was really [inaudible]... was my headache, I used to go home and cry
(female, 44 years old, Ghana, black, grade not given)

...they've got us here, and instead of using us, they almost think that they're doing us a favour by having us in the country, whereas we're actually really meant to be the other way around, you know. Well, it's give and take, it's both. And fair enough, we've got a lot to learn, but we've also got a lot to give. If they give us credit for what we do now, instead of being threatened by us and instead of just saying "well, how would you know, you're just Africans?" because they think that we've got lions prowling around outside the theatre.
(female, 55 years old, Zimbabwean, white, E grade)

Recommendation 5

Increasing professional satisfaction and career prospects of IRNs by increasing the use of APEL and validation of other qualifications gained in the country of origin, to allow IRNs to develop career pathways and benefit from professional education opportunities available in the UK.

I expected like after the adaptation course the promotion will be on merit, like if you've attended the study day, you know what you're doing, you will be promoted more easily, but it's not like that.
(female, 31 years old, Kenyan, black, D grade)

I don't think that they appreciate people who think of pushing themselves forward. They don't want you to have ambition. [They say:] "You're there, you do this, you aren't expected to know that."
(female, 40 years old, Zambian, black, E grade)

We need to be accepted, motivated to stay longer in this country. We just need to be accepted, if only people could see us for who we are, I think that wouldn't put us off staying longer in this country.
(female, 34 years old, Zambian, black, D grade)

Recommendation 6

Preventing exploitation of IRNs. This would require the following actions:

- better enforcement of existing regulations by the relevant stakeholders (Government and NMC)
- introduction of new regulations which prevent those exploitative practices not currently covered by regulation
- raising awareness among IRNs of their employment rights to ensure that IRNs:
 - a) make informed choices prior to signing contracts
 - b) know when to seek help in challenging poor or abusive practice by their employers.

Slavery is relative because if you have to look at the two angles it's like okay, you sought for labour from somewhere. Okay, you bring your labour to the country, the labour is going to contribute one thing or the other to the upliftment of the health sector in the country. It's not to downgrade the health sector. Okay, we are being brought in by an agency to this country to practice nursing, which we knew and [inaudible]...I've been practising nursing or so seventeen years ago. Even if I don't have the skill or I don't have the experience seventeen years is enough for me to have at least to really understand what nursing is. When we are being brought to this country personally to me I came here to an agency, I was posted to a nursing home where it was not accredited.

(male, 39 years old, Nigerian, black, D grade)

Recommendation 7

Tackling racism in NHS and care homes and at an institutional level in the health services.

I think the managers when they receive foreign nurses, especially black, at least if the colour is like you are they will maybe easily accept them, but if the colour is different everybody will look at you with a suspicious eye. They don't know exactly what you are capable of doing, they don't really trust you, but if the manager will stand by you, inform all the carers that they're there to say "this [inaudible]...is a qualified nurse" where she's coming from "and she's able to do this and this and this and whilst here she just doing this adaptation for three months, that's to get used to the way we do things here". And even if possible she takes you in other residents homes to tell: "This is our new nurse, you'll see her doing some caring duties at times, but she's a qualified nurse, she's just going to get used to how we go about things here." I think maybe that can help.

(female, 35 years old, Zambian, black, D grade)

Recommendation 8

Encourage the development of RCN local and regional support and discussion groups for IRNs and encourage IRNs to become involved in all aspects of RCN activity. This recommendation includes encouraging IRNs to participate in professional specialism groups in the RCN and groups for BME nurses where appropriate.

I think in some sense when we started there were very few foreign nurses in the hospital itself and I think in the separate units where we worked we sort of paved the way because our experience is they learn how we perceive things and I think that made it easier for the next big group that came in. “Well these people found this and this and this difficult, so what can we do to improve that for the next?” Especially with this huge recruitment going on.
(female, 30 years old, South African, white, E grade)

... most of the support one could say you got from your fellow black colleagues, when wemy day to day it was like this, you take out your frustration that you’ve had and then we look at it and say: “You know, we could have looked at it this way. It’s not really like that.” You know.
(female, 52 years old, South African, black, D grade)

Suggestions for further studies

Lastly, it is recommended that three further studies be undertaken.

The first, to explore further the personal motivations of IRNs in the UK by combining macro and micro level analysis in a case study of migration patterns and life in Diaspora of IRNs in relation to the wider literature of the migration of skilled workers.

The second, to explore and understand the expectations of UK nursing staff towards IRNs and how British nursing practice is influenced by professionals trained abroad.

The third, to explore the experiences and views of patients when treated and cared for by non-British health care staff.

Such research initiatives would provide valuable research evidence to expand the knowledge base with insights into structural factors as well as the experiences and views of other involved actors. Also, the research could additionally underpin recommendations for initiatives to improve policy and practice regarding international recruitment and workforce wellbeing in the health care sector.

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Appendices

Appendix 1: Information sheet

Appendix 2: Invitation to take part in research (snowballing)

Appendix 3: Pre-focus group questionnaire

Information sheet

Name of researchers: Dr Helen Allan, Mr John Larsen

Title of project: Experiences of internationally recruited nurses in the UK

Invitation

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the evaluation project is being done and what it will involve. Please take time to read the following information carefully and discuss it with your friends and colleagues if you wish. Ask Helen Allan if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of this project?

While the Royal College of Nursing knows a good deal about where internationally recruited nurses work and which countries they are recruited from, there is no research detailing the experiences of this group of nurses.

This study will explore the experiences and opinions of internationally recruited nurses (IRNs) to understand why overseas nurses come to work in the UK, what problems they encounter and whether they plan to stay in the UK or return to their countries of origin after a short period. The findings will contribute to developing a more effective recruitment process by directly addressing the expectations of the overseas nurses when recruiting. The research will also help in developing induction programmes to assist internationally recruited nurses (IRNs) to adjust to living and working as nurses in the UK.

Who is this study sponsored by?

The employment relations department of the Royal College of Nursing sponsors this study. They have commissioned Dr Helen Allan and Mr John Larsen at the University of Surrey to undertake this research as independent researchers who will report their findings to the Royal College of Nursing. The Royal College of Nursing hopes that further information on the experiences of internationally recruited nurses will assist them in supporting those nurses already working in the UK and inform future supportive measures for internationally recruited nurses.

Why have I been chosen?

You have been asked to participate in this study because you were recruited internationally to work in the UK. You are being asked by Dr Helen Allan and Mr John Larsen to participate in this study to discuss your experiences of working in the UK as an internationally recruited nurse. *Your name has been selected randomly from the RCN database of registered nurses from overseas.*

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you would be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason. If you decide not to take part in this study, your decision will not effect your employment in any way.

What will taking part involve?

If you decided to participate, you would be asked to participate in a *focus group interview* which would last approximately 60 – 90 minutes and would be arranged on a date convenient to you and the other participants. A focus group interview is an interview with other people with similar experiences to your own. The purpose of the interview is to find out about your experiences of being recruited to work in the UK. It will be tape-recorded and notes taken by one of the researchers. The tapes and notes will be stored in a safe place and only the research team will have access to them. You will not be identified by name. The interview will be led by Helen Allan or John Larsen. The date and time of the interview will be arranged by Helen Allan or John Larsen. The interview will be held in the RCN regional office nearest to you. Travel expenses will be paid and tea, coffee and biscuits served during the interview.

What are the possible benefits of taking part?

The benefit to you will be an opportunity to contribute to a broader understanding of experiences of internationally recruited nurses and to the wider debate in the health service over preparing overseas nurses for work in the UK. The opportunity will give you the chance to air your views although the research findings may not affect you directly.

What are the possible disadvantages or risks of taking part?

There are no foreseen disadvantages or risks to taking part.

Would my taking part in this study be kept confidential?

You would be given a pseudonym for the research and only the researchers would have access to consent forms, where your real name would be stored, and to the computer records. All information which is collected about you during the course of research would be kept confidential. This is in accordance with the Data Protection Act 1998.

What would happen to the results of the study?

The results are intended to be published after the report has been written in March 2003. It does take some time for journal articles to be published and you would be able to contact Dr Helen Allan or Mr John Larsen to find out when any publications were expected. You will not be identified in any report or publication. Copies of the report would be available on request from Dr Helen Allan or Mr John Larsen.

Who has reviewed the study?

Professor Karen Bryan of the University of Surrey; The Advisory Committee on Ethics at the University of Surrey and key people in the employment relations department at the Royal College of Nursing.

Contact for further information

Dr Helen Allan
tel: 01483 689745
email: h.allan@surrey.ac.uk

Mr John Larsen
tel: 01483 684548
email: j.larsen@surrey.ac.uk

Ms Verity Lewis
RCN Senior Employment Adviser
tel: 0207 647 3572
email: verity.lewis@rcn.org.uk

Thank you for reading this information sheet.

If you decide to take part, please keep this information sheet and either telephone Dr Helen Allan or Mr John Larsen, or return the reply slip below with your telephone number and one of the researchers will ring you.

Please tear here ✂-----

Title of project: Experiences of internationally recruited nurses in the UK

Contact details

Name:

Telephone number at home: _____ at work (if appropriate): _____

Best time to telephone:

Please return this reply slip to: Dr Helen Allan, Level 4
EIHMS, Duke of Kent Building
University of Surrey
Guildford, GU2 7TE

Invitation to take part in research

Experiences of internationally recruited nurses

The Royal College of Nursing has commissioned the University of Surrey to conduct a research study concerning the experiences of nurses recruited from overseas. The study explores nurses' reasons for coming to work in the UK and your experiences of working here. Initially, a number of nurses were selected randomly from the RCN database of registered nurses from overseas. They were sent letters inviting them to take part in the research.

We have still got places free for participation in the research meetings we are planning in Cardiff. Therefore, we have requested the nurses, who have already agreed to take part, to ask colleagues if they would also like to participate. The research will be conducted through focus groups meetings where 6-10 internationally recruited nurses together share their experiences and views.

If you have trained as a nurse overseas but are now working as a nurse in the UK, we would very much like to hear from you. It is entirely voluntary to participate in the research. If you choose to participate it would be valuable to us, since it would provide us with a better understanding of important issues. The research would enable The Royal College of Nursing to work to improve the experiences of nurses from overseas working in the UK.

The focus group meeting will last about 2 hours and will take place in Cardiff on either 27 or 28 January. You can call the researchers Dr Helen Allan and Dr John Larsen to receive more information and arrange a date and time to take part.

With regards,

Helen Allan and John Larsen

European Institute of Health and Medical Sciences
University of Surrey
Guildford GU2 5TE

Helen Allan 01483 689745

John Larsen 01483 684548

Experiences of internationally recruited nurses

ID Number.

Age (years)

Gender

Male

Female

Marital status

Married

Single

Separated

Widowed

Number of children

Country of origin

Ethnicity

Country of nurse education

Work experience of nursing before arriving in the UK

Years

Months

Employment status before arriving in the UK

Date of starting work in the UK

Day

/

Month

/

Year

Sector of employment (NHS, independent, agency, other)

Nursing grade

UK

Overseas

UK equivalent

Present salary (per year)

Type of accommodation in the UK (renting or owner occupier)

Living situation in the UK

Living alone

With family

Shared house/flat

What is your motivation to work as a nurse in the UK?