SURVIVING THROUGH ADVERSITY: THE EXPERIENCES OF OVERSEAS BLACK AND MINORITY ETHNIC NURSES IN THE NHS IN THE SOUTH OF ENGLAND

by

Obrey Alexis

Submitted for the degree of PhD

European Institute of Health and Medical Sciences
University of Surrey

2006

© Obrey Alexis
Abstract

Title: Surviving through adversity: The experiences of overseas black and minority ethnic nurses in the NHS in the south of England.

Aim: The aims of this study were to explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses in the NHS in the south of England.

Methods: This study utilised a combination of qualitative and quantitative approaches underpinned by interpretive phenomenology. The qualitative phase consisted of 12 semi-structured face-to-face interviews and the findings informed the focus group interviews, of which four were conducted. The quantitative phase, a survey, informed by the findings of the qualitative phase was conducted with 188 overseas nurses across 15 NHS Trust hospitals in the south of England.

Findings: The qualitative findings revealed five main themes such as: Being thrown into an unfamiliar world, encountering marginalisation and experiencing inequalities in the world, surviving in an everyday world, living in an everyday world and making a new world and these themes encapsulated their experiences. Overseas nurses indicated that they had encountered discrimination, lack of equal opportunity, bullying, separateness and a host of other encounters that appeared to have affected their experiences of the NHS. The survey showed that overseas nurses employed in NHS hospitals in London were more likely to perceive themselves to have been promoted, supported and have aggressive behaviour directed at them in comparison to those in NHS hospitals in non-London regions. The survey also revealed that African nurses were more likely to perceive themselves as being treated less favourably than their overseas counterparts.

Conclusion: Both phases showed that overseas nurses encountered difficulties and variations in treatment in the NHS in the south of England and combining the two approaches helped to confirm and reinforce the findings. This study’s results add considerably to the body of knowledge on the experiences of overseas nurses and have significant implications for nursing practice, management and health policy.
Acknowledgements

I would like to take this opportunity to thank those overseas nurses who kindly agreed to participate in this study. I am deeply appreciative of their willingness to share their unique and rich experiences of working in the NHS in the south of England with me. My thanks also go to the participating hospitals that allowed me to interview and survey their nurses. Without their support this study would not have been completed.

Also, I thank my supervisors, Dr. Vasso Vydelingum and Professor Ian Robbins for their unending patience and support throughout this project. In addition, I would like to extend my thanks to Peter Nicholls for his support in helping me with the statistical analysis of the survey data.

Lastly, I would like to express my sincere appreciation of the continual, unconditional support and encouragement given to me by my wife Sandy, daughter Hayleigh and son Dominic, during the writing of this thesis. I am indelibly grateful to you all, particularly when times were difficult. You gave me the motivation to continue and were pivotal throughout the process.

DECLARATION

I declare that the thesis presented here for the award of Doctor of Philosophy is entirely my own work.
# Table of contents

ABSTRACT ................................................................. ii  
ACKNOWLEDGEMENTS ...................................................... iii  
DECLARATION ................................................................. iii  
CHAPTER 1: INTRODUCTION .............................................. 1  
  1.1 Background .......................................................... 1  
  1.2 Rationale for the study ............................................. 5  
  1.3 The aim of the study ................................................ 7  
  1.4 Research question .................................................. 7  
  1.5 Alternative approaches for this study ....................... 8  
  1.6 The research approach for this study ....................... 11  
  1.7 Combining both qualitative and quantitative methods:  
      The rationale ....................................................... 12  
  1.8 Reason for the survey ............................................. 13  
  1.9 The black researcher .............................................. 14  
  1.10 Reasons for migration .......................................... 16  
  1.11 Adaptation programme .......................................... 18  
  1.12 Sociological concepts related to the study ............... 19  
      1.12.1 Ethnicity ....................................................... 19  
      1.12.2 Race ........................................................... 20  
      1.12.3 Minority ....................................................... 21  
      1.12.4 Minority ethnic ............................................ 22  
      1.12.5 Black .......................................................... 22  
      1.12.6 Overseas nurses ........................................... 23  
  1.13 Ethnic data collection ............................................ 24  
      1.13.1 Admissions of overseas nurses to NMC register ... 24  
      1.13.2 Ethnic nurses data ........................................ 27  
  1.14 Researchers engagement in this study .................... 28  
  1.15 The structure of the thesis .................................... 28  
  1.16 Summary ........................................................... 31  

CHAPTER 2: SYSTEMATIC REVIEW PROCESS ..................... 32  
  2.1 Introduction ......................................................... 32  
  2.2 The review process ............................................... 32  
  2.3 Aim of the review ................................................. 34
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4 Criteria for entry in the review</td>
<td>35</td>
</tr>
<tr>
<td>2.4.1 Inclusion criteria</td>
<td>35</td>
</tr>
<tr>
<td>2.4.2 Exclusion criteria</td>
<td>35</td>
</tr>
<tr>
<td>2.5 Developing the search strategy</td>
<td>36</td>
</tr>
<tr>
<td>2.6 Main computerised database search</td>
<td>37</td>
</tr>
<tr>
<td>2.7 Narrow and more focused selection</td>
<td>38</td>
</tr>
<tr>
<td>2.8 Supplementary searching</td>
<td>39</td>
</tr>
<tr>
<td>2.9 Management and acquisition of relevant literature</td>
<td>40</td>
</tr>
<tr>
<td>2.10 Quality appraisal of the literature</td>
<td>40</td>
</tr>
<tr>
<td>2.11 Literature review saturation</td>
<td>43</td>
</tr>
<tr>
<td>2.12 Thematic review of the literature</td>
<td>43</td>
</tr>
<tr>
<td>2.13 Hierarchy of evidence</td>
<td>43</td>
</tr>
<tr>
<td>2.14 Threats to valid searches</td>
<td>45</td>
</tr>
<tr>
<td>2.15 Summary</td>
<td>46</td>
</tr>
<tr>
<td><strong>CHAPTER 3: SYSTEMATIC REVIEW THEMES</strong></td>
<td>47</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>47</td>
</tr>
<tr>
<td>3.2 Equal opportunities</td>
<td>47</td>
</tr>
<tr>
<td>3.2.1 Policy practice gap</td>
<td>49</td>
</tr>
<tr>
<td>3.2.2 Equality, equity and fairness</td>
<td>51</td>
</tr>
<tr>
<td>3.2.3 Lack of clarity in intent and purpose</td>
<td>55</td>
</tr>
<tr>
<td>3.2.4 Leadership roles</td>
<td>56</td>
</tr>
<tr>
<td>3.2.5 Support system</td>
<td>59</td>
</tr>
<tr>
<td>3.3 Summary</td>
<td>60</td>
</tr>
<tr>
<td>3.4 Racial discrimination</td>
<td>61</td>
</tr>
<tr>
<td>3.4.1 Racism</td>
<td>61</td>
</tr>
<tr>
<td>3.4.2 Institutional racism</td>
<td>64</td>
</tr>
<tr>
<td>3.4.3 Ethnocentrism</td>
<td>67</td>
</tr>
<tr>
<td>3.5 Summary</td>
<td>68</td>
</tr>
<tr>
<td>3.6 Cultural differences</td>
<td>68</td>
</tr>
<tr>
<td>3.6.1 Cultural dimension</td>
<td>69</td>
</tr>
<tr>
<td>3.6.2 Cultural stereotyping of black and minority groups</td>
<td>73</td>
</tr>
<tr>
<td>3.6.3 Cultural diversity in nursing</td>
<td>74</td>
</tr>
<tr>
<td>3.7 Summary</td>
<td>77</td>
</tr>
<tr>
<td>3.8 Social exclusion and experiences of overseas nurses</td>
<td>77</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>3.8.1 Social exclusion</td>
<td>78</td>
</tr>
<tr>
<td>3.8.2 Support mechanisms</td>
<td>80</td>
</tr>
<tr>
<td>3.8.3 Skills</td>
<td>82</td>
</tr>
<tr>
<td>3.8.4 Inequalities</td>
<td>83</td>
</tr>
<tr>
<td>3.8.5 Being outsiders</td>
<td>84</td>
</tr>
<tr>
<td>3.8.6 Stress</td>
<td>85</td>
</tr>
<tr>
<td>3.9 Summary</td>
<td>86</td>
</tr>
<tr>
<td>3.10 Gaps in the literature</td>
<td>86</td>
</tr>
<tr>
<td>3.10.1 Gaps in knowledge and understanding</td>
<td>86</td>
</tr>
<tr>
<td>3.10.2 Gaps in methodology</td>
<td>87</td>
</tr>
<tr>
<td>3.10.3 Gaps in theory</td>
<td>87</td>
</tr>
<tr>
<td>3.11 Summary</td>
<td>87</td>
</tr>
<tr>
<td>3.12 Overall Summary</td>
<td>88</td>
</tr>
</tbody>
</table>

**CHAPTER 4: THEORETICAL FRAMEWORK**

<p>| 4.1 Introduction                                                 | 90 |
| 4.2 The interpretivist approach to inquiry                       | 90 |
| 4.3 Phenomenology as a research method                           | 91 |
| 4.4 Husserlian phenomenology                                     | 94 |
| 4.4.1 Essences                                                  | 95 |
| 4.4.2 Intentionality                                            | 95 |
| 4.4.3 Bracketing                                                 | 95 |
| 4.5 Heideggerian phenomenology                                   | 98 |
| 4.6 Heidegger’s examination of being and related concepts        | 99 |
| 4.6.1 Time and space                                            | 99 |
| 4.6.2 Being engaged in the world                                | 100 |
| 4.6.3 Temporality                                               | 101 |
| 4.6.4 Understanding and interpretation                           | 101 |
| 4.7 Hermeneutic philosophy                                      | 102 |
| 4.7.1 Hermeneutic circle                                        | 103 |
| 4.7.2 Gadamer                                                    | 105 |
| 4.7.3 Fusion of horizons                                         | 105 |
| 4.7.4 Prejudice                                                 | 106 |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.7.5 Dialogue</td>
<td>106</td>
</tr>
<tr>
<td>4.8 Nursing studies: The phenomenological debates</td>
<td>107</td>
</tr>
<tr>
<td>4.9 Summary</td>
<td>110</td>
</tr>
</tbody>
</table>

**CHAPTER 5: RESEARCH DESIGN AND METHODS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Introduction</td>
<td>111</td>
</tr>
<tr>
<td>5.2 The nature of qualitative research</td>
<td>111</td>
</tr>
<tr>
<td>5.3 Data collection: The process</td>
<td>114</td>
</tr>
<tr>
<td>5.3.1 Negotiating access</td>
<td>114</td>
</tr>
<tr>
<td>5.3.2 Gaining access</td>
<td>115</td>
</tr>
<tr>
<td>5.3.3 Criteria for inclusion in the study</td>
<td>116</td>
</tr>
<tr>
<td>5.3.4 The pilot study</td>
<td>118</td>
</tr>
<tr>
<td>5.3.5 Participants involved in the study</td>
<td>119</td>
</tr>
<tr>
<td>5.3.6 Being with the study participants</td>
<td>121</td>
</tr>
<tr>
<td>5.3.7 The interviews</td>
<td>122</td>
</tr>
<tr>
<td>5.4 The focus group interview</td>
<td>124</td>
</tr>
<tr>
<td>5.4.1 The process</td>
<td>125</td>
</tr>
<tr>
<td>5.5 Ethical considerations</td>
<td>134</td>
</tr>
<tr>
<td>5.5.1 Professional guidelines and Local Research Ethics Committee</td>
<td>135</td>
</tr>
<tr>
<td>5.5.2 Theoretical approaches to ethical issues</td>
<td>136</td>
</tr>
<tr>
<td>5.6 Rigour</td>
<td>143</td>
</tr>
<tr>
<td>5.6.1 Rigour related to this study</td>
<td>146</td>
</tr>
<tr>
<td>5.7 The survey</td>
<td>152</td>
</tr>
<tr>
<td>5.8 Triangulation</td>
<td>152</td>
</tr>
<tr>
<td>5.9 Summary</td>
<td>155</td>
</tr>
</tbody>
</table>

**CHAPTER 6: DATA ANALYSIS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Introduction</td>
<td>156</td>
</tr>
<tr>
<td>6.2 The process</td>
<td>156</td>
</tr>
<tr>
<td>6.2.1 Background of the researcher</td>
<td>157</td>
</tr>
<tr>
<td>6.2.2 Justification for using van Manen's framework</td>
<td>158</td>
</tr>
<tr>
<td>6.2.3 Face-to-face interviews</td>
<td>160</td>
</tr>
<tr>
<td>6.2.4 Hermeneutic circle</td>
<td>161</td>
</tr>
</tbody>
</table>
### Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2.5 Fusion of horizons</td>
<td>163</td>
</tr>
<tr>
<td>6.2.6 Computer assisted analysis</td>
<td>163</td>
</tr>
<tr>
<td>6.2.7 Focus group interviews</td>
<td>167</td>
</tr>
<tr>
<td>6.3 The survey analysis</td>
<td>168</td>
</tr>
<tr>
<td>6.4 Summary</td>
<td>169</td>
</tr>
</tbody>
</table>

#### CHAPTER 7: FINDINGS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Introduction</td>
<td>171</td>
</tr>
<tr>
<td>7.2 The journey</td>
<td>171</td>
</tr>
<tr>
<td>7.3 Being thrown into an unfamiliar world</td>
<td>173</td>
</tr>
<tr>
<td>7.3.1 Differences in nursing practice</td>
<td>176</td>
</tr>
<tr>
<td>7.3.2 Adjusting to a new environment</td>
<td>177</td>
</tr>
<tr>
<td>7.3.3 Differences in communication</td>
<td>179</td>
</tr>
<tr>
<td>7.3.3.1 Embarrassment and humiliation</td>
<td>182</td>
</tr>
<tr>
<td>7.3.4 Absence of support</td>
<td>182</td>
</tr>
<tr>
<td>7.3.4.1 Reduced confidence</td>
<td>184</td>
</tr>
<tr>
<td>7.3.4.2 No advocacy</td>
<td>185</td>
</tr>
<tr>
<td>7.3.4.3 Resentment and unhappiness</td>
<td>187</td>
</tr>
<tr>
<td>7.4 Encountering marginalisation and experiencing inequalities in</td>
<td>189</td>
</tr>
<tr>
<td>The world</td>
<td>190</td>
</tr>
<tr>
<td>7.4.1 Discrimination</td>
<td>195</td>
</tr>
<tr>
<td>7.4.1.1 Invisibility syndrome</td>
<td>197</td>
</tr>
<tr>
<td>7.4.2 Lack of equal opportunity</td>
<td>201</td>
</tr>
<tr>
<td>7.4.3 Bullying</td>
<td>203</td>
</tr>
<tr>
<td>7.4.4 Separateness</td>
<td>205</td>
</tr>
<tr>
<td>7.5 Surviving in an everyday world</td>
<td>206</td>
</tr>
<tr>
<td>7.5.1 Challenges to integration</td>
<td>206</td>
</tr>
<tr>
<td>7.5.1.1 Not feeling appreciated</td>
<td>209</td>
</tr>
<tr>
<td>7.5.1.2 Feeling inadequate</td>
<td>210</td>
</tr>
<tr>
<td>7.5.1.2.1 Lack of trust</td>
<td>212</td>
</tr>
<tr>
<td>7.5.1.3 Unwelcome feeling</td>
<td>213</td>
</tr>
<tr>
<td>7.5.1.3.1 Experiencing fear</td>
<td>214</td>
</tr>
<tr>
<td>7.5.1.4 Concept of self-blame</td>
<td>214</td>
</tr>
<tr>
<td>7.5.2 Challenges to personal growth and practice</td>
<td>214</td>
</tr>
</tbody>
</table>
# Table of contents

7.5.2.1 Lack of opportunities for skill development and training ................................................................. 214
7.5.2.1.1 Performance review ................................................. 218
7.5.2.2 Unfairness in nursing practice .................................................. 220
7.6 Living in an everyday world ................................................................. 222
7.6.1 Support from black and minority ethnic colleagues ................................................................. 222
7.6.2 Proving self ................................................................................... 224
7.7 Making a new world............................................................................ 225
7.7.1 Building ties .................................................................................. 226
7.7.2 Reflecting on the experience ........................................................ 227
7.7.3 Moving on ..................................................................................... 227
7.8 Summary ........................................................................................... 229

## CHAPTER 8: DISCUSSION ........................................................................ 231
8.1 Introduction ....................................................................................... 231
8.2 Discussion of the findings ............................................................... 231
8.2.1 Being thrown into an unfamiliar world ....................................... 232
8.2.2 Encountering marginalisation and inequalities in the world .................................................. 236
8.2.3 Surviving in an everyday world .................................................. 243
8.2.4 Living in an everyday world ........................................................ 247
8.2.5 Making a new world ..................................................................... 248
8.3 Summary ........................................................................................... 248

## CHAPTER 9: THE SURVEY .................................................................. 249
9.1 Introduction ............................................................................. 249
9.2 Rationale ..................................................................................... 250
9.3 Aim and research questions ............................................................ 250
9.4 Development of the questionnaire ................................................... 251
9.5 Content of the questionnaire ............................................................ 252
9.5.1 Biographical profile ...................................................................... 253
9.5.2 Equal opportunity .......................................................................... 253
9.5.3 Skill development and training ....................................................... 253
9.5.4 Discrimination ............................................................................... 254
Table of contents

9.5.5 Support mechanisms .................................................. 254
9.5.6 Adjustment to a new environment .................................. 254

9.6 The questionnaire layout, covering letter and information sheet .................................................. 255
9.7 The consent form ............................................................. 256
9.8 Ethical approval ............................................................... 256
9.9 Pre-testing of the questionnaire .............................................. 256
9.10 Participating organisations ................................................... 257
9.11 Distribution of questionnaires ........................................ 258
9.12 Returned questionnaires ............................................... 259
9.13 Analysis ................................................................................. 259
9.14 Results ........................................................................................... 260
9.14.1 Equal opportunity ................................................................. 266
9.14.2 Skill development and training .................................................. 272
9.14.3 Discrimination ................................................................. 274
9.14.4 Support ............................................................................... 280
9.14.5 Adjustment to a new environment .............................................. 285
9.14.6 Correlations analyses ............................................................. 288

9.15 Discussion ............................................................................. 290
9.15.1 London and non-London NHS Hospitals ........................................ 290
9.15.2 Equal opportunity ............................................................. 292
9.15.3 Training and development ....................................................... 296
9.15.4 Discrimination ................................................................. 297
9.15.5 Support ............................................................................... 298
9.15.6 Adjusting to a new environment .............................................. 299
9.16 Summary ................................................................................ 301

CHAPTER 10: DISCUSSION, IMPLICATIONS & RECOMMENDATIONS ........................................... 303

10.1 Introduction ............................................................................. 303
10.2 Discussion .................................................................................. 303
10.2.1 Power ..................................................................................... 303
10.2.2 Social closure ......................................................................... 306
10.2.3 Transition theory ................................................................. 307
Table of contents

10.3 Implications and recommendations for practice, management and policy makers 309
  10.3.1 Implications and recommendations for practice 309
  10.3.2 Implications and recommendations for management and policy makers 312
10.4 Strengths of both qualitative and quantitative methods 315
10.5 Limitations of both qualitative and quantitative methods 316
10.6 Recommendations for future research 319
10.7 Summary 321

CHAPTER 11: CONTRIBUTION TO KNOWLEDGE 322
  11.1 Introduction 322
  11.2 Contribution to knowledge and understanding 322
  11.3 Contribution to research methods 325
  11.4 Contribution to theory 326
  11.5 Critical evaluation of the research process 327
  11.6 Final thought 330
  11.7 Summary 330

REFERENCES 332
CHAPTER 1: INTRODUCTION
Table 1.1: Admission of overseas nurses to the NMC register...26
Table 1.2: Nurses, midwifery and health visiting ethnic staff employed within the south of England....... 27

CHAPTER 2: SYSTEMATIC REVIEW PROCESS
Table 2.1: Types of literature contained in the review......... 41

CHAPTER 5: RESEARCH DESIGN AND METHOD
Table 5.1: Background information for one to one interviews........................................... 120
Table 5.2: Background information for focus group interview one........................................... 128
Table 5.3: Background information for focus group interview two........................................... 129
Table 5.4: Background information for focus group interview three........................................... 130
Table 5.5: Background information for focus group interview four........................................... 131

CHAPTER 6: DATA ANALYSIS
Table 6.1: Stages of analysis........................................... 160
Table 6.2: Sub-themes........................................... 166
Table 6.3: Main themes........................................... 166
Table 6.4: van Manen’s (1990) analytical framework.............169

CHAPTER 7: FINDINGS
Table 7.1: Themes and sub-themes of the lived experience.....174

CHAPTER 9: THE SURVEY
Table 9.1: Characteristics of overseas nurses............... 261
Table 9.2: Returned questionnaires as a percentage of each organisation........................................... 262
Table 9.3: Number of years spent working in the NHS...... 263
<table>
<thead>
<tr>
<th>Table 9.4:</th>
<th>Number of years spent working in their country of origin</th>
<th>264</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 9.5:</td>
<td>Participating countries</td>
<td>265</td>
</tr>
<tr>
<td>Table 9.6a:</td>
<td>The relationship between belief about applicants being refused jobs and ethnicity</td>
<td>267</td>
</tr>
<tr>
<td>Table 9.6b:</td>
<td>The relationship between applying for promotion, success and ethnicity</td>
<td>268</td>
</tr>
<tr>
<td>Table 9.6c:</td>
<td>The relationship between refused promotion and organisations</td>
<td>268</td>
</tr>
<tr>
<td>Table 9.6d:</td>
<td>The relationship between bypass for promotion and racial features</td>
<td>269</td>
</tr>
<tr>
<td>Table 9.6e:</td>
<td>The relationship between being bypassed for promotion and organisations</td>
<td>269</td>
</tr>
<tr>
<td>Table 9.6f:</td>
<td>The relationship between equal opportunity policies and ethnicity</td>
<td>270</td>
</tr>
<tr>
<td>Table 9.6g:</td>
<td>The relationship between equal opportunity policies and organisations</td>
<td>271</td>
</tr>
<tr>
<td>Table 9.6h:</td>
<td>The relationship between the perception of opportunities to be given to white British nurses and ethnicity</td>
<td>271</td>
</tr>
<tr>
<td>Table 9.7:</td>
<td>The relationship between skills acquired from overseas and ethnicity</td>
<td>272</td>
</tr>
<tr>
<td>Table 9.8:</td>
<td>The relationship between training courses and Grades</td>
<td>274</td>
</tr>
<tr>
<td>Table 9.9a:</td>
<td>The relationship between perceived discrimination and ethnicity</td>
<td>276</td>
</tr>
<tr>
<td>Table 9.9b:</td>
<td>The relationship between aggressive white British nurses and organisations</td>
<td>277</td>
</tr>
<tr>
<td>Table 9.9c:</td>
<td>The relationship between being treated differently by managers and ethnicity</td>
<td>278</td>
</tr>
<tr>
<td>Table 9.9d:</td>
<td>The relationship between different treatment by doctors and ethnicity</td>
<td>278</td>
</tr>
<tr>
<td>Table 9.9e:</td>
<td>The relationship between deliberate bypassing of overseas nurses of patient information</td>
<td>278</td>
</tr>
</tbody>
</table>
Tables

and ethnicity......................................................... 279
Table 9.10: The relationship between age and perceived discrimination................................. 280
Table 9.11a: The relationship between feeling supported and Ethnicity........................................... 281
Table 9.11b: The relationship between feeling supported and Organisations........................................ 281
Table 9.11c: The relationship between the quality of support, guidance and ethnicity....................... 282
Table 9.11d: The relationship between quality of support, guidance and organisations........................ 282
Table 9.11e: The relationship between support systems, processes and ethnicity............................. 283
Table 9.11f: The relationship between support systems, processes and organisations.......................... 284
Table 9.12a: The relationship between satisfactory information on adjusting and ethnicity...................... 286
Table 9.12b: The relationship between adjusting to a new environment with assistance from white British nurses and ethnicity................................................................. 287
Table 9.12c: The relationship between sufficient time to adjust to procedures, methods and ethnicity............ 287
Table 9.12d: The relationship between sufficient time to adjust to procedures, methods and organisations........... 288
### Figures

<table>
<thead>
<tr>
<th>CHAPTER 2: SYSTEMATIC REVIEW THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 2.1: Stages of the review process</td>
</tr>
<tr>
<td>Figure 2.2: Databases searched</td>
</tr>
<tr>
<td>Figure 2.3: Hierarchy of evidence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 6: DATA ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 6.1: The hermeneutic circle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 7: FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 7.1: The phenomenological journey of overseas black and minority nurses</td>
</tr>
<tr>
<td>Figure 7.2: Being thrown into an unfamiliar world</td>
</tr>
<tr>
<td>Figure 7.3: Encountering marginalisation and experiencing Inequalities in the world</td>
</tr>
<tr>
<td>Figure 7.4: Surviving in an everyday world</td>
</tr>
<tr>
<td>Figure 7.5: Living in an everyday world</td>
</tr>
<tr>
<td>Figure 7.6: Making a new world</td>
</tr>
</tbody>
</table>
CHAPTER 2: SYSTEMATIC REVIEW PROCESS

Appendix 1: Alexis, O. and Vydelingum, V. (2005):
Overseas black and minority ethnic nurses:
a systematic review ......................................................371

Appendix 2: Search terms and databases searched ......................387

Appendix 3: References perceived as relevant for the
Literature review ......................................................390

Appendix 4: Methodology of the literature reviewed ..................392

Appendix 5: The CASP tool ...........................................409

Appendix 6: Oxyman and Guyatt’s (1991) framework ...............414

CHAPTER 5: RESEARCH DESIGN AND METHOD

Appendix 7: University of Surrey Ethics Committee approval
Letter .............................................................................416

Appendix 8: North and Mid-Hampshire Ethics Committee
approval letter for the face-to-face interviews ...........419

Appendix 9: Main interview proforma .........................................422

Appendix 10: Information sheet for overseas nurses for the
face-to-face interview ..................................................425

Appendix 11: Face-to-face interview consent form ...............429

Appendix 12: Main focus group interview proforma ...............432

Appendix 13: Focus group interview consent form .......................435

Appendix 14: North and Mid-Hampshire Ethics Committee
approval letter for the focus group interview .............438

Appendix 15: Information sheet for overseas nurses for the
Focus group interview ..................................................440

CHAPTER 6: DATA ANALYSIS

Appendix 16: Interview with person J ...............................................444

Appendix 17: Focus group interview one .........................................458

CHAPTER 9: THE SURVEY

Appendix 18: Alexis, O. and Vydelingum, V. (2004): The lived
experience of overseas black and minority ethnic
Appendices

nurses in the NHS in the south of England...........474

Appendix 19: The experiences of overseas black and minority
ethic registered nurses in an English hospital........483

Appendix 20: Information sheet for overseas nurses for the
survey.................................................................498

Appendix 21: Overseas nurses cover letter for the survey........503

Appendix 22: Consent form for the survey........................505

Appendix 23: North and Mid-Hampshire Ethics Committee
Approval letter for the survey..............................508

Appendix 24: Final questionnaire................................510

Appendix 25: Questionnaire evaluation sheet..............529
Chapter One

Introduction

1.1 Background

Recruiting and retaining nurses in the National Health Service [NHS] is not a new phenomenon. Over the past five decades, as early as the 1950s, nurses have been recruited to alleviate the acute labour shortage inherent within the NHS. It has been widely documented (Baxter 1988, Sen 1970, Abel-Smith 1960) that many hospitals in the United Kingdom [UK] had relied on recruiting Irish nurses. However, the numbers employed were gradually declining, so the NHS turned its attention to recruiting black and minority ethnic nurses from many Commonwealth countries such as the West Indies, some African countries, Singapore, Malaysia, and Mauritius.

Despite this early recruitment drive, the NHS was once again facing an acute labour shortage in the 1960s and 70s. It was therefore important to recruit nurses not only from the Commonwealth countries but from the Philippines as well (Baxter 1988). This was done in order to avert this crisis. The number of nurses recruited in this way peaked in the late 1970s and thereafter gradually reduced. However, due to demographic changes such as continuing fall in birth rates in the United Kingdom’s population in the 1990s and inconsistent service planning, another labour shortage was created that affected staffing in a range of professions particularly nursing (Carlisle 1996, Goodin 2003 and Buchan 2003).

Although the factors identified have contributed towards a reduction of nurses in the labour market, several other factors have been suggested to explain the current
nursing shortages. Firstly, The King’s Fund Report titled: The Last Straw: Explaining the NHS Nursing Shortage, (Meadows et al. 2000) reported that the workforce was demoralized and frustrated and these resulted in a number of nurses leaving the profession. Moreover, the report identified low pay, poor working conditions, staff shortages, racism, harassment, insufficient employee-friendly policies, a rigid hierarchical structure and the lack of training opportunities as key contributing factors (Meadows et al. 2000). These problems were further compounded by changes in society, which led to a gradual decline in the status of the nursing profession (Bradshaw 1999). In the past 50 years the value of public service has been replaced by a desire to earn a more lucrative salary in the private sector (Finlayson 2002). The King’s Fund Report concluded that the NHS could no longer rely on loyalty and commitment to keep nurses in jobs. The difficulties in retaining nurses posed as great a problem as the recruitment crisis (Meadow et al. 2000).

Secondly, the NHS reforms and the introduction of the internal market instigated by the last Conservative government in the eighties and nineties created a move towards an employer-led system to determine the intake of students for nurse training (Buchan and Edwards 2000). The involvement of Trusts was welcomed but the narrow focus, varying capacity of local training and education consortia and the lack of a national overview resulted in an underestimation of the required staffing numbers (Buchan and Edwards 2000). The effect of such planning was a marked reduction in the number of student nurses’ training in the NHS, for example in 1984 there were 75,000 student nurses but by 1994 that number was halved (Buchan and Edwards 2000).
Thirdly, the NHS, as an essential service operates twenty-four hours a day, seven days a week and has often operated inflexible working hours for staff. The unsocial nature of the duty-systems is generally incompatible with family life and given the demography of the nursing workforce, mainly female dominated, contributes to the existing shortage of nurses (Couch 2003, Bradshaw 1999, Seccombe and Smith 1997). Furthermore, it is estimated that sixty percent of nurses care for dependent children or adults and yet, the majority of nurses either do not have access to childcare facilities at the workplace or cannot afford them (RCN 1999). These issues have further compounded the shortfall of nurses in the NHS.

In 1997 there were over 648,000 nurses, midwives and health visitors registered with the Nursing and Midwifery Council [NMC]. In March 2000 this number had decreased to 634,000. However, in 2004 there were over 660,000 nurses, midwives and health visitors registered with the NMC (NMC 2004). Despite the rise in the number of health care professionals registered with the NMC the underlying trend is towards an ageing population of nurses in the UK. Today only thirteen percent of nurses are under thirty and fifty-eight percent are over forty. These statistics point to an increasingly ageing workforce and suggest that the NHS would need to provide more trained nurses to fill the gap in the labour market (Warner 1999, RCN 2002a, Mullen 2003 and Ball and Pike 2004).

In 2002, an Audit Commission (2002) report drew attention to the seriousness of the workforce shortage asserting that the biggest constraint the NHS faces is no longer a shortage of financial resources, but a shortage of human resources, for example, doctors, therapists and other health care professionals particularly nurses. Indeed, the
Department of Health has therefore recognised that nursing shortages have become a significant factor constraining health care delivery in the NHS in the United Kingdom (UK). In order to address this current issue, the Department of Health has stated that international recruitment is part of the solution to meet its staffing targets: ‘We shall build on our successes in recruiting staff, particularly nursing staff from abroad to help us, in the short term at least, to deliver the extra staff we need to deliver the NHS Plan’ (DoH 2001a: 3).

In addition, the Department of Health has funded a number of advertising campaigns to attract ‘returners’. Moreover, the government has acted by increasing the intake of nursing students and has attempted to make the working lives and conditions in the NHS more attractive (DoH 1999, DoH 2000b and DoH 2000c). However, it will take a while before ‘returners’ and students make an impact in increasing the workforce. In addition to these current initiatives, the Department of Health had also set an additional target of 20,000 (DoH 2000a) whole-time equivalent nursing posts to be met by 2004. This was done in order to reduce the acute labour shortage in the NHS. However, this target for nursing was initially an extra 20,000 which has since risen to 35,000 by 2008 (DH 2004). Although the initial target has been met, there still remains an acute shortage of nurses in the NHS (Pearson et al. 2004 and Buchan and Seccombe 2005).

In order to address the acute workforce shortage inherent within the NHS, it was therefore fundamental to recruit internationally, particularly black and minority ethnic nurses from developing countries. A number of hospitals embarked upon this initiative and were able to recruit a high proportion of overseas nurses to work in the
NHS. This recruitment drive was seen as a ‘quick fix’ to avert the acute labour shortage, however, despite what critics might think, the recruitment of black and minority ethnic nurses has remained high on the policy agenda and is fundamental to most hospitals in the UK (RCN 2003).

Given that the NHS is a major employer of black and minority ethnic nurses in the UK, there has been little research or data on how they had fared in the NHS (Akinsanya 1988). It was not until after the enactment of the Race Relations Act (1976) that the issue of racial discrimination in the NHS could be legally addressed. Moreover, it was not until 1992 that a large-scale national study of the careers of minority ethnic nurses, commissioned by the Department of Health, was undertaken (Beishon et al. 1995). Evidence relating to experiences from previous years has been fragmentary, yet suggested that many nurses had suffered injustices and inequalities (Thomas and Morton-Williams 1972, Hicks 1982a, Baxter 1988, Ward 1993). Indeed, small-scale qualitative studies have painted a very bleak picture, highlighting the difficulties that these nurses faced at all stages of their careers (Baxter 1988, Lee-Cunin 1989).

1.2 Rationale for the study

The Department of Health regards international nursing recruitment as a sound and legitimate contribution to the development of the NHS workforce. It is committed to the ethical principles and effective recruitment of all overseas nurses as seen in the publication of the Code of Practice for International Recruitment (DoH 2001b). Not only is the Department of Health interested in the legitimate recruitment of overseas nurses but also the Royal College of Nurses [RCN] as well. Therefore, the RCN
(2005) as a professional organisation representing nurses, has also published a good practice guide to facilitate employers in their recruitment practices but more importantly to enable these organisations to be legitimate in their recruitment drive of overseas nurses. In the past there have been numerous ‘anecdotal reports and media accounts of the treatment of overseas black and minority ethnic nurses’ (Edwards 2001: 24), for example, ‘some nurses arrive on these shores hoping for a better future, only to find, they are cynically exploited by agencies and employers’ both in the NHS and the independent sector (Kenny 2001: 7).

Furthermore the growth in recruitment of overseas black and minority ethnic nurses has attracted much media publicity and concerns from various quarters, and has led to some inquiries and studies into the problem (Taylor 2005, Matiti and Taylor 2005 Allan et al. 2004). However, such studies, although important in their exploration of overseas nurses’ experiences in the NHS, have had a propensity to be small scale, using qualitative designs. They have tended to focus on the recency of experiences in the light of nursing in a foreign country (Allan and Larsen 2003 and Daniel et al. 2001). No studies have specifically explored the experiences of overseas nurses’ in the NHS in the south of England using both qualitative and quantitative approaches within a phenomenological framework.

Therefore, as black and minority ethnic nurses are becoming an important part of the workforce, it is particularly crucial to find out about their experiences of working in a culturally diverse NHS and their subsequent adjustment to a new nursing system in a culture that is so different. Moreover, what challenges, if any, do they face and what effects might these have on their morale and performance? As there is very little
research that addresses the aforementioned areas, there is, therefore, no foundation on which to assess how their needs may best be met in the light of the current climate. This makes it even more important to find out about the experiences of overseas black and minority ethnic nurses in the NHS.

This study seeks to explore, describe and develop a greater understanding, through a Heideggerian hermeneutic phenomenological approach, of the lived experience of overseas black and minority ethnic nurses from culturally diverse backgrounds. By identifying the strengths and limitations of the areas where this study was conducted the findings may be of interest to nursing organisations, policy makers and employment bodies such as NHS Trusts and Independent Hospitals, at a time when the nursing workforce shortages are high in the UK.

1.3 Aims of the study

To explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses who are working in the National Health Service in the south of England.

1.4 Research question

Having made the decision to have an in-depth intensive study based on overseas nurses as the focus of this research, this has led to the development of the following research question:

*What are the experiences of overseas black and minority ethnic nurses working in the NHS in the south of England?*
The above question gave rise to the following subsidiary questions:

- To what extent do such nurses feel welcomed and integrated as part of the health care team within the NHS?
- How have their working lives been affected by working within the NHS?
- What challenges do they face whilst working for the NHS?
- To what extent are the findings applicable to the wider population of overseas black and minority ethnic nurses?

The study utilised three methods to obtain data. The fieldwork for both the face-to-face and focus group interviews took place over a period of fifteen months in a District General Hospital in the south of England. This work involved interviewing twelve overseas black and minority ethnic nurses who were trained in their country of origin (see pages 116-117 for the inclusion criteria). This was followed by conducting four focus group interviews and each focus group contained six overseas nurses thus giving rise to a total of twenty four nurses. The findings from both the face-to-face and focus group interviews informed the final phase of this study, which was a survey. Data for the survey were obtained from a number of hospitals in the south of England and this occurred within six months. All names utilised were changed to protect anonymity and confidentiality of the participants and hospitals involved in this study (Data Protection Act 1998).

1.5 Alternative approaches for this study

My initial inclination was to conduct both a phenomenological and ethnographic study of the experiences of overseas black and minority ethnic nurses. However, having discussed this with my supervisor, peers and after having reviewed the
literature, the idea of an ethnographic approach was rejected. This was because the notion of ethnography, 'is concerned with understanding culture and learning from that culture' (Spradley 1980: 3). Furthermore one of the goals of ethnography is to make explicit, through observation, what is implicit within a culture. Cultural knowledge requires an understanding of the people, what they do, what they say and how they relate to one another and what their customs and beliefs are (Spradley 1980). I felt that since I wanted to know about the meanings black and minority nurses attributed to their experiences whilst working in the NHS, this methodology was not suitable for exploring experiences.

Indeed, grounded theory was an alternative approach considered to investigate the experiences of overseas black and minority ethnic nurses in the NHS. Both Barney Glaser and Anselm Strauss who developed grounded theory in the sixties (Streubert and Carpenter 1999), were sociologists from the Chicago school and their work was an antidote to the predominance of quantitative methods at that time. The development of grounded theory revolutionised sociological research, which had begun to minimise the importance of field studies in favour of precise quantitative data. It is a research strategy that uses a systematic inductive approach to collecting and analysing data and using that data, generates theoretical frameworks or middle range theories.

Grounded theory seeks to explain variation and captures the basic social processes, thereby accounting for the issue studied. The researcher needs to be informed by, but hold in abeyance, all other literature on the issue under focus and aims to allow the theory to emerge from the data (Spradley 1980). To begin with the research area is
only broadly defined to allow what is relevant to emerge rather than what is predetermined. As usual in all qualitative research the sampling is purposeful, aiming for maximum diversity to illustrate natural variations in social processes.

An important aspect of grounded theory is theoretical sampling; a small sample is taken then data analysis begins, the concepts emerging from that data inform the next sampling frame. Thus data collection and analysis proceed in tandem, each informing the other. In analysis the researcher looks for similarities and differences, using a constant comparative method and codes accordingly, later developing codes into categories and patterns, themes and processes that become context bound substantive theory, rather than abstracted formal theory (Streubert and Carpenter 1999).

I had intended to use grounded theory as the procedures and techniques are clearly described, and the detailed coding appears to ensure that the process is as rigorous as qualitative research can be. It was also a ‘friendly’ approach to a health setting more used in quantitative research. Theoretical sampling, with its cyclical system of interviews, preliminary analysis, further interviews and further analysis seemed to be a useful strategy for moving the research onto a deeper level, maximising the variety of experiences covered in the study, and ensuring flexibility. However, the more I read, the less the approach seemed suitable to study the lived experience of nurses or to achieve the aims set. Although both ethnography and grounded theory would have been fascinating methodologies to use, I felt that due to the nature of the aims and subsequent questions, these approaches were not suitable. In view of the aforementioned information, I decided that a Heideggerian hermeneutic
phenomenological approach was the most appropriate methodology given the aims of this study.

1.6 The research approach for this study

In order to gain a greater understanding and insight into the experiences of overseas black and minority ethnic nurses working in the NHS, it was essential to use a research method that would best suit the research question. Qualitative methodology, in particular phenomenology, was seen as the most appropriate approach, as it offered a methodological and philosophical perspective whose purpose is to develop a greater understanding through description, exploration, reflection and awareness of the many meanings attributed to lived experience (van Manen 1984).

Phenomenology does not impose structures such as hypotheses, or attempt to explain, predict and control the world through generation of empirical facts and scientific generalisations. Instead it aims at gaining an insightful understanding and description of human experiences by bringing the researcher into closer contact with those experiencing a phenomenon. Thus phenomenological inquiry takes into account the meanings individuals attribute to a situation. This is considered extremely important because as a researcher I needed to understand the meanings my participants attribute to their experience of working in the NHS as overseas black and minority ethnic nurses.

This particular phenomenological approach utilised in this study was hermeneutic phenomenology informed by the ideas of Heidegger (1962). The decision to use this approach as identified earlier, was guided by my research question, which is
concerned with the experiences of overseas black and minority ethnic nurses in the NHS. Such an approach is invaluable, as it will enable me to explore a phenomenon from the participants’ perspective. By exploring this phenomenon, a greater understanding and awareness of the meaning participants attribute to their experience is achieved. Through a hermeneutic phenomenological approach and as a black researcher, I would be able to reveal how the participants experience the phenomenon and would be able to generate an understanding of this experience from an interpretation of the interview texts provided by the study participants.

1.7 Combining both qualitative and quantitative methods: The rationale

Both qualitative and quantitative research methods have been used to enhance the study on the experiences of overseas black and minority ethnic nurses in the NHS in the south of England. In the research field, it is widely known that social scientists will utilise either qualitative research methods or quantitative but rarely combine the two (Foss and Ellefsen 2002). However, it has been found that qualitative results are often used to facilitate quantitative methods and there are arguments that both qualitative and quantitative approaches should be used in future studies (Abu et al. 2001 and Johnson et al. 2001, Bourgeois 2002 and Kinn and Curzio 2005). This is because both qualitative and quantitative approaches increase the body of knowledge.

A mixed method approach was used in this study because no other research had adopted this type of method to studying the experiences of overseas nurses. Using this approach through methods triangulation might strengthen the study. The phrase methods triangulation refers to comparing data collection through qualitative methods
with that of quantitative (Foss and Ellefsen 2002) thus providing a multifaceted view of the chosen topic under investigation.

1.8 Reason for the survey

Since the aims of this study were to describe, explore and develop a greater understanding of the experiences of overseas black and minority ethnic nurses in the NHS in the south of England, throughout this thesis this could best be done by investing most energy in phenomenology as this approach sought to examine in detail some people’s experiences as they live and interact within their social world (Crotty 1998) particularly that of the NHS. Since the qualitative approach could only concentrate on a small number of overseas nurses in a particular setting, it was necessary that a quantitative approach be adopted to determine the extent to which the findings were applicable to the wider population of overseas black and minority ethnic nurses in the south of England. Thus a survey was planned as the third integral part of this study.

It was the intention that this survey should derive from, and be closely related to, the findings from both the face-to-face and focus group interviews rather than be a separate study conducted in isolation of overseas nurses’ experiences. This survey seeks to explore the following specific questions:

- How do overseas black and minority ethnic nurses perceive equal opportunity in the NHS in the south of England?
- How do overseas black and minority ethnic nurses perceive their opportunities for skill development and training?
Chapter One

Introduction

➢ Do overseas black and minority ethnic nurses perceive discrimination to be evident in the NHS in the south of England?

➢ To what extent is support available for overseas black and minority ethnic nurses within the workplace?

➢ To what extent do overseas black and minority ethnic nurses perceive their adjustment to a new environment?

No previous survey had explored the aforementioned questions and because of this, it was important to find out from overseas nurses about their experiences from a wider geographical area, particularly the south of England. The postal survey aimed to increase the body of knowledge on overseas black and minority ethnic nurses and such findings could be made more applicable to the larger population of which overseas nurses are a part of.

Within this thesis is a description of the design of the survey, which can be found in Chapter 9. This chapter will also outline how the data were collected, analysed and how the findings were derived, followed by a discussion of the results. These will provide the reader with a greater insight into the experiences of overseas nurses. The following section will now explore the author's biography and position within this study.

1.9 The black researcher

When I started my initial research on the experiences of overseas black and minority ethnic nurses working in the NHS, I thought I could ignore my own social position, but I soon realised that this had an impact on the research process. In entering the
world of the participants, I was considered as someone who held ‘a white middle class job’ and I found that some participants were constantly reminding me of my position, such as, ‘you have advanced, haven’t you?’ I kept reflecting on what they meant by this. To me I was a black person with similar racial features and this I thought had given me the opportunity to enter their world but how wrong was I?

For a while I grappled with this view in an attempt to understand why I was seen as an outsider and that created some difficulties for me as a black researcher. I needed to examine myself critically to determine whether I had any distinguishing characteristics that contributed towards the view some participants held about me as being an outsider. So, in order to breakdown this barrier I began to explain quickly my nursing career and how I became a nurse and a lecturer. They appeared to be fascinated by what I had said, how I had progressed in the NHS and in higher education. I felt that in order to develop trust and to capture their experiences and interpret their world from their perspectives I needed to give a little of myself.

Stanfield (1994) argues that only those researchers emerging from the life worlds of their participants can adequately capture their experiences. Indeed, I felt that initially I was unable to capture their ‘lived world’ because there was limited trust between participants and myself. However, once we overcame this and developed trust, they quickly delved into their experiences and offered lots of insightful information on how they were perceived in the NHS in the south of England.

On reflection, I realised that my social position initially had impacted on my ability to enter the world of my participants and I was naive to assume that because of my black
Chapter One

Introduction

racial features this had given me the opportunity to enter their world. However, once I
overcame this by explaining my social position and developed a trusting relationship
with them, I was no longer seen as an outsider. To me I felt that I had projected a kind
of racial solidarity and no doubt this connection had allowed me to enter their world.
Furthermore, I felt that they realised that I might be supportive of their views and
would understand what it was like to be marginalized and be of the ‘other’ in a
country that was so different from their own.

1.10 Reasons for migration

There are a number of reasons given in the literature to explain why health care
professionals, particularly nurses, migrate and these issues have been at the forefront
of international policy debate since the late 1990s (Chanda 2002, Martineau et al.
and the availability of sufficient, well-qualified and motivated staff is a key factor in
maintaining an effective health care service. Staff shortages, particularly in developed
countries, have been a factor constraining healthcare delivery. Given these factors,
international recruitment has increasingly become a solution to the shortage of
nursing skills in many countries. Nurses have migrated to many different countries to
work. However, there are a number of factors that influence nurses’ movements from
one country to another namely the equilibrium perspective, the ‘push’ and ‘pull’
factors.

One of the perspectives identified in the literature is the equilibrium perspective. This
perspective asserts that migrants are thought of as logical individuals who base their
migration decisions on a careful consideration of the various costs and benefits
associated with migration to a particular place (Georges 1990). On the other hand, there are also structural factors that influence individual migration decisions such as the push and pull factors. The push factors include pressures that build up within the labour market of the sending country such as high unemployment rates, poor pay and benefits and few professionals. These factors often put tremendous pressure on individuals particularly more recently on nurses to migrate so that they can take advantage of the occupational opportunities that exist elsewhere (Kline 2003, Chappell and Di-Martinto 2000, Wilson 1985).

While some factors combine to provide an element of pressure that 'pushes' individual migrants away from their home countries, receiving countries also act by attracting these individual migrants. For example, the advanced economies of the United Kingdom, United States of America and other western countries have an abundance of high paying opportunities that serve to 'pull' migrants to these advanced labour markets (Kline 2003, ICN 2000, ILO 1998). However, there is a lack of comprehensive and empirical studies on the reasons why nurses migrate (Buchan and O'May 1999). What is known is that there is widespread consensus that nurses have migrated in search of incentives and better opportunities. Nurses are genuinely motivated and have been encouraged to strive for personal and professional development. Nurses will actively seek positive learning experiences, both theoretical and practical to enhance their skills and knowledge and these may become their personal goals (Van-Lerberghe et al. 2000, Kingma 2001, Mercer 1999).

As the identified factors are evident in the NHS in the UK, nurses from the Philippines, Caribbean, Africa and Asia are attracted to these. Thus they would seek
these opportunities in order to enhance their social and financial positions. Throughout the world, health care training although different, has common value of caring. However, a number of training health care systems throughout the world are different in comparison to UK health care training and therefore some nurses recruited from overseas are subject to adapt in order to practice as registered nurses in the NHS in the UK.

1.11 Adaptation programme

All nurses trained overseas are required to obtain admission to the register of the Nursing and Midwifery Council [NMC] before practising as registered nurses. The NMC's decision to ask a nurse to undergo a period of adaptation or supervised practice before being admitted to the register is determined by the training and education undertaken in their home country (RCN 2002b). The length of the NMC determined programme could vary from four weeks to six months. Not all overseas nurses are asked to undertake a period of supervised practice. Nurses who belong to the European Union, Commonwealth countries, America and Canada are exempted because their training is considered to be similar to that of the UK (RCN 2002b).

The adaptation or supervised practice courses vary in their design. However, the overall aim of the programme is to enable the supervised practice nurse to achieve NMC registration through a process of professional development and assessment of safe and effective competence. The adaptation or supervised practice programme consists of a theoretical component and a clinical placement. The theoretical element provides an opportunity for overseas nurses to become familiar with both the health care provision in the UK and the local policies and practices. The clinical placement
means it is possible to assess a nurse’s clinical competence under supervision and ensure that he/she is able to deliver safe and effective care (DoH 2001c)

During the adaptation programme, overseas nurses are allocated mentors who are responsible for guiding, supporting, assessing and ensuring that overseas nurses’ needs in the learning contract are met. The commitment of the mentors is paramount to overseas nurses successfully completing the adaptation or supervised practice programme. Once this is completed, they are able to apply for registration to work in the UK and this is done through their employers. Processing the applications can sometimes take a while but once these applications are processed by the NMC, the ‘adapted’ nurses are able to practice in any hospital in the UK.

1.12 Sociological concepts related to the study

This section will provide a discussion and will attempt to clarify the concepts used within this study. It will also draw on contemporary and seminal literature to highlight the complexity in conceptualising some of these perspectives and will illustrate how these have been used within the academic world. Clarification of terms such as ethnicity, race, minority, minority ethnic, black and overseas nurses will enable the reader to better understand the context in which these terms are used throughout the thesis.

1.12.1 Ethnicity

In contemporary writings, the term ethnicity seemed to lack academic rigour. For many researchers the definition of the term ethnicity appeared to be constantly changing with time (Bhopal and Rankin 1999, Wallman 1979). According to Jenkins
Chapter One

Introduction

(1997) the term ethnicity has many basic elements to it. It is about cultural
differentiation but also it is centrally concerned with culture and it creates a social
identity. Jenkins adds that people are not born with an ethnic element, it is a complex
repertoire which people experience, use and do in their daily lives within which they
construct an ongoing sense of themselves and an understanding of their counterparts.

The concept of ethnicity is also referred to individuals who are thought of as different
from that of the majority group. In the UK, ethnic identity is not generally attributed
to white British people but only at minority groups who are considered to have an
ethnicity (Mason 2000). This suggests that there is a denial of their own ethnicity
which is an indication of their distinct myopia view of the world. Ethnicity is socially
constructed and there is no agreed definition on what constitutes ethnicity, however, it
usually includes cultural practices, beliefs, values and attitudes that characterises a
given group and it is because of these common characteristics that distinguish one
group from another (Mason 2000, Webb 1969). As with ethnicity, the term race is
socially constructed and this will be explored next.

1.12.2 Race

The concept of race emerged, in recognizably modern form between the end of the
18th and the middle of the 19th centuries (Malik 1996, Van den Berghe 1967). Like
ethnicity, the term race is fraught with definitional difficulties. The debate
surrounding the relationship between ethnicity and race is still controversial (Mason
between race and ethnicity as a ‘quibble’ by arguing that the phenotype or physical
appearance is just one potential ethnic boundary marker among many. Furthermore,
Wallman (1986) contends that, classifying people in terms of race is inherently suspect because it is almost inevitably tied up with bogus biology and psychology and almost presupposes an assumption that some races are superior to others.

Similarly, Miles (1993) argues that race is an ideological construct and contends that its use by social researchers serves to legitimise it, giving comfort to those who would still wish to maintain that there are indeed real biological differences between groups of humans. Miles thus further adds that there are no races, biological or social. There are however, social processes through which social relationships become racialized.

Yet, despite the fact that there are no races, the term has not disappeared from sociological writing (Phillips and Dreudahl 2003). Many have found the persistence of the concept in political and popular discourse impossible to ignore (Mason 2000 and Ratcliffe 1991). Nobles (2000) argues that, racial categories are intellectual products and policy tools that have been forged through mechanisms of colonisation, immigration and other political projects. Similarly, Mason (2000) contends that the term race has been used to characterise the social relationship between different ethnic groups for example the unequal distribution of power and resources and this has been utilised by the dominant group in their efforts to protect their positions of power.

1.12.3 Minority

The term minority is generally used in education, particularly in the United States of America to denote and distinguish the minority culture from the majority. In the UK, it usually refers to individuals who are racially and culturally different from the majority groups. Moreover, it is defined as groups of people who are seen as
subordinates irrespective of their relative size and are regarded as powerless (Mason 2000).

1.12.4 Minority ethnic

In the UK the concept ‘minority’ is usually qualified with the term ethnic. Although the phrase minority ethnic refers to a group of people whose origins lie in countries other than the UK, there are some distinct groups that are not considered as belonging to this category. Groups such as Polish, Italian, Greek Cypriots and Jews, though they are in the minority in the UK, they are not seen as ethnic minorities. This seems to suggest that groups of people are classified as minority ethnic if their racial features are non-white. This essential characteristic for membership as minority ethnic demonstrates the power imbalance within the social structures of the UK as the majority can decide on those who belong or not to minority ethnic groups (Sheldon and Parker 1992, Modood et al. 1997 Mason 2000). Although South Asians do not consider themselves as belonging to any minority ethnic groups, for the purposes of this study they will be regarded as minority ethnic.

1.12.5 Black

The term ‘black’ was derived by those who were keen to stress the commonalities in their experience of oppression of all minority ethnic groups. (Mason 2000). In the 1970s and 1980s the term acquired a considerable popular usage. More recently this term has been challenged because people from the Indian subcontinent do not readily define themselves as ‘black’ (Modood 1998).
Although this term ‘black’ has been challenged vociferously, it will be used to describe people whose racial features are not white. Furthermore, it is also appropriate to refer to all those who are victims of the exclusionary practices of white racism (Mason 1990a). Moreover, it will be used as a political term to identify people of African and Afro-Caribbean descent. As identified above, the term ‘black’ is difficult to define but for the purpose of this research, it will refer to nurses whose racial features are ‘non-white’ but are not South Asians.

1.12.6 Overseas nurses

The term overseas nurses refers to nurses who have trained, worked and registered in their country of origin and have migrated to the UK to work in the NHS. These nurses will have racial features that are ‘non white’. Although it is acknowledged that there are many white overseas nurses, such a group does not form part of the sample within this study.

Throughout this research the terms, black and minority ethnic will refer to nurses who ultimately originate from overseas and whose racial features are non-white. In academic circles it is difficult to speak about black without referring to minority ethnic groups or vice versa. It is widely believed that many proponents such as Mason (2000) and Ahmad (1993) will object to homogenised black and minority ethnic as a single group. However, this is done because their experiences of being non-white might be similar regardless of their black and or minority ethnic backgrounds. Furthermore, white nurses in dealing with overseas nurses from black and minority ethnic backgrounds may not always recognise cultural differences and may treat them
the same as long as their racial features are similar and to attempt to differentiate at this level will not be beneficial.

Finally, the terms minority ethnic and black are fraught with definitional difficulties. It is felt that due to the enormity of this subject and the limited information available on overseas black and minority ethnic nurses it is reasonable to categorise both black and minority ethnic nurses' experiences as a homogenised group. The terms overseas nurses and black and minority ethnic nurses will be used interchangeably to mean the same thing. The subsequent section will discuss the relevance of ethnic data to this study.

1.13 Ethnic data collection

This section will briefly highlight the number of overseas nurses to include black and minority ethnic nurses who have been recruited to work in the United Kingdom and have registered with the Nursing and Midwifery Council [NMC]. It will also outline the different ethnic groups of black and minority ethnic nurses who are working in the NHS in the south of England.

1.13.1 Admissions of overseas nurses to NMC register

The recording of ethnic data is seen as important however, some proponents such as Sheldon and Parker (1992) are sceptical of the political nature of this. They have argued about the extent ethnic data have succeeded in combating disadvantage and discrimination. It has been proposed that what needs to be seen is a radical change of political will rather than only the collection of statistical evidence (Ahmad 1993).
Unpublished data of the number of overseas nurses recorded on the NMC register is identified overleaf [see table 1.1 overleaf]. However, the data may not reflect the number of nurses who are actually working in the NHS. This is because nurses may have left the NHS and migrated to the US, Australia, New Zealand or Canada to work. In the period from 1998/99 to 2001/02 there has been a threefold increase in the number of annual admissions to the NMC register of nurses and midwives originally trained outside the UK (see table 1.1 overleaf).

For the period 2001/2002 to 2004/2005 the number of nurses on the NMC register has fallen with the exception of 2003/2004 when this number increased markedly by over one thousand overseas nurses. In 2004/05, a total of 11,416 entrants from abroad were recorded on the register.

For the period March 1998 to March 2005, there are approximately over 70,000 overseas nurses on the NMC register. This number is expected to rise as long as qualified nurses are recruited from overseas. Using NMC (2005) data for the year 2004/05, the four most important source countries are: India [3,690], The Philippines [2,521], Australia [981], South Africa [933].

However, other admissions from countries such as Nigeria, the West Indies and Zimbabwe have also decreased significantly over this period. Although the number of overseas nurses on the NMC register is decreasing there are new entrants on the register from countries such as China, Sierra Leone and Singapore (NMC 2005).
The figures overleaf (see table 1.1) show the number of overseas nurses who have been recruited from the 'top twenty seven' countries. These figures do not include nurses and midwives trained within the European Union.

Table 1.1: Admission of overseas nurses to the NMC register [NMC 2005]

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>30</td>
<td>96</td>
<td>289</td>
<td>994</td>
<td>1830</td>
<td>3073</td>
<td>3690</td>
</tr>
<tr>
<td>Philippines</td>
<td>52</td>
<td>1,052</td>
<td>3,396</td>
<td>7,235</td>
<td>5593</td>
<td>4338</td>
<td>2521</td>
</tr>
<tr>
<td>Australia</td>
<td>1,335</td>
<td>1,209</td>
<td>1,046</td>
<td>1,342</td>
<td>920</td>
<td>1326</td>
<td>981</td>
</tr>
<tr>
<td>South Africa</td>
<td>599</td>
<td>1,460</td>
<td>1,086</td>
<td>2,114</td>
<td>1368</td>
<td>1689</td>
<td>933</td>
</tr>
<tr>
<td>Nigeria</td>
<td>179</td>
<td>208</td>
<td>347</td>
<td>432</td>
<td>509</td>
<td>511</td>
<td>466</td>
</tr>
<tr>
<td>West Indies</td>
<td>221</td>
<td>425</td>
<td>261</td>
<td>248</td>
<td>208</td>
<td>397</td>
<td>352</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>52</td>
<td>221</td>
<td>382</td>
<td>473</td>
<td>485</td>
<td>391</td>
<td>311</td>
</tr>
<tr>
<td>New Zealand</td>
<td>527</td>
<td>461</td>
<td>393</td>
<td>443</td>
<td>282</td>
<td>348</td>
<td>289</td>
</tr>
<tr>
<td>Ghana</td>
<td>40</td>
<td>74</td>
<td>140</td>
<td>195</td>
<td>251</td>
<td>354</td>
<td>272</td>
</tr>
<tr>
<td>Pakistan</td>
<td>3</td>
<td>13</td>
<td>44</td>
<td>207</td>
<td>172</td>
<td>140</td>
<td>205</td>
</tr>
<tr>
<td>Zambia</td>
<td>15</td>
<td>40</td>
<td>88</td>
<td>183</td>
<td>133</td>
<td>169</td>
<td>162</td>
</tr>
<tr>
<td>USA</td>
<td>139</td>
<td>168</td>
<td>147</td>
<td>122</td>
<td>88</td>
<td>141</td>
<td>105</td>
</tr>
<tr>
<td>Mauritius</td>
<td>6</td>
<td>15</td>
<td>41</td>
<td>62</td>
<td>59</td>
<td>95</td>
<td>102</td>
</tr>
<tr>
<td>Kenya</td>
<td>19</td>
<td>29</td>
<td>50</td>
<td>155</td>
<td>152</td>
<td>146</td>
<td>99</td>
</tr>
<tr>
<td>Botswana</td>
<td>4</td>
<td>87</td>
<td>100</td>
<td>39</td>
<td>90</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>196</td>
<td>130</td>
<td>89</td>
<td>79</td>
<td>21</td>
<td>89</td>
<td>88</td>
</tr>
<tr>
<td>Nepal</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>43</td>
<td>73</td>
</tr>
<tr>
<td>Swaziland</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>81</td>
<td>69</td>
</tr>
<tr>
<td>China</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>60</td>
</tr>
<tr>
<td>Malawi</td>
<td>1</td>
<td>15</td>
<td>45</td>
<td>75</td>
<td>57</td>
<td>64</td>
<td>52</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>23</td>
<td>36</td>
<td>47</td>
</tr>
<tr>
<td>Lesotho</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>50</td>
<td>43</td>
</tr>
<tr>
<td>Japan</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20</td>
<td>37</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Singapore</td>
<td>13</td>
<td>47</td>
<td>48</td>
<td>43</td>
<td>-</td>
<td>-</td>
<td>28</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>24</td>
</tr>
<tr>
<td>Jordan</td>
<td>3</td>
<td>3</td>
<td>33</td>
<td>49</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>6</td>
<td>52</td>
<td>34</td>
<td>33</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>181</td>
<td>227</td>
<td>357</td>
<td>480</td>
<td>468</td>
<td>514</td>
<td>319</td>
</tr>
<tr>
<td>Total</td>
<td>3,621</td>
<td>5,945</td>
<td>8,403</td>
<td>15,064</td>
<td>12,730</td>
<td>14,122</td>
<td>11,416</td>
</tr>
</tbody>
</table>
1.13.2 Ethnic nurses data

The percentages identified in table 1.2 are estimates of the number of different ethnic nurses who are currently working in the NHS in the south of England. Accurate percentages were not available as the different Workforce Confederations for the south of England found it difficult to keep such data due to fluidity of nurses moving from one hospital to another. Therefore the percentages given are only estimates.

Table 1.2: Nurses, midwifery and health visiting ethnic staff employed within the south of England.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>0.5%</td>
</tr>
<tr>
<td>Black African</td>
<td>0.2%</td>
</tr>
<tr>
<td>Black Other</td>
<td>0.1%</td>
</tr>
<tr>
<td>Asian Indian</td>
<td>0.3%</td>
</tr>
<tr>
<td>Asian Pakistani</td>
<td>0.1%</td>
</tr>
<tr>
<td>Asian Bangladeshi</td>
<td>0.1%</td>
</tr>
<tr>
<td>Asian Chinese</td>
<td>0.1%</td>
</tr>
<tr>
<td>White</td>
<td>85.3%</td>
</tr>
<tr>
<td>Other</td>
<td>1.3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>12.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Department of Health Workforce Census (DoH 2001d)
1.14 Researchers engagement in this study.

This study sought the help of the researcher's supervisors. The researcher, Obrey Alexis conducted the main part of this research. However, this study utilised the expertise of key people such as Dr Vasso Vydelingum, Prof. Ian Robbins and Peter Nicholls and they were involved at one stage or another throughout the research process. As an overview Dr Vasso Vydelingum was involved in helping to design the proforma questions for both the face-to-face and focus group interviews. Dr Vasso Vydelingum, Prof. Ian Robbins and Peter Nicholls were involved in ratifying the questionnaire for the survey and they assisted in the statistical analysis. Although these key people were involved throughout various stages of the research process, it is important to note that the actual writing of this thesis was undertaken by the researcher.

1.15 The structure of the thesis

This is an interpretive phenomenological study of the experiences of overseas black and minority ethnic nurses in the NHS in the south of England. Twelve overseas nurses were involved and each shared his or her experiences with the researcher. Although each story was unique, a number of shared meanings emerged thus resulting in major themes. From these major themes a phenomenological journey was revealed based on overseas nurses' experiences of working in the NHS in the south of England.

This thesis is organised into eleven chapters. The first chapter introduces the study and the justification for why such a study should be undertaken. The background of the study is described and the justification for using Heideggerian phenomenology as
the most appropriate research methodology is explained. Chapter two discusses the process involved in undertaking a systematic review.

Chapter three provides the themes derived from the systematic review and these were used as the focus for critically analysing the literature based on the chosen study. While these studies have identified through a variety of research approaches, important factors relating to minority groups and indeed black and minority ethnic nurses, they have failed to specifically explore using a Heideggerian phenomenological approach the experiences of overseas black and minority ethnic nurses in the NHS in the south of England. This present study aims to address this topic, fill the gap in the literature and provide further dimensions based on overseas nurses particularly in the south of England.

A description of phenomenology is provided in chapter four which explains the philosophical tenets underpinning Heideggerian (1962) phenomenology and the importance of such an approach for this study. The final part of this chapter outlines the academic critiques by a number of authors concerning the use of phenomenology in nursing research.

Chapter five outlines the research process and methods utilised in this study to explore the research question. It provides a description of where the researcher is situated in the study thus reflecting Heidegger’s stance. The issue of rigour is described to highlight the importance of ensuring methodological consistency with the chosen approach throughout the entire research process. The procedures for data collection are described in detail and the ethical considerations are outlined.
Chapter six describes the analytical framework used in order to analyse the data obtained from both the face-to-face and focus group interviews. The use of van Manen's (1990) analytical framework and the hermeneutical circle are described to illustrate how the data were analysed and how themes were derived.

The findings, through a thematic analysis of overseas nurses' experiences in the NHS in the south of England are presented in chapter seven. Five major themes emerged from the data such as, ‘Being thrown into an unfamiliar world’, ‘encountering marginalisation and inequalities in the world’, ‘surviving in an everyday world’, ‘living in an everyday world’ and ‘making a new world’. These themes represent the totality of the experience from the viewpoint of overseas nurses.

The discussion of the overall findings from face-to-face and focus group interviews is provided in chapter eight. It compares and contrasts overseas nurses' perspectives with the relevant research and contributes to the existing body of knowledge.

Chapter nine discusses the survey and the importance of using such an approach. Within this chapter both the process involved in seeking approval from the various organizations and the distribution of the questionnaires to overseas nurses are described. This chapter also provides a description and development of the questionnaire. It presents the findings and discusses these in relation to the literature.

Chapter ten will present the contributions that both the qualitative and quantitative phases of this study make to the body of knowledge. Chapter eleven provides an overall discussion of the findings for both the qualitative and quantitative phases and
will include a number of implications and recommendations based on the findings for both the qualitative and quantitative phases of the study and finally, will evaluate the research process and will draw conclusions.

1.16 Summary

This section has set the scene for this study. It has illuminated why there is a shortage of nurses in the NHS and has identified many reasons for recruiting overseas nurses particularly black and minority ethnic nurses to be part of the NHS workforce. It proposes why this study is necessary particularly in the light of the current climate in the NHS. The aims, objectives and also alternative approaches are discussed. The reasons for migration, followed by a discussion of the different terminologies used within this study. Finally, this section concludes by highlighting an approximate ethnic data based on the number of nurses who are working in the NHS in the south of England. It also provides data obtained from the NMC to illustrate the number of overseas black and minority ethnic nurses who have obtained registration from the NMC for the period 1998 to 2005.
Chapter Two

Systematic Review Process

2.1 Introduction

Before undertaking any type of research it is essential to review the relevant literature to establish the current state of knowledge and to identify key issues for further exploration (Alexis and Vydelingum 2005) [see appendix 1]. This literature review has utilized a comprehensive and systematic approach. This type of approach differs from other types because it has an explicit and exhaustive literature review, with the sources and methods made clear. Therefore, this review will explore the necessary steps using Hek et al.'s (2000) framework to conduct a systematic review. The strengths and the drawbacks of conducting a systematic review in relation to overseas black and minority ethnic nurses will be highlighted.

2.2 The review process

A systematic review is defined as the application of scientific strategies that limit bias to the systematic assembly, critical appraisal and synthesis of all relevant studies on a specific topic (Evans 2004 and Greener and Grimshaw 1996). On the other hand, a literature review is prepared with the aim of providing a background or overview of the subject. The topic is typically broad and the sources of the literature are not necessarily specified. There is no attempt to obtain all papers written on the subject.

---

A paper based on this chapter has been published:
and while papers are summarized and critiqued, this is not done in a rigorous or a systematic way. This type of review is consequently subject to bias and the reviewer may include papers that support his or her views and discard those that do not (Cook et al. 1997 and Parahoo 2006). Therefore, in order to minimize this bias a systematic review was adopted.

Systematic reviews include studies that have low susceptibility to bias, and randomised controlled trial is the preferred design because it provides reliable information about the effectiveness of health care (Hek et al. 2000 and Forbes 2003). Meta-analysis is used commonly as a statistical method for summarizing quantitative studies. This term is often used to refer generally to quantitative reviews but more accurately refers to the statistical method used to combine and analyse data (Droogan and Song 1996). The process has been described as, ‘a specific methodology and statistical technique for combining quantitative data that provide a combined estimate of effectiveness of a particular treatment’ (Mulrow et al. 1997: 597).

Recent literature has stressed the importance of systematic reviews in preventing the waste of scarce research resources on projects that aim to find solutions for questions that have already been addressed satisfactorily by previous studies (Chalmers and Altman 1995 and Evans and Pearson 2001). Systematic reviews not only inform the development of research proposals but can also inform healthcare practice.

There has been a clear drive for comprehensive literature reviews in nursing (Cullum 1994) however, published reviews in nursing journals have been subjected to criticisms in recent years for a number of reasons. For example, reviews do not
Chapter Two Systematic Review Process

identify the strengths and weaknesses in primary research and non-research literature. The reviewers only use a subset of the available literature and only include published studies (Hek et al. 2000). Little of the methodology is reported and the reviewers often draw simplistic, erroneous or inaccurate conclusions from the research's findings (Cullum 1994). Therefore, to overcome the weaknesses identified earlier, a comprehensive and systematic approach was adopted. The evidence accumulated from eighty-three research and non-research papers based on black and minority groups and nurses was critically analysed, evaluated and synthesized.

There is an acute shortage of nurses in the NHS and indeed in the UK and it is unlikely that this will decrease in the future. Although some areas are being affected at different rates and in various nursing specialities, it remains largely undisputed that there is a national shortage of registered nurses both in the United Kingdom and worldwide (Goodin 2003). It is believed that the shortage of nurses is affecting the delivery of health care in many hospitals in the United Kingdom and around the world. Therefore, in order to alleviate this problem, recruiting nurses from overseas has been one of the numerous human resource initiatives employed within the NHS. For the purpose of this review it is important to identify why this study is necessary and therefore the aim of the review is outlined below.

2.3 Aim of the review

The question that this review attempts to answer is:

What is the evidence on the experiences of black and minority ethnic nurses working in the NHS and are there gaps in knowledge, methodology and theory?
2.4 Criteria for entry in the review

2.4.1 Inclusion criteria

♦ The review included both primary studies and non-research evidence published between January 1981 and December 2005. This period was selected to ensure that both up-to-date and relevant information were included. Major 'landmark' studies reported outside this time period were included if they substantially added to the discussion.

♦ The review attempted to locate literature primarily reporting on the UK population but included articles based in Europe, North America, Canada, New Zealand and Australia, if they provided additional information. These countries are thought to have cultures, healthcare and economic systems similar to that of the United Kingdom (Abel-Smith 1994).

2.4.2 Exclusion criteria

♦ Primary research and reviews that were written in languages other than English were excluded due to the expense of translation.

♦ The review excluded duplicate publications.

♦ The review excluded research from non-westernised countries because of difficulties in retrieving such information.
2.5 Developing the search strategy

The first factor that needed to be considered was the development of the search strategy. This was important because it provided a comprehensive list of published and unpublished studies for inclusion in the review. The main search took two separate approaches. The first was a computerised search including all 'hits' for overseas nurses and experiences, ethnicity, culture and associated terms related to the study. The second stage was to review the reference list from the selected articles. These two approaches were appropriate and important because the author was able to identify the relevant literature that was to be included in the review.

Hek et al. (2000) describe seven stages for searching and reviewing the literature. Therefore, these were adopted as the framework for this review (see figure 2.1).

Figure 2.1: Stages of the Review Process

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Main computerised database search</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Narrow and more focused selection</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Supplementary searching</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Management and acquisition of relevant literature</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Quality appraisal of the literature</td>
</tr>
<tr>
<td>Stage 6</td>
<td>Literature review saturation</td>
</tr>
<tr>
<td>Stage 7</td>
<td>Thematic review of the literature</td>
</tr>
</tbody>
</table>
2.6 Main computerised database search

Seventeen electronic databases were selected for inclusion in this review on the experiences of overseas black and minority ethnic nurses working in the NHS. These databases provided wide and inclusive coverage of relevant papers. Databases, other than the ones identified, were excluded, because they were not particularly relevant for this study. The databases selected are as follows (see figure 2.2).

**Figure 2.2: Databases searched**

- Medline (Jan 1966 – Dec 2005)
- PsycINFO (Jan 1995 – Dec 2005)
- Cumulative Index to Nursing and Allied Health Literature (CINAHL) (Jan 1982 – Dec 2005)
- British Nursing Index (Jan 1985 – Dec 2005)
- Caredata or Social Care online (Jan 1986 – Dec 2005)
- Cochrane Library (Jan 1994 – Dec 2005)
- Social Science Citation (Jan 1981 – Dec 2005)
- Your journals@Ovid full text (Jan 1996 – Dec 2005)
- Igenta Connect Journals (Jan 1997 – Dec 2005)
- Internurse (Jan 1995 – Dec 2005)
- Psychology and Behavioural Sciences Collection (Jan 1986 – Dec 2005)
- Zetoc (Jan 1982 – Dec 2005)
- Dissertation abstract
These databases provided wide and inclusive coverage of relevant papers. Databases such as Medline cover health and medical information while caredata [social care online] focuses on social, community and care work. Ovid online is a biomedical service that provides access to the Cumulative Index Nursing Allied Health Literature, the British Nursing Index and Medline. Igenta and the National Electronic Library for Health offer particularly good coverage of science, medicine and health. Internurse gives information relevant to nursing unlike the Index to Scientific and Technical Proceedings which provides conference papers in science and technology. The Cochrane Library covers all areas of health care and Your Journals@ovid full text provides up to thirty nursing journals electronically in full text.

PsycINFO and Psychology and Behavioural Sciences Collection databases have good sources of literature in psychology and related subject areas. Social Science Citation and Sociological Abstract databases cover sociology and related disciplines in social sciences. International Bibliography of Social Sciences provides literature on the Arts, Humanities, Social Sciences and Sciences. Zetoc provides access to the British Library’s vast resource and the Index to dissertation abstract provides information on primary research conducted in the United Kingdom.

2.7 Narrow and more focused selection

Seventeen databases were searched and many articles were considered to be relevant to this study (see appendix 2 and 3). In view of the vast number of potential articles and the time constraints, most of the terms adopted for this study were combined (see appendix 2) and used throughout the seventeen databases. This was to reduce the number of articles that needed to be reviewed. Following this lengthy process, a total
of two hundred and thirty-nine potential articles were considered relevant for this review. Once these were reviewed, the final number of papers that were selected for inclusion was seventy-three.

2.8 Supplementary searching

In addition to the main computerised database searches, many journals were hand searched for relevant articles (Magarey 2001), as it has been predicted that electronic searching would identify only half of the relevant articles (Magarey 2001). It is important to note, that only 25-50% of studies commenced are published (Hughes, 1996). Sindhu and Dickson (1997: 40) suggest that, ‘much nursing research is never seen in published journals.’ The reasons for this might include the reluctance of editors to publish studies with negative results or those with small treatment groups. Therefore accessing unpublished literature was important for this review. Unpublished literature includes, dissertation, conference papers, and discussion papers. However, these were found to be limited in information, and duplicated what had already been known on the topic. The internet was also searched for government and other national bodies’ documents using the search engine google at http: www.google.com and thirteen useful sources were identified.

The reference lists of the seventy-three articles and unpublished literature were searched and of these, ten articles were found to be relevant for this study. Supplementary searching therefore gave an overall total number of eighty-three articles relevant for this review (see appendix 4).
2.9 Management and acquisition of relevant literature

Given that seventeen databases were searched, the potential for overlap was large. Precise figures on overlap were difficult to estimate, however, it would appear that CINAHL and Medline overlapped by approximately 20-25% (Hek et al. 2000) and the majority of 'hits' in the British Nursing Index database would have been found through CINAHL and Medline. Therefore, the difficulty faced in determining the exact nature of this due to time constraints, posed a weakness in this review. However, this could be an important area to explore to determine the cost-effectiveness of the search strategy.

2.10 Quality appraisal of the literature

Assessing the validity and critically appraising the quality of the literature prior to inclusion in the review were essential for this comprehensive review. This review has identified a variety of literature, such as, surveys, literature reviews, an evaluative study, qualitative studies, discussion papers, brief reports/news, opinions/comments, and dissertation (see table 2.1). The nature of this topic and the importance of gathering any available good quality work in an area that had been widely researched, meant that all relevant literature obtained was critically appraised and included in the review. Relevant literature in books and policy documents were included because they added value to the review. However, such literature was not appraised because the appraisal criteria used were not suitable.
### Table 2.1: Types of literature contained in the review

<table>
<thead>
<tr>
<th>Survey</th>
<th>6</th>
<th>Literature Reviews</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Studies</td>
<td>1</td>
<td>Qualitative Studies</td>
<td>24</td>
</tr>
<tr>
<td>Description/Discussion/Overview</td>
<td>34</td>
<td>Experiment</td>
<td>1</td>
</tr>
<tr>
<td>Opinion/Comments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualitative and Quantitative Literature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[surveys &amp; interviews / observations]</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There are many scales and checklists that exist for the purpose of assessing the quality of the literature. However, many of these are flawed. For example, a review of 25 scales designed to assess the quality of randomised controlled trials revealed that only one had been developed following rigorous, accepted procedures to establish its psychometric properties (Moher et al. 1995). There was also considerable variation within the instruments regarding which dimensions of quality should be included, with many failing to consider external validity (Moher et al. 1995). Most instruments are not generic but focus on particular types of design (NHS Centre for Reviews and Dissemination 2001) and the vast majority is designed to assess the quality of randomised studies (Downs and Black 1998 and McDonnell et al. 2003). These frameworks could only be utilised for RCTs, therefore in view of these limitations the following frameworks were used to critically appraise the literature.

Primary research studies were appraised using the Milton Keynes Primary Care Trust Critical Appraisal Skills Programme Tool (2002) (see appendix 5 for CASP Tool). This tool was selected because it incorporated appraisal of different types of studies, for example qualitative research, and surveys. Literature reviews were appraised using
Oxman and Guyatt’s (1991) framework (see appendix 6). Literature that was neither primary nor a review was assessed for accuracy, credibility and quality using Depoy and Gitlin’s (1994) framework as outlined below. This framework was modified to include other important questions that were deemed appropriate for appraising non-primary research or non-literature review. This framework is identified below:

➢ Is the work clearly presented?
➢ Where is the knowledge generated?
➢ What is the purpose of the paper?
➢ Are there other supporting sources of evidence?
➢ What new ideas/confirmatory ideas are presented?
➢ What are the strengths and weaknesses of the paper?
➢ Who wrote the paper and why?
➢ Is it well written?
➢ Is it peer reviewed in anyway?

(DePoy and Gitlin 1994).

Moreover, it was important that assessments of quality were based on extrinsic factors such as the source journal, and the reputation of the author and the institution (Booth 1996). These were seriously considered in the assessment of each of the non-primary research and literature review sources.
2.11 Literature review saturation

This was done in order to update the literature used in the review. Ten articles from reference lists were methodically reviewed and consequently no new material was found. This was taken as some indication that saturation had been reached at this stage of the review.

2.12 Thematic review of the literature

The overall aim of the literature searching process was to provide a comprehensive review of the literature to highlight why a study of this kind should be conducted. The literature was critically analysed thus giving rise to a number of themes that were subsequently used to develop a framework for justifying the usefulness of such study.

The themes are as follows:

- Equal opportunities
- Racial discrimination
- Cultural differences
- Social exclusion and experiences of overseas nurses

2.13 Hierarchy of evidence

Evidence based healthcare is founded on the principle that health care practitioners should act in accordance with the best evidence available to improve healthcare practice and the care of patients. There are many drawbacks to the achievement of this goal however, such as the evidence not always being available and the best evidence not being based on rigorous research.
Therefore, this systematic approach adopted a hierarchy of evidence devised by Sackett et al. (1996) which is used mainly for randomised controlled trials (RCTs). This hierarchy of evidence is as follows (see fig 2.3):

**Figure 2.3: Hierarchy of evidence**

<table>
<thead>
<tr>
<th>Level</th>
<th>Evidence type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strong evidence from at least one published systematic review of multiple well-designed RCTs</td>
</tr>
<tr>
<td>2</td>
<td>Strong evidence from at least one published properly RCT of appropriate size and in appropriate clinical setting</td>
</tr>
<tr>
<td>3</td>
<td>Evidence from published well-designed trials without randomisation, single group pre-post cohort, time series or matched case-controlled studies</td>
</tr>
<tr>
<td>4</td>
<td>Evidence from well-designed non-experimental studies from more than one centre or research group</td>
</tr>
<tr>
<td>5</td>
<td>Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert consensus committees</td>
</tr>
</tbody>
</table>

(Sackett et al. 1996)

This framework as illustrated above has identified different categories that have been used to classify studies based on the evidence presented. Many papers published in nursing, medical and allied health care journals have serious methodological flaws. Studies can be categorised within the levels of hierarchy of evidence framework to identify sound and legitimate research that can be used as credible evidence.
Chapter Two

Systematic Review Process

One of the criticisms of the hierarchy of evidence framework is that qualitative studies do not fit neatly into this framework and consequently there is a failure to acknowledge the usefulness of qualitative research except as descriptive studies at the lowest level (Isaacs and Fitzgerald 1999). Therefore, the review undertaken for this study has identified thirty-nine articles that can be categorised as belonging to level 4 and the rest as level 5 (see appendix 4). The paucity of good empirical studies on this topic highlights the need for rigorous high quality research on the experiences of overseas black and minority ethnic nurses in the NHS.

2.14 Threats to valid searches

Despite the steps taken to ensure a valid search, there are other threats to validity over which one has no control. For example, most database systems such as Medline and CINAHL employ human indexers who naturally are subject to human frailties and can make mistakes from time to time when entering information into an electronic citation database (Coletti and Bleich 2001; Hjorland 2001; Meadow et al. 2001 and Barroso et al. 2003). There could also be other types of errors from authors and editors that could affect the validity of a search as well. A study that examined the accuracy of entries in Medline by searching for misspelled text words found a total of 200 citations from the 10 selected search terms (Barroso et al. 2003). In this review, forty articles were duplicated in seven of the databases and therefore, recognising and accounting for these errors has enabled the review to be conducted in a more thorough manner (Depoy and Gitlin 1998).
2.15 Summary

Reviewing the literature and using several search terms enabled the researcher to identify the most appropriate literature to be included in this review. Four themes emerged and these were used as the focus for producing a comprehensive and analytical literature review.

This review found eighty-three articles and these were categorised using the hierarchy of evidence framework as belonging to level 4 and 5. No studies were found to be within levels 1 to 3 because they did not meet the criteria as identified in the hierarchy of evidence. Within this chapter, it is highlighted how important a systematic review is and how pivotal it is to the development of the literature review. Finally, this chapter describes how the review was conducted and the processes involved. Additionally, it discusses the threats to undertaking a systematic review and identifies how these threats could be minimized. Overall this review has provided the much needed themes and sources necessary for developing a comprehensive literature review and these will be utilised to demonstrate the gaps in the literature.

The subsequent chapter will focus on the four themes derived from reviewing the literature and will critically analyse and synthesize the sources obtained from reviewing the literature in a systematic way.
Chapter Three

Systematic Review Themes

3.1 Introduction

This chapter reviews the growing body of literature based on overseas nurses, race, ethnicity, culture and equal opportunity and it is predominantly embedded in the field of sociology. This increasing interest in exploring aspects of culture, race and ethnicity as they relate to overseas nurses may provide us with a better understanding of the issues surrounding overseas black and minority ethnic nurses in the NHS.

The main themes are presented as well as the need for this study to be conducted on the experiences of overseas black and minority ethnic nurses in the NHS. The review has been arranged into the following areas: equal opportunities, cultural differences, racial discrimination and experiences of overseas nurses and within these four main themes are sub-themes. Overall, the literature review emphasizes the importance of this study and has identified the gaps in knowledge and understanding, methodology and theory. This chapter concludes with a summary of the main themes and justifies why this study should be conducted.

3.2 Equal opportunities

Equal opportunity theory has identified two interventions to equalize individual prospects and to restore the rights of those suffering from declines in self-determination. The first intervention includes individual capacity to self-determine by increasing autonomy, which is the ability to make choices and take actions consistent
with one's needs, interest and abilities (Mithaug 1996). The second is that of social opportunity and this involves decreasing obstacles and increasing options. In combination both interventions might increase the chances of those with fewer prospects to engage in opportunities for self-determination.

It is widely accepted that all individuals have the right to self-determination, all societies have some individuals who lack the capacity to self-determine, all societies generate unequal opportunities to self-determine, and some individuals do not exercise their right to self-determine because they lack the capacity and opportunity to do so. Therefore it has been urged that all societies should optimise prospects for self-determination amongst the least advantaged members by increasing their capacity and improving their opportunity for self-determination (Mithaug 1996).

Although the theory makes the claim for fairness by arguing from the assumption that all individuals have a right to self-determination and this should be equally distributed among all individuals and groups in society, this has not been the case in practice. (Mithaug 1996). This is because some individuals within any given society might be constrained by discriminatory practices that are inherent within the structures of that society (Alder 1987) and this has been alluded to in a study conducted by Beishon et al. (1995) who found that black and minority ethnic nurses were experiencing discriminatory practices particularly in the NHS in the UK.

The following section will discuss, the policy practice gap, equality, equity and fairness, lack of clarity in intent and purpose, leadership roles and support systems as issues related to equal opportunity.
3.2.1 Policy practice gap

A qualitative and quantitative study conducted by Beishon et al. (1995) consisting of 150 interviews and a postal survey of 14,330 staff found that there were significant gaps between written policies identified by senior managers and the actual practices undertaken in the workplace. Although there was a firm commitment to equal opportunities, the follow through of formal policies into specific objectives, such as implementing appraisal schemes and examining the allocation of training opportunities, were not apparent. Equally the findings from this study are consistent with those of the NHS Confederation's (1998a) study in that a continuing gap was found between formal policies and their effective implementation, as well as poor communication of policies to staff.

Evidence from education to illustrate a fundamental point on the extent to which the lack of equal opportunity continues to prevail within the British society is used. In a recent survey on black and minority ethnic academics in universities, Macleod (2000) found that minority ethnic staff received approximately 13% lower pay than their white counterparts - an average of £2,500 to £3,000. He adds that black and minority ethnic academics had encountered difficulties in promotion and could not identify a single black professor of economics in the UK.

Similarly, the report Commissioned for Black Staff in Further Education (Leatherwood et al. 2002) sought to explore and to find out how many black staff were working in colleges, compared with the number of black people in the overall population. The study utilised both qualitative and quantitative methodologies and revealed that a significant number of black and minority ethnic academics had been
unfairly treated in job applications and promotion. Equally, Purcell (2002) reported similar findings and highlighted that black academics in higher education were in less senior positions than their white British counterparts. As a result of black academics being in disadvantaged positions. Purcell (2002) began to question the legitimacy of equal opportunity policies in higher education institutions. These findings suggest the ongoing challenges faced by black and minority ethnic staff in the UK.

The Departments of Health and Education have published many significant policies that aim to promote equality of opportunities in both the NHS and education. For example, The Vital Connection (DoH 2000d), Positively Diverse (DoH 2000e), The NHS Equality and Diversity in Employment (DoH 2000f), Getting on Against the Odds (DoH 2002) and Improving Equal Opportunities for Higher Education Staff (Department for Education and Skills 2000). However, despite these policies being available there was little evidence to suggest how these would change staff’s attitudes, but more importantly, how the implementation and evaluation of these policies would be monitored.

Equally, in the publication of the Department of Health’s Policy on Working Together: Securing a Quality Workforce for the NHS, (DoH 1998), the overall aim was for black and minority ethnic groups to work collaboratively with other members of the inter-professional team. However, it was difficult to determine the success of this policy initiative as few measures had been arranged to monitor either the progress or the effectiveness of such policy by both the Department of Health and NHS Trusts (Culley 2001 and Mwasandube 2000). Therefore, it is fair to say that although these
policies have been poorly implemented and enacted, it clearly shows that the Department of Health is committed to promoting equality.

3.2.2 Equality, equity and fairness

There are two kinds of argument commonly used to support equal opportunity measures in the field of employment, namely, the liberal and radical change approaches (Jewson and Mason 1986). Witz and Savage’s (1992) booklet provide a liberal approach thus arguing that men and women were essentially the same and that equality would be achieved once employment policies and procedures became identical for both sexes. However, in the UK several writers such as Morgan (1996), Healy and Reynolds (1998) and Cockburn (1989) have argued that in fact, formulating identical rules and procedures for both sexes in employment had traditionally been used to conceal inequalities based on race, sex and other disadvantaged groups.

The NHS with its ‘business case’ arguments has recognised the importance of this approach and has recently attempted to introduce these business case principles within its organisation. One of the ways was the introduction of equal opportunity policies in recruiting and retaining minority ethnic nurses. In a previous initiative in 1993 the Health Secretary stated in the foreword to the Programme of Action on Ethnic Minority Staff in the NHS, that ‘taking action to promote equality in employment is not just a matter of moral fairness to people from minority ethnic groups but it is good sound common sense’ (Department of Health 1993: 1). Achieving equitable representation of black and minority ethnic groups at all levels in the NHS would reflect the ethnic composition of the British population. Therefore the business case
principles have been regarded as significant even more so than in the previous years particularly in recruiting, retaining and having equitable representation of black and minority ethnic nurses in the NHS.

In contrast, there are two arguments against the business-case approach. First, promoting equality for some marginalised groups is not cost-effective. Despite the claims that equal opportunity is 'good for business', it is obvious that this is not a widely held view. For example, many disadvantaged groups such as minority ethnic and women continue to be devalued and overlooked in the labour market (Dickens 2000) and therefore if they are to be valued then equal opportunity must be part of the labour market, however, implementing equal opportunity strategies can be expensive. Investing in good quality training is not cheap and adapting management information systems to provide for effective ethnic monitoring for NHS Trusts will be costly. The business case initiative may well be problematic at a time when resources are curtailed within the NHS (Dickens 2000).

Furthermore, many NHS hospitals are in severe financial difficulties and have many other pressures to curtail expenditure. In this current climate, equal opportunity initiatives may be seen as low priority to the best interests of the organisation (Dickens 2000). It is important to note that despite Dickens' account in identifying some relevant and interesting points that may prevent the implementation of equal opportunity policies, it must be said that some parts are uncorroborated and are therefore anecdotal.
Second, the business-case arguments were reliant on organisations’ financial gains and naïve about the discriminatory motives of some employers. For example, in a recent survey of Financial Times Stock Exchange companies sponsored by the Runnymede Trust, black and minority ethnic groups remain seriously under-represented at senior management level in private sector organisations in the UK (Sanglin-Grant and Schneider 2000). Black Afro-Caribbean workers experience even greater under-representation than any other ethnic group. Yet nearly all companies participating in the survey reported that their recruitment, retention and employee development policies do not discriminate against minority ethnic groups. Importantly, however, the study also collected responses from black and minority ethnic employees themselves. There was a gap between companies’ beliefs about their equal opportunity policies and how individuals perceived their employers’ treatment of them (Sanglin-Grant and Schneider 2000).

Furthermore, nearly all companies participating in the survey reported that their recruitment, retention and employee development policies were non-discriminatory towards black and minority ethnic groups. This evidence clearly suggests that current approaches to workplace equality continue to be disregarded. Minority ethnic groups did not feel that their interests were being protected and promoted in organisations such as these. (Sanglin-Grant and Schneider 2000). Although this study revealed interesting findings and would add to the body of knowledge on black and minority ethnic professionals, it is important to note that only 40% of the companies participated in the research and therefore this rendered the applicability of the findings problematic.
In contrast, Kirton and Greene’s (2000) argue that the radical change approach to equal opportunities aims to achieve equal outcomes, however, several criticisms were made against the radical approach. In a well written discussion paper, Crow (1995) asserts that members of disadvantaged groups experience varying degrees of discrimination and therefore, improving the group’s position through radical action will not necessarily provide equal opportunities for all members of the same group. Similarly, Cockburn (1989: 217) stated that, ‘the radical approach would inevitably lead to further division in the already powerless groups.’ She also asserted that, although the use of a radical approach could promote the relative position of one disadvantaged group, it did not promise any improvement in the structures that might perpetuate inequalities at work and moreover, it did not challenge the structures that discriminate against disadvantaged groups.

Indeed, Cockburn’s (1989) qualitative study found that organisations did not necessarily commit to equal opportunities in outcome in the long term. Some organisations were inconsistently implementing equal opportunity policies and therefore some individuals were disadvantaged as a result. Cockburn’s work thus brings a different but important perspective that helps qualify and illuminate some concerns raised by others in the field (Singh 2002, Flathman 1973 and Dickens 2000). She confronted the issue of disillusionment among disadvantaged groups concerning the lack of progress resulting from equal opportunity policies in organisations, and argued that these approaches might not necessarily reduce inequalities in opportunities (Cockburn 1989). Although attempts were made (Cockburn 1989) to highlight some concerns regarding these approaches, there was little revelation on how equal opportunities could be achieved within any organisation.
Chapter Three

Systematic Review Themes

The subsequent section will focus on the lack of clarity and purpose of equal opportunity policies.

3.2.3 Lack of clarity in intent and purpose

The Race Relations Amendment Act [2000] (Home Office, 2000) supported by the CRE (2000) outlines that organisations like many NHS Trust Hospitals, Strategic Health Authorities and education institutions should focus on eliminating unlawful discrimination and promote racial equality and good race relations. It is important to note that the duty to promote race equality covers all aspects of an organisation’s activities - policy and service delivery as well as employment practices.

Bhatt’s (2003) qualitative study involved interviewing sixteen senior managers in six Strategic Health Authorities and found that implementing the requirements of the Race Relations Amendment Act [2000] was not apparent. Furthermore, the study found that managers had limited knowledge and understanding of the act and its implications as well as a lack of clarity about how to link the race relation work with the Strategic Health Authorities main agendas. The findings from this study although useful have limitations. The research method adopted was qualitative and the findings could not be generalised to the wider population. In addition, the researcher made little attempt to explain how the findings were derived. Yet, despite these weaknesses the findings are consistent with Parish’s (2003) discussion, in that senior managers have consistently failed to implement and understand the Race Relations Amendment Act [2000] (Home Office 2000) and its intent, particularly, equal opportunity. Although this discussion paper has its limitations, it has highlighted the challenges that the NHS faces in implementing the Race Relation Amendment Act [2000].
One of the difficulties that faces some NHS organisations in implementing the Race Relation Amendment Act [2000] is a lack of clarification on what constitutes equal opportunity. The term equal opportunity is in common use in Britain and it has been argued that its meaning has not been defined with precision (Barry 2001). Equal opportunities are difficult to theorise because a wide variety of meanings are assumed (Kirton and Greene 2000) and therefore many proponents have argued about the basis on which the objectives of equal opportunity policies should be achieved (Culley 2001; Law 1996; Modood et al. 1997 and Rattansi, 1992).

Moreover, it has been argued that the aims of equal opportunity policies are often not clearly articulated and appear to be grounded in the modernist approach to issues of racism and ethnicity (Law 1997 and Kirton and Greene 2000). Although these arguments are legitimate, much of what these writers have expressed, does not articulate how organisations like the NHS can effectively manage equal opportunity policies. In addition there is little attempt to clarify the meaning of the term equal opportunity and consequently equal opportunity policies may not necessarily safeguard groups that may be considered disadvantaged particularly black and minority ethnic nurses. Despite this, the literature herewith serves to highlight a lack of clarity and the conceptualisation of equal opportunity policies.

3.2.4 Leadership roles

Despite what has been suggested about the lack of leadership roles for black and minority ethnic nurses (Culley 2001; Miller 1999 and Carter, 2000), there are many black and minority ethnic nurses who have overcome the obstacles and have achieved leadership positions. Mayor (1996) conducted a study on the career experiences of
leading minority nurses using oral histories, biography and supplementary questionnaires. A total of 88 informants were interviewed (28 males and 60 females) and of these, seventeen categorised themselves as Black African, thirty-seven as Afro-Caribbean and thirty-four as Asian. Of these, four were British born. Participants were employed at clinical grade H or above. Although this study revealed rich data into the speed of promotion and the leadership positions of black and minority ethnic nurses, it failed to provide much detail on the research methodology and analytical framework used.

In contrast, Pudney and Shield (1997) using data from gender, race, pay and promotion, found a rather different mechanism. Their study revealed a significant advantage in terms of speed of promotion for whites over black and minority ethnic groups. Similarly, Knight (2003: 14) indicated that a black nurse, after having had 30 years of experience, 'became extremely frustrated’ because promotion was not apparent. Despite her years of experience, she was still a D grade (A grade the lowest and I grade the highest) and saw no prospect of promotion. These accounts indicate the extent to which black and minority ethnic nurses appeared to be unfairly treated particularly in obtaining promotion.

On the other hand, Keighley (2001) highlighted the success of Beverley Stevens, a black nurse who was able to achieve a leadership position in the NHS. Although Keighley revealed the success of a black nurse, caution should be exercised here, as this is an isolated case with little evidence of empirical research. Furthermore, it is difficult to draw valid conclusions, as the literature is somewhat anecdotal.
In the publication of the document, ‘Getting on against the odds’ (DoH, 2002b), the government is committed to improving black and minority ethnic nurses positions in the NHS. Yet despite the government’s commitment several criticisms can be drawn from this document. First, it offers limited suggestions of how black and minority ethnic nurses are able to advance into leadership positions despite resource implications and the inherently monolithic culture of the NHS. Second, and more importantly, to what extent both the rhetorical commitment to this policy and its practical expression have been embraced at an operational level in the NHS?

According to the NHS Confederation (1998b) findings based on racial equality in the NHS, there has been an increase in the percentage of members of NHS Trust Boards from black and minority groups. The proportion of NHS Trust and Health Authority Non Executive Directors from minority groups has increased from 4.7% in 1996 to approximately 9% in 1998. In contrast, Knight (2003) revealed that the promotion of nurses above grade F is minimal, with only a trickle of nurses going on to higher levels, for example only 3% reaching I grade and at most senior levels, non-white representation is exceptionally poor. Out of 400 directors of nursing, only three were from ethnic minority backgrounds. It is therefore arguable that despite the government’s commitment to promoting leadership in the NHS for black and minority ethnic nurses, progress is still patchy and is not as rapid as it could be when compared to white British nurses. Similarly, Ball and Pike’s (2004) study found comparable findings to the above research and they argued that black and minority ethnic nurses continued to be disadvantaged and under-representation in a range of health service occupations, in particular leadership positions. Such findings highlight the extent to
which black and minority ethnic nurses continue to be under-represented in senior positions in the NHS.

Equally, Beishon et al.'s (1995) study critically examined the predictors of nursing level and showed that although there were no indicators of minority ethnic nurses being at a disadvantage in access to middle-ranking posts up to E grade, those in the Black and Asian categories in particular were at a significant disadvantage in access to F grade and above. Approximately one quarter of staff believed that they had been denied opportunities for training because of their ethnicity and the same proportion thought they had been denied promotion because of their race. Although, Beishon et al.'s study was conducted a few years ago, these findings are still significant in today's NHS. More recently Harrison (2003) commented that black and minority ethnic nurses were denied promotion and were therefore disadvantaged and discriminated against based on their racial features. Therefore, these aforementioned authors have extended our understanding on the issues surrounding black and minority ethnic nurses.

3.2.5 Support system

In Davidson's (1997) account participants had emphasized the importance and role of mentoring and networks in their career development. However, participants were only able to recognise scanty and in some instances limited mentoring like inputs from line managers, peers, nurse tutors and other professional staff. Yet, despite the lack of support from peers and managers, black and minority ethnic groups were able to advance in both their careers and leadership positions. It is important to note that in Davidson's account, the participants had support from their partners, families, friends,
church seniors and informal peer support networks, which operated outside the workplace. This was more helpful for their career development than what they had received at their workplace (Davidson 1997).

In contrast, Wedderburn-Tate’s (1998) revealed that black and minority ethnic managers benefited from mentoring, shadowing and networking in government. Despite this conclusion, due care and concern must be exercised here as Wedderburn-Tate’s account does not specifically include NHS employees however, the conclusions cannot be relegated to insignificance.

3.3 Summary
This section has emphasised the difficulties that, both the NHS and education institutions face in achieving equal opportunity for black and minority ethnic groups. It draws on studies from other disciplines to support and illustrate the extent to which inequalities exist for black and minority ethnic groups in particular, nurses. The literature identified within this review reveals that equal opportunity is difficult to define. Many policies instigated by the Department of Health have attempted to address inequalities however, such policies have been neither thoroughly followed through by NHS staff nor implemented appropriately and consequently these have had limited impact on the well being of black and minority ethnic groups, in particular nurses. In summary, this section explored the policy practice gap, equality, equity and fairness in relation to black and minority ethnic groups and where possible drew on sources related to nursing. Following on from this was a discussion on the lack of clarity in intent, purpose and leadership roles and finally this review explored the support system for black and minority ethnic nurses in the NHS.
A discussion based on racial discrimination as experienced by black and minority ethnic groups and nurses will be the focus of the subsequent section.

3.4 Racial discrimination

In Beishon et al.'s (1995) study, equity issues had been identified as one of the major contemporary challenges facing the nursing profession in the United Kingdom. Although racism in nursing has attracted the attention of scholars outside the nursing profession (Calliste 2000; Das Gupta 1996; Flynn 1999; Shields and Price 2002 and Culley and Leatham 2001), to date, nursing researchers have given little attention to the problem of racism. Therefore, racism, institutional racism and ethnocentrism will be the focus of the subsequent sections of this review.

3.4.1 Racism

The term racism does not only involve race, it is also commonly used to describe a system of oppressive ethnic and race relations in which one social group benefits from dominating another (Kendall and Hatton 2002). Moreover, racism is a multidimensional and complex system of power and powerlessness. It is a process through which powerful groups, using deterministic belief systems and structures in society are able to dominate. Racism operates both at micro and macro levels and is developed through specific cognitions and actions, and perpetuated and sustained through policies and procedures of social systems and institutions (Burke and Harrison 2000).

The words ‘racism’ and ‘racist’ also trigger tension, feelings of discomfort, estrangement and defensiveness. Racism combines the belief that people can be
identified as belonging to a particular race based on their physical characteristics and hereditary origins with the belief that some racial groups are inferior or superior to others purely on phenotypical differences (Kendall and Hatton 2002; Verberk et al. 2002; Greipp 1996; Harris and Cummings 1996 and Karlsen and Nazroo 2002). In a qualitative study, Culley et al.'s (2001) interviewed eight females and six males, all of whom were either first level nurses or midwives. The findings revealed that both racism and managers’ dominant behaviour contributed to Caribbean nurses feeling unhappy in their workplaces. Furthermore, this study found that Caribbean nurses were infuriated, frustrated and aggrieved that their chances of promotion were blighted by both racism and the hierarchical management structure within their working environment.

However, in an earlier qualitative study, Fenton (1988) interviewed 101 Afro-Caribbean workers and ex-workers and found mixed experiences. For example, although some highlighted that racism and the hierarchical structures within their workplace were apparent, they reported that these had not affected their experiences within their workplace. However, for others, it was evident that racism and the effects of such hierarchical structures within their working environment could have accounted for their negative experiences.

These findings were echoed in further studies by many proponents who suggested that racism permeated both the National Health Service and Educational institutions that provide nursing and midwifery education (Akinsanya 1988; Lee Cunin 1989; Bharj 1995; Dowell 1996; Sawley 2001; Coker 2001 and Cortis 2003). However, racism is not universally accepted and it is therefore highly contested with mixed evidence.
In Mellor et al.'s study, eighty participants were observed as to how they would respond following racist scenarios. The findings revealed that those who were victims of racism failed to make use of their general knowledge when confronted with scenarios of racism. Therefore this would suggest that racism was circumstantial rather than real. It is interesting to note that several limitations can be drawn from this study. First, the age group utilised was not clearly stated and this made it difficult to draw appropriate conclusions. Second, such findings could not be generalised to the wider population because a qualitative research design was employed. Finally, this study utilised only Asian participants and therefore generalising yet again to the wider ethnic population of black and minority groups would be difficult. This is because the study does not reflect the experiences of the wider ethnic composition. It is therefore fundamental to say that given these methodological limitations, the findings must be treated with caution.

Using evidence from student recruitment to illustrate differences in the interpretation of racism, Iganski et al. (1998, 2001) found that ethnic minority applicants were over-represented at the applications stage of the recruitment process compared with their numbers in the population. They indicated that these students were more likely to be rejected without being interviewed for pre-registration nursing courses. The findings from this study of both over-representation and under-representation were based on a three-year research project across a sample of universities providing pre-registration nursing education in England.

Their study revealed that while discriminatory practices occurred at the application stage for Asians, they were not convinced that racism was the main factor that
prevented a majority of black applicants commencing nurse training. Other factors play a significant part in this process. In contrast, Chevannes (2001) was highly critical of these authors' findings because they failed to offer any information on the different factors in the recruitment process that might have prevented black and minority applicants from progressing beyond the submission of their applications. In view of this, it was difficult to draw appropriate conclusions and therefore their research gave some cause for concern. While it is useful to discuss racism, it is also important to explore institutional racism and its impact on black and minority ethnic groups in the NHS.

3.4.2 Institutional racism

Institutional racism is depicted as an enduring structural feature of a society that is recognisable by social patterns of disadvantage and inequality, which run along racial lines. However, according to Mason (2000) this concept was introduced and used with little analytical rigour. Miles (1989, 1993) for example, presents a coherent argument that supports the point raised by Mason (2000) and therefore draws the conclusion that institutional racism is 'over-inflated' because it tends to refer to all beliefs and actions of 'white people', which ensure their domination over black and minority ethnic groups and this he considers to be of limited analytical value. While both Miles and Mason indicate that institutional racism has limited analytical value, they assert that in most instances it is a structural rather than an individual concept.

Sir William Macpherson's Inquiry (1999: 28) into Stephen Lawrence's murder, revealed that the police service in London were institutionally racist and he offered a
powerful explanation and an authoritative definition on institutional racism as noted below;

‘the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages ethnic minority people. Racism persists because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation. It is a corrosive disease.’

The report asserts that institutional racism is the reason why the public sector has significantly failed to provide an adequate, professional and appropriate service to black and minority ethnic groups. The report also suggests that a colour-blind approach fails to take account of the nature and needs of black and minority groups. Treating everyone the same will not provide equal opportunities for those who are substantially disadvantaged and discriminated against and whose culture may not be well understood (Macpherson 1999).

Although institutional racism was evident within the police service, Coker (2001) argues that such a term is poorly understood by health service staff. Similarly, Jones (1997) argues that such a term continues to be mis-understood and has indicated that
whites have learned to pay lip service to the norm of equality, while maintaining negative attitudes towards black and minority ethnic groups and will either deny, ignore or minimise the presence of racism in their institution. In Sir William Macpherson’s Enquiry, he revealed that racism is apparent and is affecting black and minority ethnic groups in the UK. In a recent report into the death of David Bennett, the findings revealed that institutional racism was embedded within the structures of the NHS (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003). Therefore, it is fair to say that the Race Relations Amendment Act [2000] (Home Office, 2000) continues to be overlooked and poorly implemented within organisations such as Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

The Race Relations Amendment Act [2000](Home Office 2000) supported by the (CRE, 2000) in the UK, the Human Rights Act [2000] and Article 13 of the Amsterdam Treaty (1997) made it illegal to discriminate in employment, education and in the provision of services and goods. These Acts define two types of discrimination, direct and indirect. Direct discrimination occurs when a person is treated less favourably than others on the grounds of their race or sex. On the other hand indirect discrimination occurs when a rule or condition that applies equally to everyone has a disproportionately adverse effect on black and minority or sexual groups and there is no objective justification for the rule (CRE 2000).

Yet, despite the Race Relations Amendment Act [2000] to protect individuals, discrimination still persists. For example, Dyer (2002) revealed that the British Medical Association paid compensation to an Asian surgeon after the association
refused repeated requests to assist in a race discrimination claim against the medical training authorities over recognition of his training. Although this incident occurred in the medical profession, it clearly demonstrates that racism permeates other professions as well. It would be impossible to give a reasonable account of the experiences of black and minority ethnic groups in Britain without making reference to ethnocentrism. Therefore the subsequent section will now explore this concept.

3.4.3 Ethnocentrism

Sutherland’s (2002) study explores the concept of ethnocentrism and feels that although frequently used in a nursing context, it has not been clearly defined. According to Webster’s Dictionary (1989) ethnocentrism is, the belief in the inherent superiority of one’s own group and culture accompanied by a feeling of contempt for other groups and culture. From a nursing perspective, there is an assumption that our ways are correct and do not take into account the cultural diverse backgrounds of other groups particularly black and minority ethnic groups (Sutherland 2002).

Equally, a number of authors such as (Alexis and Chambers 2003, Kagawa-Singer 1997, Fishbein 1996 and Thiederman 1986) delineate that ethnocentrism can include feelings that one’s beliefs and values are the only ones of any worth. They emphasize that ethnocentric tendencies occur naturally as a result of exposure to one’s own culture. Similarly, Harris and Cummings (1996) revealed that ethnocentrism was apparent in the United States of America [U.S.A]. They concluded that, given the enormity of a diverse community such as the United States of America, some whites still consciously and unconsciously upheld beliefs and values that reflected their ideology, consequently perpetuating superior races.
A study by Perrault and Bourhis (1999) sought to gain an understanding of the nature of the discriminatory behaviour between both men and women. The authors utilised ninety-one women and thirty-one men and found highly authoritarian participants were endorsing ethnocentric views. They also found that participants demonstrated a high level of in-group identification. For example, they had strong perceived connections to their particular group and this then led to participants displaying ethnocentric behaviours. Although this study provided valuable insights and contributed to an understanding on ethnocentrism, it did not indicate the number of men or women that had ethnocentric views.

3.5 Summary

This section explored racism, institutional racism and ethnocentrism and some of the difficulties in defining these terms. Although these have been used in academic and other circles, interpretation of these concepts continues to be mixed. The review emphasized that racism, institutional racism and ethnocentrism are apparent in both the NHS and in other institutions as well and the mixed evidence that is available in this area. Moreover, many key sources were critically analysed and synthesized throughout this section of the literature review. The following section will explore the cultural differences of black and minority ethnic groups but will pay particular attention to nurses in the NHS.

3.6 Cultural differences

Cultural differences are not always recognised in research involving nurses from different cultural backgrounds. Many proponents such as Senior and Bhopal (1994) have argued that some researchers have tended to categorise black and minority ethnic
people as a homogenous group and consequently they are treated the same. However, there are differences within and between these groups. It is therefore integral to discuss, cultural dimensions, cultural stereotyping of black and minority groups and cultural diversity in nursing.

3.6.1 Cultural dimensions

Much of the debate surrounding issues related to the recruitment and retention of black and minority ethnic nurses focuses on their inability to adapt to the cultural norms and values of the dominant culture. Papadopoulos et al. (1998) trans-cultural perspective offers an alternative perspective that focuses on issues of power and structural aspects that influence culture. Many proponents within nurse education, are critical of the models of cultural adaptation for ignoring structural factors and the effects of racism. They argue that the culturalist approach renders other people’s culture as problematic (Ahmad 1993 and Papadopoulos et al. 1995) such as the needs of black and minority ethnic nurses. Moreover, Kushnick (1988) suggests that such attempts to understand culture are counterproductive, as they both rely upon and reinforce stereotypes of ethnic differences. Equally, Papadopoulos et al. (1998) argue for an approach that will actively promote anti-racism as well as an understanding of the lifestyles, beliefs and values that constitute culture.

Authors such as Fernando (2002) and Ollie (1995) have argued that the term culture is often confused in its interpretation by health care professionals and the public in general. Helman (2000) suggests that culture is an inherited lens of shared concepts and rules of meaning whereby society’s members perceive the world, guide their behaviour and determine their emotional reactions in daily living. Helman argues that
it is the starting point for interacting with others since their cultural background shapes everybody's perception. Similarly, Hofstede (1984: 21) states that, 'culture is the interactive aggregate of common characteristics that influence a human group's response to its environment. It determines the identity of a human group in the same way as personality determines the identity of an individual. Hofstede also points out that in addition to what has been previously noted, culture is a collection of individuals who share common values, beliefs and ideas.'

However, Leininger (1995) and Bauwens and Anderson (1992) have argued that culture has not only physical characteristics but also implicit rules that individuals may not consciously recognise. Consequently, people's cultural heritage cannot be separated from the way in which they communicate with each other. Yet, despite this, there is an expectation that black and minority ethnic nurses will eventually integrate and adopt the language, values and norms of the dominant culture. Moreover, Baxter (1997: 72) cautions us about the use of the term culture and multi-cultural, in that 'such usage ignores issues of race and does not provide an adequate explanation of how racial discrimination arises or how it can be addressed.'

Hofstede (1984) conducted the most comprehensive study on national cultural differences and found significant differences in value orientations between organisational members of different national groups. These national differences explained more of the differences in work-related value than did the position within the organisation, profession, age or gender. In contrast, Tyson and Jackson (1992) were highly critical of Hofstede's work, arguing that his work dealt in generalisations. Indeed there might be national characteristics but it was likely that there were major
variations within societies. The diversity at organisational level meant that the research must be used with caution, and not seek to perpetuate stereotypes.

Similarly, Furnham and Gunter (1993) argued that Hofstede’s work seemed to have little evidence demonstrating the veracity of the different systems. The study also offered little in the way of process. Although Hofstede’s research may have some weaknesses, this study has highlighted the need to understand the values underpinning culture and the impact culture has on organisations. However, it would be unwise to relegate it to insignificance.

In North America a number of authors (Grossman and Taylor 1995, Davies 1995 and Martin et al. 1994) have highlighted the conflicts in a multicultural hospital. A comparison of ‘American ways’ versus black and minority ethnic ways, particularly Filipino ways was debated for almost two decades. According to Martin et al. (1994), in the United States a great value is placed on the needs and desires of the individual and the adoption of an assertive style in the work place. Unlike the United Kingdom, American nurses are comfortable with overt expressions of affection, such as hugging. There is an expectation that overseas black and minority ethnic nurses should readily adapt and conform to their new culture (Pekerti and Thomas 2003).

However, Pilette (1989) cautions us and argues that time is of the essence in terms of overseas nurses overcoming cultural differences and contends that this will not happen overnight. She asserts that nurses move through different phases of adjustment for example, acquaintance, indignation, conflict resolution and finally integration. There are no studies that specifically explore black and minority ethnic
nurses adjustment to a new environment, however, despite this Pilette (1989) has provided valuable insights on a new perspective and it is anticipated that overseas black and minority ethnic nurses may experience a similar process when adapting to a new culture. Indeed, Berry and Sam (1997) identify a comparable model to that of Pilette's and assert that individuals adapting to a new environment will experience conflict and they will take some time before they become integrated into a new culture.

In a study, Lopez (1990) examined the process of acculturation that Filipino nurses would go through in the United States. The author used both qualitative and quantitative approaches and found that Filipino nurses spent limited time with their patients because of the language barrier and there was conflict between Filipino nurses and their US counterparts. However, the results from this study based in the United States of America [USA] were difficult to assess, as the author provided limited explanation of how the themes emerged and how the data were analysed.

Similarly, Spangler (1992) explored the trans-cultural care and nursing practices in Philippines-American nurses and revealed that communication and interaction with patients and families were identified problems for Filipino nurses in their adjustment to a different culture. Although the literature identified by Spangler is anecdotal in parts, it supports an earlier but major study on communication differences of nurses from a non-westernised society.
3.6.2 Cultural stereotyping of black and minority groups

In Vydelingum's (1998: 30) study he argues that, Mares, Henley and Baxter's (1985) handbook for health care professionals, though anecdotal in parts, uses real life accounts of black and minority ethnic groups experiences to 'illustrate the negative stereotypes' in the health care settings. According to Vydelingum, Mares, Henley and Baxter set a word of caution against the misuse of background information and the dangers of placing people into particular cultural or ethnic groups. The central argument with many of the publications (Greipp 1996, Vydelingum 2006) is that they sadly reinforce negative stereotypes of black and minority ethnic people with a strange culture consequently the 'utilisation of such reductionist conceptions of culture' leads to generalisations and stereotyping (Sheldon and Parker 1992:108).

Equally, Mensah (1997) observed the frequent negative stereotyping of black people by colleagues and argued that this created a source of pain and frustration for black and ethnic minority nurses. To speak of black people as if they are all of one monolithic culture is itself a stereotype that must be challenged. The term Afro-Caribbean draws attention to the range of cultural backgrounds that black people come from. People of Nigerian, Zimbabwean and Filipino descent do not have synonymous culture (Koh 1997). Therefore, treating black and minority ethnic people as a homogenised group with no differences between or within them can result in a reinforcement of stereotypes. The same could be said for overseas black and minority ethnic nurses, that negative stereotypes are not uncommon (Alexis 2002, Flynn and Aiken 2002).
3.6.3 Cultural diversity in nursing

One of the pioneers in the field on cultural diversity in nursing is Madeleine Leininger. According to Leininger (1994), attempting to gain an understanding about and working with different cultural groups who speak and behave in different ways, is sometimes difficult for host nurses. Leininger (1994: 254) believes that, ‘as nursing becomes recognised as a trans-cultural profession, nurses must be prepared to offer trans-cultural care based on recent trans-cultural nursing evidence.’ Nurses have become increasingly aware of the need to become more knowledgeable about caring for patients and working with colleagues who are from cultures other than their own.

Leininger (1994) suggests that health care and educational institutions have adopted a mono-cultural approach to both health and education and argue for a multi-cultural focus. Nurse educators and academics have begun to recognise that nursing curricula must move away from a mono-cultural focus in order to help students and nurses from different cultures operate in a multi-cultural world. Nurse education is seen as an avenue to facilitate professional change. Although there has been a long-standing need to prepare nurses through formal educational programmes in trans-cultural nursing, there has been a very slow response and limited recognition of the critical need and problem (Leininger 1994; Duffy 2001 and Gerrish et al. 1996).

Due to the slow response time, nursing education has a deficit in preparing nurses to be culturally competent, sensitive, and equipped to serve multicultural communities. Moreover, there has been a lack of educational institutions that are qualified to meet the needs of nurses who arrive to work and study from different parts of the world. Despite the shortcomings in nurse education, providing culturally sensitive education
should be one of the priorities of educational institutions as they plan to function in a multi-cultural society (Leininger 1994).

Culley (1996) acknowledges the above perspective and argues that the basic assumptions of the multi-culturalist education model clearly imply that with greater knowledge of different cultures and with improved skills in cross-cultural communication, sensitivity to different cultural groups will be improved. Whilst this ideology has been vociferously challenged within other welfare services, particularly social work (Troyna, 1992), it clearly dominates much contemporary writing in health care in the UK and within nursing in particular. Troyna (1992) argues that appropriate education coupled with integration and socialisation of different cultural groups will inevitably bridge the dichotomy between nurses and patients but also between nurses and different ethnic groups, in particular, overseas nurses.

Leininger’s (1995) culturalist model, however, has not been without criticisms. Culley (1996) argues that Leininger’s cultural education model, as currently taught, is too narrow in its focus on increasing cultural awareness. The approach may give the impression that problems of minority ethnic groups are solely a result of cultural insensitivity and can be remedied by appropriate education. While increasing awareness of other cultures and reducing intolerance are important, focusing solely on these, Leininger’s culturalist model is in danger of neglecting how inequalities are embedded in society.

Similarly, Ramsden (2000) argues that Leininger’s (1995) model ignores sociological factors such as gender, class, religion and politics. Indeed, Leininger does concede
that while sociology and other social sciences help to understand people and their cultures, the major focus of the model is on care phenomena within a nursing perspective (Leininger 1995). She asserts that valuable descriptive knowledge has been gained on different cultural values, approaches to nursing, beliefs and health, however, some nursing theorists have been making inappropriate use of the terms, concepts and methods, which have their roots in anthropology. They also have made assumptions of how different cultures care for patients (Leininger 1995).

Equally, Vydelingum (1998) argues that the general assumptions made by Leininger that cultures can be learned and ‘packaged’ imply a degree of stereotyping. Moreover, the assumptions that all members of a cultural group share the same beliefs and values often lead to the production of checklists or assessment tools to sieve people through, which may result in oppressive practices if applied inflexibly. In addition, the tendency for Leininger’s ‘trancultural nursing’ to focus on cultural categories ignores the individual and may lead to victim blaming and pathologising of culture and stereotyping.

Omeri and Atkins’ (2002) study took a phenomenological approach to explore the experiences of immigrant nurses. Five nurses were interviewed and the data analysis revealed that there was a need to develop trans-cultural nursing knowledge as a means to overcome cultural differences. Such a study highlights the importance of breaking down barriers and avoiding stereotyping of immigrant nurses and this lends itself to a more inclusive society.
In a similar vein, Burner et al. (1990) postulate that the lack of understanding on the part of some western cultures of other cultural backgrounds is an indication of the narrow focus to recognise issues of racism and how these might affect their relationships with other cultural groups. They argue that gaining knowledge about different cultures can be obtained in educational institutions. Furthermore, they contend that this may reduce the barriers between nurses from the dominant culture and nurses from other cultural groups thus creating an inclusive environment for all. It is important to note that while, Burner et al.'s (1990) highlight such crucial points, they fail to realise that obtaining education will not necessarily reduce inequalities.

3.7 Summary
This section explored the cultural differences in terms of cultural dimension, stereotyping of black and minority groups and cultural diversity in nursing. It also highlighted that resulting from these differences, stereotyping of minority ethnic groups continues. It is evident from the review that multicultural education in the UK is still patchy, consequently affecting the delivery of trans-cultural nursing and the relationship between black and minority ethnic nurses and the majority culture. This review has emphasised that inequalities exist in nursing and has attempted to highlight a number of key issues surrounding cultural differences in nursing.

3.8 Social exclusion and experiences of overseas nurses
This section commences with a discussion on social exclusion. Reference will be made to black and minority ethnic nurses and where possible to overseas nurses. This review will draw on a number of studies that utilise overseas nurses as their sample and will critically analyse and synthesize these studies and will categorise these
studies into themes. Finally, the review will examine the gaps in the literature and will provide valuable insight into why this present study should be conducted.

3.8.1 Social exclusion

Social exclusion refers to the multiple and changing factors resulting in people being excluded from the normal practices and rights of modern society (Percy-Smith 2000). Social exclusion also affects individuals and groups, including minority ethnic groups in many different ways, such as loneliness, frustration and feelings of anger (Percy-Smith 2000). The Commission stated that, 'a fatalistic acceptance of social exclusion must be rejected and that all individuals, irrespective of their creed, race, gender or political affiliation have a right to be respected of human dignity' (Commission of the European Communities 1993: 1). Despite this statement, there is evidence to suggest that social exclusion still exists in nursing, particularly between black and minority ethnic nurses and that of their white British counterparts (Culley 2001).

Percy-Smith (2000) argues that one of the causes of social exclusion may be structural and therefore introducing appropriate government policies can ameliorate its effects. However, despite the introduction of many government policies in attempting to reduce inequalities in the NHS, black and minority ethnic groups particularly nurses continue to be discriminated against and experience exclusion in the workplace (Beishon et al. 1995, Cortis and Rinomhota 1996 and Sawley 2001).

Similarly, Madanipour et al. (1998) support the above and add that structural process may affect society in ways that may create barriers to prevent particular groups from forming those kinds of social relationships with other groups. It is not that some
groups consciously exclude other groups, but that processes affecting the whole of society mean that some groups experience social boundaries as barriers preventing their full participation in the cultural life of the society within which they live and work. Equally, Burgess (1962) supports this aforementioned perspective and argues that it is often this societal process that creates and maintains the identities of those defined as 'others' thus resulting in exclusion.

Within the health care setting, othering is often the result of nurses from the majority culture failing to acknowledge those they perceive as different from themselves, such as misinterpreting the actions of another, listening to those perspectives that are familiar or consistent with their own thinking but not attempting to listen to voices other than their own. Often the consequence is that these nurses direct their actions according to stereotypes and myths rather than to an understanding of the other (Canales, 2000).

Similarly, like othering, marginalisation is a concept that has been recognised for some time in the health care arena, particularly with disadvantaged groups for example, black and minority ethnic groups. Marginalisation is therefore defined as, 'the process through which individuals are peripheralized on the basis of their identities, associations and experiences' (Hall et al. 1994: 25). Marginalised people are different and are monitored and scrutinised closely in society. Thus as Foucault’s (1979) description implies, they are prone to incarceration particularly if they are from non-westernised countries.
According to Hall (1999), individuals who do not belong to the majority culture are normally seen as outsiders. This is because they are characteristically different and their approach to in-group values is seen as different. Similarly, Calliste (1993) supports this view and argues that there is evidence of marginalisation and segregation practices in nursing based on race and gender. Equally, Hall (1999) reveals that nurses need to explore thoroughly their euro-centric beliefs and values so as to ameliorate their relationship with marginalized groups. Furthermore, Hall (1999) argues that once marginalisation and segregation are addressed within health and education, nurses from the main culture may be transformed into being more inclusive and accepting of differences rather than marginalizing groups that are different in characteristics from their culture. These findings are consistent with Omeri and Atkins' (2002) study and they add to the knowledge based on overseas minority ethnic nurses.

3.8.2 Support mechanisms

In seeking to find out about the experiences and expectations of Filipino nurses in an English hospital in the UK, Daniel et al.'s (2001) qualitative study utilised two focus group interviews and found that British nurses had been supportive and helpful towards Filipino nurses. However, Filipino nurses indicated that their expectations about nursing roles in the UK had differed to what they had experienced. Although this study provided an understanding of Filipino nurses' experiences of the NHS, caution must be exercised here when interpreting the findings, as the sample of nurses used had only been on their adaptation courses for a minimum of three months and because of this, their accounts may reflect their limited experiences of the NHS.
In an attempt to address this deficit a similar but phenomenological study of the expectations and experiences of overseas Filipino nurses in Oxford in the UK was conducted (Withers and Snowball 2003). They employed both a survey type approach and face-to-face semi-structured interviews. Eight Filipino nurses were interviewed and a 38% response rate was obtained for the questionnaires. These authors reported that Filipino nurses indicated that their ward managers were supportive and the adaptation programmes were invaluable. However, their expectations of nursing in the NHS had not matched their experiences. As there is a mis-match between met expectations and reality, this could affect overseas nurses’ job satisfaction, their commitment and job performance, and all of this has implications for recruiting and retaining of overseas nurses.

Although the Market and Opinion Research International poll in England [MORI] (2002) examined the experiences of internationally recruited nurses on behalf of the Royal College of Nursing it did not assess expectations, however the results showed that international nurses experienced inadequate support, poor working conditions, lack of recognition for their hard work, and unfriendly and unaccommodating staff. Equally, Smith (2004) qualitative study explored the perceptions of overseas nurses during their induction programme and this involved interviewing twenty overseas nurses on a face-to-face basis. The findings revealed that both support and valuing of overseas nurses were required. Although the MORI poll (2002) and Smith (2004) provide significant insights into this issue, they are in contrast with those of Daniel et al. (2001) and Withers and Snowball (2003) particularly in relation to support.
A more recent study (Matiti and Taylor 2005) has attempted to address the support mechanisms in the NHS for overseas nurses by investigating the cultural experiences of internationally recruited nurses in the UK particularly within the Trent region. Using a qualitative approach, they interviewed twelve overseas nurses and the results showed that adapting to the NHS for overseas nurses was difficult, and although support was needed, it was influenced by the type of environment in which they were a part of.

3.8.3 Skills

In the UK, Cooke’s (1998) phenomenological study examined the views of overseas nurses from different countries visiting clinical areas in Britain and compared their views with opinions of the host nurses and midwives. The findings revealed that the experience, skills and the contribution overseas nurses made to the NHS were not recognised by both managers and white British nurses. Cooke (1998) concluded that recognising the skills and contribution of overseas nurses would be beneficial for developing relationships between British nurses and that of their overseas counterparts.

Equally, Hardill and Macdonald’s (2000) qualitative study explored the experiences of overseas nurses who migrated to work in the United Kingdom. The authors interviewed sixteen overseas nurses from a variety of nationalities and found a lack of appreciation of overseas nurses skills. Similarly, in a more recent study Taylor (2005) tried to address this by conducting an anthropological approach to examine the views and experiences of nurses who were trained overseas. The study revealed that overseas nurses felt deskilled and frustrated, and concluded by suggesting that if
overseas nurses became de-skilled while employed in the NHS, then this would have implications should they wish to return to their home country.

In another but similar study, Gerrish and Griffith (2004) sought to evaluate an adaptation programme for overseas registered nurses by interviewing overseas nurses as well as ward managers, senior nurse managers, clinical mentors, a recruitment manager, a diversity officer and academics. They found that overseas nurses’ skills could have been better used in their working environments and indicated that these nurses would benefit from their experiences of the NHS. Whilst, on the one hand overseas nurses may benefit from working in the UK, on the other, they may become de-skilled, as they are unable to practice their skills because of the bureaucracy in the NHS. It is important to note that although these studies have offered significant knowledge into this area by identifying that overseas nurses skills are often not utilised, they raise our awareness of such issues and these need addressing in the NHS as it may have implications for recruiting and retaining of overseas nurses.

3.8.4 Inequalities

A number of studies (Allan and Larsen 2003, Allan et al. 2004 and Larsen et al. 2005) investigated the experiences and perspectives of international nurses in the UK using qualitative and explorative research designs. Eleven focus group interviews were employed and the authors found that international nurses felt discriminated and unable to progress in their careers. In another study, Winkelmann-Gleed and Seeley (2005) utilised both qualitative and quantitative approaches to investigate the experiences of internationally recruited qualified migrant nurses with the aim of understanding aspects of their work-related identities. Twenty-two overseas nurses were interviewed
and one hundred and forty overseas nurses participated in the survey. The results showed that discrimination and a lack of promotion were apparent. In other studies, (Buchan 2003 and Ross et al. 2005) comparable findings were found with those of Winkel-Gleed and Seeley (2005) and these authors indicate that discrimination and equities issues are challenges facing the NHS. They conclude by suggesting that the NHS should be an equitable employer where everyone is treated fairly and equitably.

Although these authors found that both discrimination and the lack of promotion were evident, Magnusdottir's (2005) study revealed a different mechanism. This study aimed at examining the lived experience of foreign nurses working in hospitals in Iceland. Eleven overseas nurses were interviewed and data analysis revealed that discrimination and career advancement were not challenges that overseas nurses encountered. Although this study was conducted in Iceland and offered some insightful information into overseas nurses' experiences, it was in contrast with the findings found in the UK studies. Such contrast may be due to cultural differences between the UK and Iceland, and the context in which these studies were conducted.

3.8.5 Being outsiders

In Australia, Omeri and Atkins (2002) conducted a phenomenological study with five overseas nurses. The themes otherness and cultural separateness were found. Similarly, in Canada, Turrittin et al. (2002) investigated the experiences of nurses of colour and found that they encountered marginalisation and difficulties in adjusting. Equally, in a more recent study in the USA, DiCicco (2004) sought to describe the experiences of a group of immigrant women nurses working in a culture other than their own. Ten semi-structured interviews were employed and the findings revealed
that Indian nurses encountered alienation and cultural displacement throughout their experiences. Adapting to a different culture would normally take some time, and as these studies had not indicated how long these nurses had been working in their clinical environments, it was difficult to draw valid conclusions. However, despite this, these studies were able to offer invaluable insights and challenges that overseas nurses faced.

3.8.6 Stress

In America, Yi and Jezewski’s (2000) grounded theory methodology aimed to understand how Korean nurses adjust to the United States of America (USA) hospital settings. They interviewed twelve female Korean nurses and data analysis revealed that Korean nurses encountered psychological stress and frustration. In a similar study, Flynn and Aiken (2002) utilised a survey of seven hundred and ninety-nine nurses of which five hundred and forty seven were born in the United States and two hundred and fifty two were from thirty-four different countries. This study reported that the absence of supportive environment had produced high levels of burnout in nurses. In another study in Canada, Hagey et al. (2001) interviewed nine immigrant nurses of colour and found that they experienced both physical stress and emotional pain. These studies (Yi and Jezewski’s 2000, Flynn and Aiken 2002, Hagey et al. 2001) are consistent with those of Omeri and Ahern (1999) and have increased our understanding of overseas nurses from different cultural context but also, by raising our awareness, through knowledge this can facilitate in helping to reduce stress and burnout in overseas nurses in the UK.
3.9 Summary

This section has reviewed the literature based on social exclusion and overseas nurses experiences in a number of health care systems. In undertaking this process, the literature was critically analysed and synthesized. The review revealed the gaps in the literature but despite these, a greater insight and understanding of the experiences of overseas nurses was achieved.

3.10 Gaps in the literature

In reviewing the literature, it is evident that there are the gaps in knowledge, understanding, methodology and theory. Therefore, it is important to emphasize here why this study is fundamental and why it should be conducted.

3.10.1 Gaps in knowledge and understanding

Although a number of studies (Taylor 2005, Matiti and Taylor 2005) have highlighted and generated some knowledge and understanding of the experiences of overseas nurses, none have specifically explored the experiences of overseas black and minority ethnic nurses collectively and because of this paucity of studies examining this area, this research would attempt to increase our knowledge and understanding in this relatively new and unexplored area. In addition to this, with any new study there is always the opportunity to enhance knowledge and understanding and it is hoped that this study would add to the existing body of knowledge based on overseas black and minority ethnic nurses in the NHS in the south of England.
3.10.2 Gaps in methodology

The review has identified that a number of studies have utilised different approaches to elicit data from overseas nurses however, none have specifically explored from a Heideggerian hermeneutic phenomenological perspective the experiences of overseas black and minority ethnic nurses. Furthermore, this review has found no research that utilises semi-structured face-to-face interviews, focus group interviews and a survey as part of the same study. As these gaps were found, it is anticipated that this study will contribute to methodology.

3.10.3 Gaps in theory

In reviewing the literature, it has been noted that many of these studies have not developed any theory on overseas nurses' experiences. Although the focus of phenomenology is to describe and develop a greater understanding of lived experiences, this study will attempt to provide a theoretical understanding based on this topic area.

3.11 Summary

This section has emphasized the gaps in knowledge, understanding, methodology and theory. As highlighted in this review, there are no UK studies that have specifically explored the experiences of overseas black and minority ethnic nurses using the aforementioned approaches. As indicated in background literature, most of the studies have tended to focus on the immediacy and the impact of recent arrival to the UK. Where qualitative and/or quantitative approaches have been utilised, these have tended to be superficial and lacked the in-depth scrutiny into overseas nurses' experiences. Therefore this section has identified the gaps in the literature.
3.12 Overall summary

A systematic review of the literature was conducted and this enabled the researcher to identify appropriate articles to be included and critiqued. This review of the literature has highlighted several issues. It was found that the literature based on equal opportunity highlighted the difficulties in defining the term and as such the NHS and other institutions felt that equal opportunity was difficult to achieve for black and minority ethnic groups. This review has explored the following aspects, the policy practice gap, equality, equity and fairness, lack of clarity intent and purpose, leadership roles and support systems and found inconsistencies in their findings. Emanating from the literature is the implementation of equal opportunity policies and this has been patchy in the NHS. The review has identified that there is a notable lack of empirical data that specifically explore overseas black and minority ethnic nurses in the NHS.

This review has extensively discussed racial discrimination, cultural differences and has emphasized some of the inequalities that exist for both black and minority ethnic groups and nurses. Findings from these studies provide the researcher with some understanding of the experiences of overseas nurses. Furthermore this review has identified marginalisation and othering of black and minority ethnic groups and the evidence suggests that these areas are still fragmentary particularly for overseas nurses.

This review of the literature has served to highlight the lack of comprehensive literature concerning the experiences of overseas black and minority ethnic nurses and has identified a notable lack of empirical studies that utilised a phenomenological
approach and there are, therefore, gaps in knowledge, theory and methodology. Findings from this study would hopefully increase our understanding and add a further dimension to the body of knowledge on the experiences of overseas black and minority ethnic nurses working in the NHS.

Given these limitations as identified within this review, it is therefore essential that this study that seeks to explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses in the NHS in the south of England should be conducted.
Chapter Four

Theoretical Framework

4.1 Introduction

This chapter provides a description of the overall philosophical and methodological frameworks that underpin this study. The first section discusses the interpretive approach of inquiry and provides a rationale for using a Heideggerian phenomenological approach. Section two describes phenomenology as a research method and this is followed by a discussion of some of the main philosophical perspectives underpinning Heideggerian. This chapter will provide an overview of hermeneutic philosophy with reference to the work of Heidegger (1962) and Gadamer (1975). The researcher will provide the main critiques relating to the use of interpretive methodology based on Heidegger's philosophy and will conclude with an overall summary.

4.2 The interpretivist approach to inquiry

There are four basic research approaches to inquiry as identified in the literature and these are classified as, positivism, post-positivism, critical theory and constructivism (Guba and Lincoln 1994). This study is embedded in the interpretivist paradigm, which is an approach that seeks to examine in detail human experience as people live and interact within their social world (Crotty 1998). Interpretivism aims to understand the variety of constructions that people possess, trying to achieve some consensus of meaning, but always being alert to new explanations with the benefit of experience and increased information (Guba and Lincoln 1994). This is echoed in Drew’s (1999: 263) account who describe constructions as ‘created realities’ and ‘sense making.
representations.' Indeed, Guba and Lincoln (1994) support this perspective and argue that, as time passes both participant’s and researcher’s constructions mature and become insightful. These constructions endeavour to help individuals make sense of their experiences (Schwandt 1998).

In contrast, the goal of positivism is based on the systematic identification of fact using scientific methods (Wainwright 1997 and Ray 1990). Post-positivism’s goal is to seek explanations in an attempt to predict and control phenomena, while critical realism searches for an explanation of the mechanisms that underpin the phenomena within a constantly changing social world (Wainwright 1997).

Interpretism has been linked to the thoughts of Max Weber (1864-1920) who suggests that the human sciences are concerned with understanding, exploring and describing in contrast to both seeking of explanation and the cause and effect that is inherent within the natural sciences (Crotty 1998). Throughout the scientific world the natural sciences has been dominant in studying humans by the way of objective and detached observations. However, attempts were made to objectify human experiences by the natural sciences but these were criticized for the lack of philosophical knowledge of humans. As a reaction to this criticism, the interpretivist phenomenological approach emerged (Lopez and Willis 2004, Omery 1983).

4.3 Phenomenology as a research method

Interpretive phenomenology is a qualitative form of research method that seeks to study phenomena. Within the field of phenomenology, the Greek word phenomenon, meant to ‘show itself’ (Heidegger 1962: 57), in other words to reveal something that
cannot be visible in itself. Interpretive phenomenology centres on the study of phenomena as they are perceived or experienced and offers a means of identifying the essential elements or the essences of the experience. The aim of interpretive phenomenology is to elicit a deeper understanding of the lived experience from an insider’s (participant’s) perspective (Streubert and Carpenter 1999).

Researchers undertaking phenomenological research begin by going to the participants who have had experience of a phenomenon. It is within the world of the participants that the researcher can explore the lived experiences of the participants. Phenomenology is therefore concerned with participants and their experiences of the world they ‘live in’ or ‘Lebenswelt’ as identified by Husserl (Koch 1996: 175).

It is widely believed that researchers using a phenomenological approach to investigate a phenomenon are seen to be creating a construction of the participants’ experiences. The phenomenological researcher attempts to create a construction of the phenomenon from subjectively interpreting the words of the participants who have experienced the phenomenon. When this approach is utilised, the researcher does not aim to take an objective stance (Clandinin and Connelly 2000) but aims to create a lived account of the participants’ stories (Annells 1999, Beck 1994).

The purpose of phenomenology is to describe a particular phenomenon and hermeneutic phenomenology inquiry is situated within the interpretivist framework. This is because hermeneutic is the interpretation, articulation of our understanding of phenomena as described by participants (Streubert and Carpenter 1999, Madjar and Walton 1999). The hermeneutic inquiry is phenomenological as it seeks to reveal
phenomena and the inquiry process aims to identify and provide an understanding of
the variety of constructions that exist about a phenomenon.

As a result of the historical development of the phenomenological movement and the
multi-disciplinary usage of phenomenology, a number of different interpretations and
modifications of the phenomenological approaches was evident. Cohen (1987) argues
that the philosophy of phenomenology has changed markedly and has been viewed
differently by each philosopher. It is believed that the philosophy of phenomenology
may be affected by culture and language and therefore, the different types of
phenomenology will often reflect the cultural background and tradition of the
philosopher. The German, French and North American phenomenology differ in their
approaches and studies conducted in these areas reflect their understanding of

Van Manen (1984) claims that through existential (being in the world) and
hermeneutic (interpretative) thought, phenomenology as a research methodology is
concerned with gaining access to the life world of the participants (van Manen 1984).
Through reflecting on human experience a greater understanding of the meaning of
the experience is achieved. Both Heideggerian and Husserlian are two important
phenomenological approaches that researchers may utilise in order to gain knowledge
and understanding. Heidegger's is based on an existential, ontological perspective that
emphasises that the researcher cannot separate himself/herself from the world. In
contrast, Husserl's phenomenology is epistemological and it focuses on the
description of the life world of the participants and how they interpret the world that
they live in (Streubert and Carpenter 1999).
The purpose of this study is to provide a constructed reality of overseas black and minority ethnic nurses' experiences in the NHS. Therefore, the methodological approach chosen to answer this question must be compatible with the question asked (Spence 2001). Qualitative research, in particular phenomenology is well suited to researching the human experience as its focus is on the lived experience and the meaning participants attribute to their particular experience which they have lived through.

Within this chapter, it is necessary to briefly review the origins and the historical development of phenomenology in order to make clear the distinction between Husserlian and Heideggerian phenomenological perspectives and to illuminate why this study has adopted a phenomenological approach informed by Heidegger's (1962) underpinning philosophical framework and these will be discussed in the subsequent section.

4.4 Husserlian phenomenology

Both philosophers, Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976) work dominated the German phase of the phenomenological movement (Spiegelberg 1982). It is generally accepted that Husserl was the dominant figure of the phenomenological movement and was a mathematician who attempted to include mathematical rigour in his research method. Within Husserl's phenomenological philosophy, objectivity, researcher detachment, suspension and bracketing of the researcher's assumptions and biases are fundamental (Koch 1995). Husserl was keen to illuminate the ultimate structures of consciousness (essences) and views a person's knowledge, understanding and actions as originating in the mind where the mind is
the only source of meaning and interpretation (Benner and Wrubel 1989). In attempting to establish phenomenology as a science Husserl identifies three aspects such as essences, intentionality and bracketing (Cohen 1987, Kock 1999).

4.4.1 Essences

In Husserl’s world, these are elements related to the true meaning of something. In other words, those concepts that give common understanding to the phenomenon under investigation (Palmer 1994). Although this study is not embedded in a Husserlian framework but essences such as, experiencing fear and feeling unwelcome would help us to understand overseas nurses’ experiences.

4.4.2 Intentionality

Husserl believed that meaning and understanding could only be gained through direct experience of a phenomenon and placed consciousness as the foundation of knowledge. He claims that individuals are always conscious of something and using an example taken from Palmer (1994), one can’t just be frightened or upset, one is frightened of or upset about something and this he referred to as intentionality.

4.4.3 Bracketing

Streubert and Carpenter (1999) postulate that phenomenological reduction is often referred to as bracketing and this is an important concept in Husserl’s phenomenological philosophy. As a philosopher, Husserl devised the notion of the life world or Lebenswelt, which he saw as the everyday world in which people live (Spiegelberg, 1975). Husserlian phenomenology suspends and puts aside temporarily the usual assumptions in order to understand the life world of the participants. Husserl
indicated that a detached view must be undertaken in order to let the phenomenon be seen from an objective stance. He saw this as the only means by which the phenomenon in question can be revealed in its purest form. Husserl was dedicated to seeking both understanding and absolute knowledge by revealing the underlying essence (Schutz 1970, Koch 1995).

4.5 Heideggerian phenomenology

In 1889 Martin Heidegger was born in Messkirch in Germany and became a student and friend of Husserl. He studied theology but later switched to mathematics and philosophy. He was awarded a Doctorate in Philosophy in 1913 for his thesis based on, The Doctrine of Judgement in Psychologism (Guignon 1993a). Although Husserl’s ideas initially influenced Heidegger’s ideas, it soon became evident that his philosophical stance was different from Husserl’s (Palmer 1994).

In Leonard’s (1989: 42) account of Heidegger’s work, he explicates how Heidegger turned the phenomenological focus from Husserlian stance that asked the epistemological question, ‘how do we know what we know?’ to an ontological perspective that asked, ‘what does it mean to be a person?’ This difference in philosophical view, from Husserl’s epistemological to an ontological stance by Heidegger resulted in the development of a second branch of phenomenology known as hermeneutic phenomenology.

Annells (1996) explicated that Heidegger considered phenomenology as one way of illuminating the ontological foundations of understanding Being. Like Husserl, Heidegger also refers to the lived world and argues that an understanding of Being.
can be reached through 'being in the world' and he sees this as fundamental to human everyday experience (Annells 1996: 3). The term 'Dasein' as coined by Heidegger to depict human being literally means being-there (Crotty 1998). Heidegger explicated that 'Dasein' is pertinent to human existence. Thus 'Dasein' in a Heideggerian sense is the basic structure of humans where each human's own way of being in the world cannot be separated from the experience (Crotty 1998).

In contrast to Husserl's philosophical perspective of phenomenological reduction and bracketing of pre-understandings, Heidegger postulated that to separate oneself from the world was virtually impossible. Rather there is 'Dasein' which is, 'interwoven into the world' (Heidegger 1962: 27-28). Being in the world is therefore an imperative part of the structure of 'Dasein', and one cannot separate oneself from being in the world. Heidegger (1962: 92) stated that, 'there is no pure superiority point to which we can retreat that will enable us to see the world from a different perspective. This is because the world and 'Dasein' are not separate. Thus 'Dasein' cannot be understood without considering the world, since the world is an essential characteristic of 'Dasein' itself.' As the world and 'Dasein' are inseparable and since being in the world as human existence is the only possible position, there is no dichotomy between the world and 'Dasein'. Therefore, from a Heideggerian phenomenological perspective, it is widely acknowledged that there is no possibility of separating oneself from the world and so it is impossible for the researcher to bracket or separate his or her assumptions of the world (Heidegger 1962).

Heidegger further indicated that the idea of phenomenology begins with a description of the phenomenon and it reveals itself to us in relation to our being in the world and
our pre-understandings of what things are all about (Guignon 1993b). Participants in a shared world are able to grasp the human beings experiences of ‘being in the world’ and as such the hidden meanings attached to these will emerge. In Heidegger’s view, the hidden meaning of a phenomenon is revealed through a description of everyday existence of ‘being in the world.’ As a result, being in the world, when combined with hermeneutic (interpretation) illuminates the hidden meaning of the life world of the participants’ experience (Guignon 1993b).

Annells (1999) suggests that Husserl’s philosophical stance and phenomenological approach, although providing an extremely useful approach to undertake some research questions, is not appropriate for this study. This research seeks to explore and understand the experiences of being overseas black and minority ethnic nurses working in the NHS. This particular question is embedded in Heideggerian phenomenology as it is concerned with what it means to be a person experiencing a particular phenomenon in a particular context. As this study is situated within this framework, it requires an approach that reflects such perspective. The researcher will clearly bring to this study his pre-understandings and these will arise from his life experience. The researcher did not believe it was necessary or realistic to set aside his pre-understanding in an attempt to bracket them and therefore chose to adopt the perspective of Heideggerian phenomenology, which also derives from the German phase but whose philosophical underpinnings differ from those of Husserl’s.

4.6 Heidegger’s examination of being and related concepts
There are a number of aspects underpinning Heideggerian phenomenology that are relevant to explore the research question however, the researcher has considered the
following Heideggerian perspectives to be useful and relevant for this study. These perspectives are as follows, time and space, being engaged in the world, temporality and understanding and interpretation.

4.6.1 Time and Space

Heidegger (1962) suggests that both time and space are concerned with the relationships between the two ideas. He uses the term space to refer to a situation in which one finds oneself and the way one experience the world as a human being, has a crucial relation to time. Equally, both Benner and Wrubel (1989) discussed time and space in relation to situation. They suggest that situation is best described as revealing of being in the world. As a result of our everyday encounters, situation helps us to comprehend the kinds of people we are and the involvement we have in the world. Thus the concept of ‘being in’ is what makes one familiar with the world and the meaning is embedded within everyday experiences. Heidegger sees the world as the relational whole within which human beings exist and within which we are inextricably linked (Guignon 1993b) unlike Husserl, who believes that both human being experiences and being in the world are separate entities.

Allied to these viewpoints is another important perspective. According to Leonard (1989: 40), ‘people not only have a world in which things have significance and value but they have qualitatively different concerns based on culture, language and individual situations.’ Therefore, people are engaged in living their lives in their world, and it is unrealistic to assert that people’s interpretation of their lives and experiences is unrelated to their being in the world. The concept of being in the world
recognizes that the context of people's lives is crucial in the interpretation of their lived experiences (Mackey 2005, Mulhall 1996).

This research focuses on the meaning participants attribute to their lived experience of working as overseas black and minority ethnic nurses in the NHS and this study embraces this perspective of being in the world. It is through being in the world and working for the NHS in the south of England that overseas black and minority ethnic nurses will derive the meaning of their situation from their own unique background and previous life experiences.

4.6.2 Being engaged in the world

This concept is used to characterise everyday involvement in the world. Heidegger (1962) explicated that Being was already part of the world. This meant to dwell and be involved with other people and activities in the world (Heidegger 1962). He reveals that people engage in the world in terms of their different relationships between people and the environment but also, based on their unique understanding of the world.

The perspective of engagement is relevant to this study because the participants will have had some experiences of working in the NHS as overseas black and minority ethnic nurses in the south of England. Their level of engagement in their world may fluctuate depending on their exposure to the phenomena. It is anticipated that the findings from this study may bring to light a new understanding of how overseas black and minority ethnic nurses engage and experience the world that they work in, particularly the world of the NHS.
4.6.3 Temporality

Temporality is the way in which people live in the present. It also refers to people’s awareness of time through the experience of being in the world (Heidegger 1962). People are influenced by the past and this may influence the future (Benner and Wrubel 1989). Temporality refers to the way in which people are situated or embedded in a present that is made meaningful by the past but also in the future (Benner and Wrubel 1989, Brandhorst 1989, Walters 1995). In other words, past experiences may influence the present and future. By reflecting on the past this will inevitable influence both the present and the future.

Temporality is another important concept for rendering meaning in this study. It can provide valuable insights and increase our understanding of the lived experience by being alert and listening to participants’ rich descriptions of their past experiences in the present, new knowledge can be gained in order to influence the future for other participants. So listening to overseas nurses past experiences in the present new knowledge can be achieved.

4.6.4 Understanding and interpretation

Heidegger (1962) suggests that individuals are self-interpreting and have the ability to reflect upon their existence whilst engaged in everyday activity in the world. Moreover, both Palmer (1994) and Stumph (1994) argue that humans are unique beings, not only because they think about and question Being, by doing so they put their own being into question. Therefore, through ‘Dasein’, (being there), people are able to interpret, disclose and reflect upon their own experience.
Heidegger (1962) explicates that we cannot have a world and cannot have life at a cultural level except through acts of interpretation. Understanding occurs because people are born into the world and are part of the world. By engaging in the world as human beings and interpreting and understanding the world that they live in, meaning is derived. Therefore people interpret the world based on their interaction with their practices and others whom they encounter in the world. (Dreyfus and Dreyfus 1987, Taylor 1987).

Therefore Heidegger’s (1962) view that humans are able to self-interpret is also relevant to this study. Overseas nurses will hopefully be reflecting on and interpreting their experiences of working in the NHS. They will be able to reveal a range of meanings and insights into a phenomenon that has not been fully explored in the field of nursing. The next section will discuss hermeneutic philosophy.

4.7 Hermeneutic philosophy

Hermeneutics is derived from the Greek word ‘hermeneuein’, meaning to understand or to interpret. Hermes was the divine messenger of the gods, whose role was to convey to humans the decisions of the gods. It is not known whether the name Hermes was derived from ‘hermeneuein’ or the other way round. Although the term ‘hermeneutics’ is far more recent (about 250 years old) the practice has its origins in ancient Greece with the study of literature and then in the Judaeo-Christian interpretation of biblical and other sacred texts (Crotty 1998). In scriptural hermeneutics the focus was: what is God’s message?
According to Palmer (1994), hermeneutics involves both interpreting and understanding texts, particularly where the process involves language. Because language is a shared experience for human beings influenced by social, historical and cultural factors, meaning comes to humans in different contexts as they live in the world. The underlying assumption of hermeneutics is that humans experience the world through language that provides understanding and knowledge. Thus language enables humans to understand the world in which they live. Hermeneutic interpretation, therefore, enables us to make sense of our experience and of being in the world in a meaningful way (Palmer 1994). In the nineteenth century hermeneutics took a practical turn and formed the basis for all human sciences for understanding meaning attributed to the lived experience (Palmer 1969). Heidegger (1962) stipulates that everyone exists hermeneutically through interpreting and finding meaning in their life world and he saw that hermeneutical inquiry could be applied to search for the meaning of Being.

4.7.1 Hermeneutic circle

In understanding human experience, the hermeneutic circle is a concept derived from the Greek word ‘hermeneuein’ to express, interpret and translate. Meanings are hidden in phenomena and these are revealed as knowledge from hermeneutic thinking (Barton 2004). Koch (1996) argues that the concept of the hermeneutic circle involves a continuous circular process whereby the researcher moves between the whole and the part of the text derived from the participants.

In order to gain new perspectives and increase depth of understanding, it is important to systematically analyse the whole data transcript (Leonard 1989). Moving back and
forth within the hermeneutic circle may increase the researcher’s awareness and understanding and may also reveal meaning that may have previously been concealed. The hermeneutic circle includes the participants, their stories and the researcher. The participants tell their stories from their interpretation and the researcher interprets these from his own background and experience. Thus there is a moving back and forth especially if the researcher takes back to the participants the interpretation for their consideration (Crist and Tanner 2003 and Barton 2004).

Essential to understanding are three considerations that Heidegger termed the structure of understanding or fore-structure. These three considerations are integral to human interpretation and understanding and these take place within the hermeneutic circle (Gelven 1989). Indeed these considerations are, ‘fore-having’ and this relates to the taken for granted, background practices that are already understood and allow for interpretation to occur. ‘Fore-sight’ relates to the particular point of view from which we make an interpretation, that is the awareness and background of the researcher that directs him/her in a specific way towards the phenomena. While pre-understanding is used to describe the meaning and organisation of a culture such as language and practices, which are already in the world before we understand (Gelven 1989).

Indeed Heidegger’s perspective on hermeneutics is important to this study as it positions the researcher within the research process. This means that the researcher is involved with the phenomena under investigation and incorporates his own perspectives throughout the interpretive process in order to reveal the essence under investigation. This reflects the researcher’s position as a black nurse, educator and researcher involved in the research process. As a researcher, full involvement with the
participants rather than distancing oneself would facilitate a fusion of horizon of understanding to be achieved. The ideas of Gadamer will be discussed in the following section as these will assist in our understanding of hermeneutics.

4.7.2 Gadamer

Hans Georg Gadamer, a German Philosopher built on the work of Heidegger and extended his discussion on many concepts underpinning hermeneutics. In Gadamer’s book entitled, Truth and Method, he argues that all understanding is hermeneutical because hermeneutics consists of the whole experience of the world and the meaning attributed to this experience (Gadamer 1975). Like Heidegger, Gadamer contends that understanding is an ontological in nature rather than epistemological. He also emphasises historicity, by asserting that it is impossible to understand human beings and society from a non-historical perspective and therefore, understanding occurs within the context in which individuals live. It cannot be derived through methods that have been associated with the natural sciences that objectify the phenomena under investigation (Gadamer 1975). Indeed Gadamer (1975) asserts that fusion of horizons, the hermeneutic circle, prejudice and dialogue are all metaphorical constructs that are pertinent in understanding human experiences and this is akin to Heidegger’s philosophy.

4.7.3 Fusion of horizons

Gadamer (1975) built on Heidegger’s concept of horizon and described how a fusing of horizons occurs through a process of understanding when researchers immerse themselves in the analysis of the text and the meaning of the text is revealed through interpretation. This continuous interaction between the researcher and the text
introduces Gadamer’s notion of effective fusion of horizons. This notion refers to the conscious task of understanding the text. It is through this interpreting the text that a greater understanding can be achieved.

4.7.4 Prejudice

Gadamer (1975) asserts that the concept of prejudice has preconceived ideas that originate from researcher’s background and past history. He states that prejudice is not something negative or something that should be eliminated, but instead it would be useful to allow prejudices to facilitate our understanding of the world. Prejudices are biases of our ‘openness to the world’ (Gadamer 1975: 9). Prejudices are merely the conditions by which individuals encounter the world as they experience something. They take prejudices (value positions) with them into the research process and these assist them to understand.

4.7.5 Dialogue

Gadamer equates the metaphor of dialogue with the logic of question and answer. The idea of Gadamer’s hermeneutic circle includes keeping the dialogue open through question and answer. Engaging in a dialogue with the data will enable meanings to be revealed. This constant questioning of the text will allow the researcher to reach a greater understanding of the lived experience and the meaning attributed to this experience (Gadamer 1975). During dialoguing with the text, the researcher remains true to the text and free from external distractions that might impinge on the analytical process. (Gadamer 1975).
4.8 Nursing studies: the phenomenological debates

Phenomenology is a way of viewing the lived experience of people and the meaning they attribute to their experiences. As nursing embraces a holistic approach to care, it is essential that people's lived experience should be explored and described by research methods that most effectively serve nurse's goal. Phenomenology has gained respect in nursing as a valid approach to the study of nursing as a human science, and to the art and science of human caring (Watson 1985). It offers a means by which human phenomena or the lived experiences of the life world of nurses and their participants can be studied and understood (Madjar and Walton 1999).

One of the benefits of phenomenology is gaining an understanding of the lived experiences of individuals (Reeder 1985). Similarly, Madjar and Walton (1999) support this and argue that there is a need for an increasing global awareness of the advantages of phenomenology to nursing. Although phenomenology, particularly hermeneutic has its uses in nursing, many contemporary nurse researchers have been criticised for using hermeneutic phenomenology. This is because the underpinning method adopted is deeply rooted in description and subjectivity (Holmes 1996).

Holmes (1996) questions the appropriateness for nurse researchers to use Heideggerian phenomenology specifically on the grounds of his alliance with the Nazis and National Socialism. Whilst it is not possible to overlook this fact, an awareness of the issue enables the researcher always to read his work critically. Sheehan (1993) contends that, there is no need to adopt his philosophy totally but instead use only those parts of his philosophy that are considered to be of value and relevant to the chosen study.
Crotty (1996) brought a different but important perspective to the phenomenological debate. He argues that nurses have adopted and misused traditional European phenomenology (Crotty 1996). In his book, Phenomenology and Nursing Research (Crotty 1996) provides an analysis of selected phenomenological nursing research projects and argues that nurse researchers from North American have misinterpreted European phenomenological philosophy and instead produced an uncritical exploration of culture. Crotty’s point of contention was that this particular approach, which he termed the North America influence, should not be called phenomenology because it does not espouse either Husserl’s or Heidegger’s constructionist position that he regarded as essential to pure phenomenology.

Crotty (1996) also argues that nurse researchers have always claimed that their work is embedded in Heideggerian’s phenomenology when in fact it is Husserlian’s. Although this might be the case, Darbyshire et al. (1999) has argued that it was Crotty rather than nurse researchers who were often misguided and ill-informed in his view of Heidegger. These authors have argued that the central task of interpretative phenomenology is to interpret everydayness in order to uncover the possibilities that would increase our understanding of human experiences. They assert that as nurses we do not have to experience the phenomenon ourselves in order to conduct a phenomenological study. It is through understanding the shared meaning and textual interpretation of the experience of others that we can appreciate and better understand the different perspectives. Similarly, Benner (1996) also takes Crotty to task and criticises his lack of impartiality, narrow viewpoint and rejection of nursing phenomenology. Crotty’s work and the continued debate gave nurse researchers the
opportunity to openly demonstrate their understanding of the issues and defend their use of phenomenology.

Although Crotty’s book has been described as being subjective and lacking in analysis (Benner 1996), theorists such as Turale (1997) describes it as a must read for nurses interested in the philosophy and methods of phenomenology and Garett (1998) calls it a gift to nursing. Both de Laine (1997) and Beanland et al (1999) refer to Crotty’s book as an essential reading for those students pursuing hermeneutic phenomenology as a research approach. Similarly, Giorgi (2000) acknowledges and supports Crotty’s assertion that there are two phenomenologies though he calls them philosophical and scientific.

Although Crotty has been criticized for his narrow viewpoint, Koch (1995, 1996) commented that many researchers mistakenly identify their phenomenological research as being based on Heidegger’s philosophy, when in fact they base their research method on Husserl’s philosophy, thereby confusing these methods. Similarly, Paley (1998, 2002) claims that nurse researchers based their approach on hermeneutic phenomenology but in fact the process they undertake lacks rigour and characteristically contains issues that are not in line with the philosophy of hermeneutic phenomenology as identified by Heidegger.

On the other hand, Lawler (1998) takes a different perspective and cautions nurses against wholeheartedly embracing phenomenology, as there are difficulties in adapting phenomenology to practice. These discussions emphasise the importance of nurse researchers who use Heidegger’s philosophy to adhere to a sound interpretive
and rigorous approach and it is fundamental that this particular philosophy informs and guides their research process. Thus, it has been the researcher's intention throughout this chapter and in this study to reveal how Heideggerian hermeneutic phenomenology has informed the research process and data analysis.

4.9 Summary
This chapter has provided a discussion of phenomenology and shown that it is an approach that is important within this study. Husserl and Heidegger are two types of phenomenology that are extensively discussed within the philosophical and methodological framework. This chapter has explored the work of Husserl as being pivotal to the development of Heidegger's and has examined a number of related concepts of interpretive phenomenology such as time and space, being engaged in the world, temporality, understanding and interpretation.

In understanding phenomenology the researcher draws on a number of tenets such as fusion of horizons, prejudice and dialogue as these metaphoric constructs are pertinent in facilitating our interpretation of human experiences and indeed the experiences of overseas nurses in the NHS particularly in the south of England. In addition, this section has shown that the phenomenology of Heidegger has been most appropriate to answer the research question. It has also provided the researcher with a direction of how to uncover meanings that participants attribute to their experience of being overseas black and minority ethnic nurses working in the NHS in the south of England and concludes with the phenomenological debate.
5.1 Introduction

Phenomenology was adopted for researching the experiences of overseas black and minority ethnic nurses in the NHS in the south of England. The rationale for such an approach was to explore, describe and develop a greater understanding of the participants' experiences of working in the NHS. This chapter will describe the methods utilised in this study to explore the research question. Included in the research process is also a description of where the researcher is situated in the study, thus reflecting Heidegger's stance of the researcher being involved in the research process. The procedures for data collection are described in detail and ethical considerations are outlined. This chapter will conclude with a discussion on aspects of rigour when using hermeneutic phenomenology.

5.2 The nature of qualitative research

Qualitative research methods involve the systematic collection, organisation and interpretation of textual data derived from a dialogue between the researcher and the participant(s) (Malterud 2001). It is anticipated that the use of a qualitative paradigm, in particular a phenomenological approach to study the experience of overseas black and minority ethnic nurses working in the NHS in the south of England would provide valuable insights on how these nurses engage and experience the world in which they work, particularly the world of the NHS.
Qualitative research is multi-method in focus, involving an interpretive naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings by attempting to make sense of, or interpret phenomena in terms of the meaning people attribute to these experiences (Denzin and Lincoln 1998). The nature and definitions of qualitative research have been extensively discussed in recent years, as has the quantitative versus qualitative research debate and it is not the intention of this chapter to replicate these discussions. Any attempt to summarise such a debate here might lead to a trivialization of the issues. Therefore the reader is directed to the vast literature that expounds these methodological concerns such as Silverman (2001), Carr (1994) and Vidich and Lyman (1998). However, for the sake of completeness, a brief summary of the concerns as they apply to this study is presented here.

Qualitative research has in the past often been viewed as less scientific when compared to the more scientific quantitative methods. Pope and Mays (1995: 45) state that, 'the two approaches such as quantitative and qualitative are frequently presented as adversaries in a methodological battle.' Qualitative methods, when used, are sometimes relegated to the preliminary phase of quantitative studies. However, a shift in thinking appears to have occurred resulting in what seems to be an exponential growth of investigations using qualitative methods within the health care field (Greenhalgh and Hurwitz 1999).

There has previously been much debate between proponents of quantitative and those of qualitative research but as Mays and Pope (2000) point out the rigid demarcation of qualitative and quantitative research as opposing traditions does not encourage
movement or interaction between these two opposing research methods. In effect, researchers on either side have become entrenched and are often ignorant of each other’s work (Mays and Pope 2000). They warn against the potential scenario of the pendulum swinging too far in the other direction if researchers begin to claim that qualitative research methods are superior to quantitative ones. According to Pope and Mays (1995: 45), ‘we need a range of methods at our disposable if we are to understand the complexities of modern health care.’

There is a consensus among the majority of healthcare researchers that if an area of study is relatively unexplored then a qualitative approach is, at least the method of choice. The qualitative approach is of particular use when researchers want to understand the meaning people attribute to their experience (Peters et al. 2002 and Morse and Field 1996). Qualitative research is generally conducted in the natural setting of the participants, with an exploration of all aspects of the context as compared with the experimental approach in which the researcher attempts to control the variables that are not under investigation (Clarke 2004).

In attempting to define qualitative research, Kirk and Miller (1986: 10) interpret the meaning of qualitative research as ‘a commitment of field activities that does not imply a commitment to innumeracy.’ Selecting the most appropriate method cannot be seen merely in terms of right and wrong. No method is perfect, each having inherent strengths and weaknesses. These need to be considered in the light of the focus of the study (Bulmer 1984). Different methods have something different to contribute to the exploration of a research area and the development of knowledge base. This study would utilise both qualitative and quantitative methods as they both
have something to contribute to this relatively unexplored area based on overseas black and minority ethnic nurses’ experiences of working in the NHS in the south of England.

5.3 Data collection: The process

In this phenomenological hermeneutic inquiry it was imperative to gather data of the lived experience of overseas black and minority ethnic nurses in the NHS, through several methods. In the first instance, data were collected from semi-structured face-to-face interviews from participants in their own homes. Following this, focus group interviews were utilised to corroborate the interview data and finally a survey was conducted. The survey was utilised as a form of data triangulation (see chapter nine).

5.3.1 Negotiating access

This study focused on describing, exploring and developing a greater understanding of the experiences of overseas black and minority ethnic nurses in the south of England. In order to do this it was necessary to turn to the participants who had experienced this phenomenon. Initially, it was planned that the participants would be recruited from two NHS hospitals in two counties in the south of England. However, due to an unexpected refusal from the ethics committee from one of the counties, gaining access to the participants from a larger geographical area was not possible for the qualitative phase of this study. Therefore, participants were recruited from one county in the south of England to participate in both the face-to-face and the focus group interviews.
5.3.2 Gaining access

In order to locate and recruit participants, it was necessary to gain the support of the hospital where the study was conducted, particularly the stakeholders or gatekeepers (Denscombe 2002). This is because they had the authority to grant or deny access. The researcher met with the ward managers and made a formal presentation of the research proposal at the sisters’ meeting. The aim of the study was described and any questions that arose answered. This was an extremely important activity, as gaining access to participants relied heavily on gaining support and assistance of the ward managers. The gatekeepers needed more information about the project and its aims. They were generally looking for evidence that the research would be carried out competently and that the researcher would adhere to the guidelines outlined by the ethics committee (Burton 2000).

Each ward manager present was persuaded of the importance of the study and was informed that approval had been sought through ethics committee (see appendix 7 and 8). Such information was deemed necessary, as it would give the study a level of acceptance. The information sheet thus outlining the project was circulated to all ward managers present for their perusal and they were given full assurances that anonymity and confidentiality would be adhered to at all times, as the researcher was duty bound by the code of professional conduct (Nursing and Midwifery Council 2002a). During the meeting the interview proforma was offered to each manager and this outlined the questions each participant was expected to explore during the interview process. The meeting appeared to be progressing well when one manager stated, ‘I hope you don’t cause any anarchy on my ward.’ This ward manager in particular was led to believe that I was there to ‘stir up’ problems. By reiterating the purpose of the research, which
was to describe, explore and develop a greater understanding of the experiences of overseas black and minority ethnic nurses in the south of England, managers present, saw the significance of this study and gave it their seal of approval. Equally, the researcher wanted to emphasise yet again how important this study was and how the findings might help managers and policy makers address how best they could meet the needs of and support overseas nurses.

Bowling (2002) contends that accessing support can be a lengthy and very daunting process. This was less of a problematic issue with this study because of the researcher’s experience as a nurse, researcher, manager and educator. These no doubt had accorded him sufficient experience of negotiating with the various stakeholders within Mount Hope Hospital NHS Trust (pseudonym). Another factor considered to be crucial was the importance of adequate preparation prior to entering the field. Had the researcher not been committed to this line of research and had such a deep understanding of the aims, significance and relevance of the study, it was doubtful whether support from the ward managers would have been received. Approval was sought and all ward managers were asked to display ten information sheets on their wards, to which they all agreed. A few days later three overseas nurses made contact and expressed their interest in the study.

5.3.3 Criteria for inclusion in the study

The sample strategy selected for this study was ‘a non-probability judgement sample’ (Berg 2001: 32). In this type of sampling frame the researcher would decide on a number of criteria to select participants for the study. Therefore, the sampling process
used was a ‘theoretical or purposeful sampling’ as suggested by Polit et al. (2001: 247). The participants were chosen according to the following criteria:

❖ have originated from outside the UK.
❖ are of black and minority ethnic origin.
❖ are working in the UK.
❖ have studied nursing and qualified as a nurse in their country of origin.
❖ are registered and gained work experience in their country of origin.
❖ are willing to participate.
❖ are able to communicate in English.
❖ are of a diversity in age and sex; male and female between the ages of 20-60 years.
❖ are working in the NHS for at least a minimum of one year in an acute NHS Trust Hospital in the south of England but no more than 10 years.
❖ Is a registered general (adult) nurse

Of the three black and minority ethnic nurses who contacted the researcher, one originated from the Caribbean and two were from South East Asia, and they all met the study criteria. Arrangements were made to meet each individual at a convenient place. A discussion of the purpose of the research took place and each had the opportunity to ask questions. When asked whether they would be interested in participating in the pilot study, they agreed to take part. Full explanation was given as to their involvement in the pilot study and what would be required of them. The researcher stated that they would only be involved in the pilot study and not the main study.
5.3.4 The pilot study

In a phenomenological hermeneutic inquiry a full report of the pilot study is rare (Clarke et al. 1998). Pilot studies fulfil a range of important functions such as assessing the adequacy of the research instruments used to test the concepts and questions. Indeed pilot studies can provide valuable insights for other researchers but they are inadequately used, under discussed and or under reported (Prescott and Soeken 1989). When reported they often only justify the research methods and /or particular research tool used. De Vaus (1993) contends that too often research papers only refer to one element of the pilot study for example, pilot testing of a questionnaire. Such papers often simply state that the questionnaire was tested for validity and reliability.

Even when pilot studies are mentioned in more detail in academic papers and reports, researchers regularly comment that they had learned something from the pilot study and would make the necessary changes, without offering the reader details about what exactly was learned. Some of these processes and outcomes from both successful and failed pilot studies might be very useful to researchers embarking on projects using similar methods. This is particularly important because pilot studies can be time consuming, frustrating and fraught with unanticipated problems (Mason and Zuercher 1995).

Indeed, for this study, it was necessary to conduct a pilot study for two reasons: to ensure content validity and to check the clarity of the questions that participants were expected to answer (Silverman 2001). The interview questions were tested on three participants as alluded to previously from Mount Hope Hospital NHS Trust.
(pseudonym). By conducting the pilot interview with three participants, it became apparent that a couple of the questions needed simplifying, as the participants appeared not to have understood them. For example, ‘can you tell me about the circumstances which led you to come to the UK to work?’ This question was subsequently changed to, ‘can you tell me what has led you to come to the UK to work?’ By making the relevant changes to the interview proforma, the data from prospective participants were obtained with ease (see appendix 9 for main interview proforma).

5.3.5 Participants involved in the study

For this study a total of twelve overseas nurses contacted the researcher and agreed to participate. This number was appropriate as it is congruent with phenomenological studies, where sample sizes tend to be small. Also, it enabled the researcher to manage the large volume of textual information that had been generated, and sufficient, rich data to provide an in-depth understanding of the phenomenon (Marcus and Liehr 1998).

In this study there were seven females and five males whose ages ranged from 26 to 53 years. They were identified as Interview with person A, Interview with person B and so on. This was done to ensure anonymity. The participants originated from the following areas, the Caribbean, Philippines, South Africa, and Sub-Sahara Africa. Background information including age, sex, qualifications, experience in home country, experience in the UK and grade in the NHS is provided in Table 5.1. Despite the sample being mixed, it is recognised that the experiences will be different for each participant in this study because of their ethnic background.
Table 5.1: Background information for one-to-one interviews

<table>
<thead>
<tr>
<th>Name Interview with Person</th>
<th>Country of origin</th>
<th>Sex</th>
<th>Age</th>
<th>Qualifications</th>
<th>Grade in the NHS</th>
<th>Experience in the UK</th>
<th>Experience in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Philippines</td>
<td>M</td>
<td>29</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3 years</td>
<td>2 years</td>
</tr>
<tr>
<td>B</td>
<td>Philippines</td>
<td>F</td>
<td>28</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>4 years</td>
<td>2 years</td>
</tr>
<tr>
<td>C</td>
<td>Philippines</td>
<td>M</td>
<td>32</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>E</td>
<td>4 years</td>
<td>5 years</td>
</tr>
<tr>
<td>D</td>
<td>Philippines</td>
<td>M</td>
<td>35</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3 years</td>
<td>3 years</td>
</tr>
<tr>
<td>E</td>
<td>Philippines</td>
<td>F</td>
<td>26</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>18 months</td>
<td>2 years</td>
</tr>
<tr>
<td>F</td>
<td>Philippines</td>
<td>F</td>
<td>35</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>E</td>
<td>4 years</td>
<td>9 years</td>
</tr>
<tr>
<td>G</td>
<td>Philippines</td>
<td>M</td>
<td>31</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>E</td>
<td>2 years</td>
<td>6 years</td>
</tr>
<tr>
<td>H</td>
<td>Philippines</td>
<td>F</td>
<td>47</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>20 months</td>
<td>25 years</td>
</tr>
<tr>
<td>I</td>
<td>Sub-Sahara Africa</td>
<td>M</td>
<td>32</td>
<td>Registered Nurse (UK and Home country)</td>
<td>E</td>
<td>4 years</td>
<td>9.5 years</td>
</tr>
<tr>
<td>J</td>
<td>Philippines</td>
<td>F</td>
<td>30</td>
<td>BN (Philippines), Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3 years</td>
<td>5 years</td>
</tr>
<tr>
<td>K</td>
<td>South Africa</td>
<td>F</td>
<td>33</td>
<td>Registered Midwife, Diploma in Community Nursing (South Africa), Registered Nurse</td>
<td>D</td>
<td>4 years</td>
<td>20 years</td>
</tr>
<tr>
<td>L</td>
<td>Caribbean</td>
<td>F</td>
<td>47</td>
<td>Registered Nurse (UK and Home country)</td>
<td>D</td>
<td>3 years and 3 months</td>
<td>26 years</td>
</tr>
</tbody>
</table>
5.3.6 Being with the study participants

As previously stated all twelve participants contacted the researcher by telephone and arrangements were made to explain the purpose of the research. The information sheet (see appendix 10) was offered and each participant was given the opportunity to ask questions based on what they had read. They all gave verbal consent to participate following full explanation of the purpose of the study. Participants were reminded that they could withdraw at any time as they were under no obligation to participate. Following this, arrangements were made to meet each participant at his or her convenience so that the taped face-to-face interview could be conducted. All participants requested that the interviews took place in their own homes.

Before commencing the formal taped interviews, it was important to establish a rapport with each participant. This process involved discussing the transition from being a nurse to a lecturer. Following this, an explanation of the purpose of the study and the reasons why it was necessary to conduct this study were offered. During the discussion emphasis was placed on how sharing their experiences with the researcher might help to paint a picture of their experiences while working in the NHS in the south of England. This process of explaining the study and sharing information about myself as a nurse and researcher enabled the researcher to be with the participants in this journey of inquiry.

The next step was to obtain informed consent prior to commencing the interviews. The information sheet and the interview consent form (see appendix 11) were then discussed with each participant and any questions answered. Explanation was once again given for the need to tape the conversation so that an exact recording of their
experience would be obtained and this would assist in the analysis of the data. None of the participants expressed any concerns about the conversation being tape-recorded. Indeed the overwhelming and unanimous response was that if they could help other colleagues like themselves then this was fine. The researcher was humbled by these expressions of good will and support, and these gave a great deal of positive affirmation to the value of the research.

After obtaining written consent, the researcher proceeded to set up the tape recorder and the interviews commenced. At the completion of each interview, it was usual to stay for a cup of tea and an informal chat. This was an extremely important part of the process as it allowed us to talk without the formality of tape recording. Although the information obtained from these informal dialogues was not included as formal verbatim text, it was used to assist the researcher to interpret and make sense of the tape recorded data.

5.3.7 The interviews

The phenomenological interviews conducted focused on revealing the meaning black and minority ethnic nurses attributed to their experience of working in the NHS in the south of England. Many methods are used to collect data in qualitative research, however the interview is the most frequently used method. According to Bulmer (1984: 211), 'sociology is concerned with the interpretative understanding of social action as well as with its causal explanation. It is therefore essential to study social action from the actor's point of view to provide some account of the actor's experience of the phenomenon.' Indeed qualitative interviews help us to share the world of others, to probe beneath the surface of the research topic, to find out how
people experience, interpret and make sense of the world they live in (Fontana and Frey 1998). Therefore, this study involved the use of semi-structured interviews.

Taped interviews were carried out between November 2003 and April 2004. A semi-structured interview format was used. Taped interviews conducted lasted for approximately sixty to ninety minutes with each participant. The researcher began by asking each participant to recall his or her experience of the phenomenon as best he/she could. The following open-ended questions as identified below were utilised to elicit participants views:

❖ Please can you tell me about your past hospital employment experience prior to coming to the UK?
❖ What was it like to work in your country?
❖ Please can you tell me what has led you to come to the UK?

The aim of these open-ended questions was to allow the participants to respond in their own words. This allowed the researcher to obtain a greater breadth of data as compared to structured interviews (Fontana and Frey 1998). Open-ended questions allowed the participants to approach the questions from their own perspective and to feel more relaxed in answering the questions. An interview proforma (see appendix 9) was utilised to guide both the participants and the researcher.

It must be said that there are similarities between qualitative interview and an ordinary conversation, as questions follow one another in a logical way in that the interviewer and the participant take turns to speak and listen. The interview, like a conversation,
differs each time, questions cannot be decided in advance and pursued rigidly. The participant is also able to direct the interview to areas that he or she feels is important and which describe their understanding and experience. There are also significant differences between the interview and an ordinary conversation, the most obvious being the presence of the research agenda (Dingwall 1997). In this study a dialogue developed between the participants and the researcher and this enabled in-depth information to be obtained from all participants.

Throughout the whole data collection process comprehensive field notes were taken and these were later typed up. Field notes taken after each interview consisted of personal, methodological and interpretive writings that facilitated the researcher in organising data and explaining how particular interpretations were derived (Clandinin and Connelly 1998). This source of information provided an individual context for each participant, which reflected the chosen methodology. Heidegger (1962) considered that individuals are embedded in a world where they experience a phenomenon. These participants were able to recall their experiences of being overseas black and minority ethnic nurses working in the NHS in the South of England. Once the taped face-to-face interviews were completed and the data analysed, the findings were used to inform the focus group interviews.

5.4 The focus group interviews

Using focus group as a method for obtaining data from participants seems to have become popular in nursing in recent years (Webb and Kervern 2001). A focus group can be defined as simply a discussion in which a small group of people under the guidance of a facilitator or moderator, has a dialogue on selected topics (Macleod-
Clark *et al.* 1996). According to McDaniel and Bach (1996) such discussion takes place in a social setting and the outcome generates descriptive or explanatory data.

In phenomenological inquiry the purpose is to obtain rich and in-depth data from the participants using methods that are compatible with the research approach. Webb and Kervern (2001) state that a phenomenological approach is incompatible with a focus group method. Within phenomenology the lived experience of participants is important and this could be obtained from either the face-to-face interviews or focus group interviews. Gray-Vickrey (1993: 21) claims that, ‘focus groups are well suited for a full range of qualitative studies including grounded theory, ethnography and phenomenology.’ Indeed, Gray-Vickery was able to obtain rich and meaningful data from participants and demonstrate the compatibility of focus group interviews within a phenomenological approach. Therefore, as focus group is another important method that phenomenological researchers can use. It is only appropriate that this research adopts this approach to triangulate the data from the face-to-face interviews and this study utilised a focus group approach as a method for obtaining information from participants.

5.4.1 The process

This study comprises of three phases of which the focus group interviews are the second phase. Participants were selected as identified in the criteria outlined for the face-to-face interviews. Although the researcher perceived that random sampling might provide an accurate representation of the study population and would reduce research bias, it was felt that this type of sampling frame might yield low responses (Roberts 1997) and the participants might not be as conveniently or readily accessible.
as purposive samples. Therefore, purpose sampling was used to access overseas
nurses in the NHS in the south of England.

As previously stated, the information sheet was left with all ward managers at Mount
Hope Hospital NHS Trust. Overseas nurses made contact with the researcher and
agreed to participate in this study. In addition to the twelve participants who made
contact, ten more nurses had emailed or phoned to say that they would be interested in
participating. However, they stated that before they could agree to this, they needed
more information about the study. The researcher met these nurses individually and a
full explanation of the purpose of the study was given such as, what would be
expected of them and their involvement in the process. Following this, they agreed to
participate.

Participants also indicated that there were many other overseas nurses whom they felt
might be appropriate and interested in this study. They stated that they would give
their friends the relevant information about the study. Within a couple days six
overseas nurses made contact and expressed their interest in this project. They wanted
to know how best they could help with the research. Each individual was met and
informed of the study’s purpose and each gave consent to be fully involved in the
study.

Morgan (1997) contends that the primary aim of focus groups is to bring people
together who have similar characteristics and this is supported by Krueger (1994) who
argues that the use of focus groups is not to infer but to understand, not to generalise
but to provide insights into how people perceive a situation. The creation of
homogeneity was important when establishing the focus groups because it allowed the participants to capitalise on their shared experiences (Kitzinger 1995) by supporting the free flow of dialogue. Throughout the focus group interviews participants were allowed to be challenged by individuals with the same cultural background while at the same time their individual experiences were valued.

While size was a key issue in the planning and formulation phase of the focus groups, it was a starting point in qualitative research (Parahoo 2006). Each focus group had six participants and they originated from areas such as the Philippines, South Africa, India, Caribbean and Sub-Sahara Africa (see tables 5.2 to 5.5). Krueger (1995) indicates that six to eight people are ideal for focus group interviews. In this study the facilitator made personal telephone contact with all potential participants and negotiated a time and date to meet. Eight overseas nurses were invited to participate in the pilot focus group interview and the remaining eight were involved in the main focus group interview. Of the eight who were invited, only six attended and the remaining two made no contact with the researcher to offer any explanations as to why they were unable to attend. Attempts were made to obtain participants of different ethnic backgrounds however, due to either some participants cancelling their meeting at such short notice or failing to inform the researcher of their inability to attend the group discussion, this was not possible.

In pilot interviewing a test of the focus group and interview method was important to avoid poor style and flow of questions (Webb 2002). Morgan (1995) indicates that a common error in focus group interview question guidelines is too much emphasis on what is of interest to the researcher and not enough focus on what is of interest to the
Chapter Five

Research Design and Methods

participants. With this idea in mind, the pilot study was conducted using the focus group interview proforma and amendments were made to the focus group interview proforma following the interview (see appendix 14).

Table 5.2: Background Information for focus group interview one

<table>
<thead>
<tr>
<th>Name Interview with Person</th>
<th>Group</th>
<th>Country of origin</th>
<th>Sex</th>
<th>Age</th>
<th>Qualifications</th>
<th>Grade in the NHS</th>
<th>Experience in the UK</th>
<th>Experience in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>1</td>
<td>Philippines</td>
<td>F</td>
<td>40</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>E</td>
<td>3 years</td>
<td>5 years</td>
</tr>
<tr>
<td>1B</td>
<td>1</td>
<td>Philippines</td>
<td>F</td>
<td>36</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3.5 years</td>
<td>4 years</td>
</tr>
<tr>
<td>1C</td>
<td>1</td>
<td>Philippines</td>
<td>F</td>
<td>45</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3.5 years</td>
<td>6 years</td>
</tr>
<tr>
<td>1D</td>
<td>1</td>
<td>Philippines</td>
<td>F</td>
<td>34</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>4 years</td>
<td>6 years</td>
</tr>
<tr>
<td>1E</td>
<td>1</td>
<td>Caribbean</td>
<td>M</td>
<td>48</td>
<td>Registered Nurse (UK and Caribbean)</td>
<td>D</td>
<td>2.5 years</td>
<td>10 years</td>
</tr>
<tr>
<td>1F</td>
<td>1</td>
<td>Philippines</td>
<td>F</td>
<td>30</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>2.5 years</td>
<td>2.5 years</td>
</tr>
</tbody>
</table>

128
Table 5.3: Background Information for focus group interview two

<table>
<thead>
<tr>
<th>Name Interview with Person</th>
<th>Group</th>
<th>Country of origin</th>
<th>Sex</th>
<th>Age</th>
<th>Qualifications</th>
<th>Grade in the NHS</th>
<th>Experience in the UK</th>
<th>Experience in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>2</td>
<td>India</td>
<td>F</td>
<td>30</td>
<td>Registered Nurse (India and UK)</td>
<td>D</td>
<td>3 years</td>
<td>3.5 years</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>Philippines</td>
<td>M</td>
<td>28</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3 years</td>
<td>2 years</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>Caribbean/Jamaica</td>
<td>F</td>
<td>43</td>
<td>Registered Nurse (UK &amp; Caribbean-Jamaica)</td>
<td>E</td>
<td>3.5 years</td>
<td>6 years</td>
</tr>
<tr>
<td>13</td>
<td>2</td>
<td>South Africa</td>
<td>M</td>
<td>38</td>
<td>Registered Nurse (UK and South Africa)</td>
<td>D</td>
<td>4 years</td>
<td>11 years</td>
</tr>
<tr>
<td>14</td>
<td>2</td>
<td>Philippines</td>
<td>M</td>
<td>48</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3.5 years</td>
<td>17 years</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td>Sub-Sahara Africa/ Malawi</td>
<td>M</td>
<td>50</td>
<td>Registered Nurse (UK and Sub-Sahara Africa-Malawi)</td>
<td>D</td>
<td>3.5 years</td>
<td>21 years</td>
</tr>
</tbody>
</table>
## Table 5.4: Background Information for focus group interview three

<table>
<thead>
<tr>
<th>Name with Person</th>
<th>Group</th>
<th>Country of origin</th>
<th>Sex</th>
<th>Age</th>
<th>Qualifications</th>
<th>Grade in the NHS</th>
<th>Experience in the UK</th>
<th>Experience in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A</td>
<td>3</td>
<td>Philippines</td>
<td>F</td>
<td>30</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>2 years</td>
<td>5 years</td>
</tr>
<tr>
<td>2B</td>
<td>3</td>
<td>Philippines</td>
<td>M</td>
<td>27</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>1.5 years</td>
<td>3 years</td>
</tr>
<tr>
<td>2C</td>
<td>3</td>
<td>South Africa</td>
<td>F</td>
<td>46</td>
<td>Registered Nurse (UK and South Africa)</td>
<td>D</td>
<td>2.5 years</td>
<td>15 years</td>
</tr>
<tr>
<td>2D</td>
<td>3</td>
<td>Caribbean/Trinidad</td>
<td>F</td>
<td>36</td>
<td>Registered Nurse (UK and Caribbean - Trinidad)</td>
<td>D</td>
<td>3 years</td>
<td>7 years</td>
</tr>
<tr>
<td>2E</td>
<td>3</td>
<td>India</td>
<td>M</td>
<td>28</td>
<td>Registered Nurse (UK and India)</td>
<td>D</td>
<td>3 years</td>
<td>3 years</td>
</tr>
<tr>
<td>2F</td>
<td>3</td>
<td>Sub Sahara Africa/Nigeria</td>
<td>M</td>
<td>32</td>
<td>Registered Nurse (UK and Sub-Saharan Africa - Nigeria)</td>
<td>D</td>
<td>3.5 years</td>
<td>5 years</td>
</tr>
</tbody>
</table>
Table 5.5: Background Information for focus group interview four

<table>
<thead>
<tr>
<th>Name Interview with Person</th>
<th>Group</th>
<th>Country of origin</th>
<th>Sex</th>
<th>Age</th>
<th>Qualifications</th>
<th>Grade in the NHS</th>
<th>Experience in the UK</th>
<th>Experience in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>3A</td>
<td>4</td>
<td>Sub-Sahara Africa/Ghana</td>
<td>F</td>
<td>43</td>
<td>Registered Nurse (UK and Sub-Sahara Africa – Ghana)</td>
<td>D</td>
<td>2 years</td>
<td>12 years</td>
</tr>
<tr>
<td>3B</td>
<td>4</td>
<td>Philippines</td>
<td>M</td>
<td>40</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>E</td>
<td>3.5 years</td>
<td>12 years</td>
</tr>
<tr>
<td>3C</td>
<td>4</td>
<td>Philippines</td>
<td>F</td>
<td>25</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>2 years</td>
<td>1 year</td>
</tr>
<tr>
<td>3D</td>
<td>4</td>
<td>Caribbean/Jamaica</td>
<td>F</td>
<td>30</td>
<td>Registered Nurse (UK and Caribbean/Jamaica)</td>
<td>D</td>
<td>3 years</td>
<td>3 years</td>
</tr>
<tr>
<td>3E</td>
<td>4</td>
<td>Philippines</td>
<td>M</td>
<td>27</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>2 years</td>
<td>2 years</td>
</tr>
<tr>
<td>3F</td>
<td>4</td>
<td>South Africa</td>
<td>M</td>
<td>51</td>
<td>Registered Nurse (UK and South Africa)</td>
<td>D</td>
<td>3 years</td>
<td>25 years</td>
</tr>
</tbody>
</table>

Following the completion of the pilot interview, one of the participants stated that she would contact and encourage a few colleagues to participate in this study. Within a week sixteen overseas nurses made contact, six by phone and ten by email to express their interest in the study. The researcher met with each participant and explained the
Chapter Five

Research Design and Methods

research purpose. Once full explanation was given they agreed to participate. Arrangements were made to interview these participants in a focus group setting. Overall, a total of four focus groups were utilised and each group comprised of six overseas nurses. Using such small numbers of focus groups were considered appropriate for phenomenology as the focus was on obtaining in-depth information in order to further understand the phenomenon under investigation.

As previously stated in the pilot interview, personal telephone calls were made with potential participants and a date and time to conduct the focus group interviews were agreed. The interviews took place in a quiet setting, a hall, and each group was arranged in a close circle where all members could see each other. Failure to acknowledge this issue may have inhibited the group synergy thus resulting in some members feeling excluded from the group.

With all ethically sound research, the focus group participants were provided with the information sheet and this outlined the aims and objectives. This sheet was provided so that participants could fully understand what they were consenting to. Consent was sought from all participants for the interview (see appendix 13) and to use the tape recorder. Having the tape recorder enabled the researcher to maximise the accuracy of the data and, also it had the effect of enhancing the potential validity of data analysis. One of my roles as the facilitator was to ensure that the participants felt welcome and as relaxed as possible. The purpose of the group interview was explained and they were reassured that confidentiality would be adhered to at all times. Participants were invited to introduce themselves and this served as an icebreaker. Before each group interview began ground rules were set and all participants agreed with these.
Using the focus group interview proforma (see appendix 12), the interview began with an activity followed by more general questions as highlighted in the proforma. During the interview process, the facilitator probed further with more specific questions until all the participants got an opportunity to express their views, and also sought clarification from the participants when needed. Each focus group lasted for at least ninety minutes and each session ended with a summary of the discussion.

The benefit of having a skilled facilitator cannot be overstated (Doyle 1993). The researcher adopted the role of the facilitator having had experience of interviewing. Appropriate skills for interviewing participants were gained following a masters degree. These skills have certainly helped the researcher to overcome some of the pitfalls that Morgan (1995) alluded to in his account. Throughout the discussion participants were encouraged to debate and the facilitator explored inconsistencies and encouraged those reserved participants to contribute. As with this type of method, participants will divulge information that they believe the facilitator should hear rather than their deep seated experiences. In order to address this, emphasis was placed on the importance of confidentiality and the need for honesty in their responses. Focus groups have the potential to bring the researcher closer to the research topic through a direct intense encounter with key individuals (Clarke 1999). Indeed, conducting this study enabled the facilitator to ‘experience’ what participants had experienced of working in the NHS as overseas black and minority ethnic nurses.

During the four focus group interviews, the observer was present and her role involved recording, observing group interaction, making notes and generally ensuring that a rounded interview took place. She was available to highlight any possible
discrepancies (Krueger 1998 and Mansell et al. 2004). At the end of each session participants were asked whether they had anything they would like to add. Two participants recalled their experiences of having to move from one ward to another without having the choice. They stated that this was unfair as illuminated in this verbatim report, ‘ward managers ought to be fair in their management of their wards.’ Following this final account, participants had nothing more to add. It must be mentioned that both the pilot focus group interviews and the main study focus group interviews adopted similar approaches and were conducted under strict ethical guidelines.

5.5 Ethical considerations

Some of the ethical issues involved in a study of a qualitative nature are common to any form of research involving human participants. The primary aim of ethical considerations in research is to ensure that the goals of the research do not override the interests of the research participants. Researchers conducting qualitative studies have to address issues of an ethical nature. In order to conduct this research, it was necessary to seek and gain ethical approval from the relevant bodies. The purpose of the Ethics Committee is to ensure that the research to be conducted on human participants abides by ethical principles. Thus it was essential that the research to be conducted caused no harm to any of the participants (Polit et al. 2001). The researcher obtained informed consent from all participants involved and had followed a rigorous methodology and design in line with the principles of phenomenology particularly those of Heidegger (1962).
5.5.1 Professional guidelines and Local Research Ethics Committee

Professional associations of researchers such as the British Sociological Association (BSA 2001) and the Research Governance Framework for Health and Social Care (DoH 2001e) have drawn up a number of ethical codes that provide guidance to researchers as to the nature of their ethical obligations to research participants. Other professional bodies such as the Nursing and Midwifery Council (NMC 2002a and b), and the Royal College of Nursing (RCN 1998) have also drawn up ethical guidelines that researchers must adhere to when conducting studies with participants.

The Local Research Ethics Committee [LREC] is required by the Department of Health to be established within each health authority in England and Wales (DoH 2001f), and exists to protect the interests of patients and staff of the NHS, and individuals within other organisations. The Local Research Ethics Committee examines and approves proposals for research involving these, and ensures that all studies adhere to the sound and legitimate ethical principles as laid down by the research governance framework for health and social care (DoH 2001e).

Ethical approval from both the University of Surrey and North and Mid Hampshire Ethics Committees was sought (see appendices 7, 8 and 14). Ethical approval from a hospital in the south of England was also obtained. Having obtained ethical clearance, commencement of recruitment of participants and data collection began. The process for this is outlined in this chapter under the section titled: ‘data collection: the process.’ In obtaining consent the participants must be able to understand the information relevant to their decision to participate in the research, and be able to communicate their decision.
5.5.2 Theoretical approaches to ethical issues

There has been much work and debate on ethical issues which has led to a variety of theoretical approaches in the field of health and social care (Beauchamp and Childress 1994). There are four ethical principles relevant to research undertaken on human beings:

- Autonomy
- Beneficence
- Justice
- Non-maleficence

The principle of autonomy implies that participants consent to participate without coercion. Many authors have claimed that the protection of human rights (Wadham and Mountfield 1999) is imperative in health care research (Dresser 1998 and Kvale 1996). It must be said that any kind of research must be guided by the principles of respect for people, beneficence and justice. According to Capron (1989) participants have rights and these include, the right to be informed about the study, the right to freely decide whether to participate in a study and the right to withdraw at anytime without any repercussions. Despite having this opportunity none expressed any desire to withdraw from the study. In both qualitative and quantitative research this principle is honoured by informed consent. Informed consent requires participants to understand the risks and benefits of being involved in the study (Normand et al. 2003).

Indeed all participants understood what was expected of them and informed consent was obtained following a lengthy and detailed explanation of the study. Each
participant was given an information sheet which outlined the aims and objectives of
the study, and gave the name, contact telephone number, email address and
institutional link (on the University’s headed paper) of the researcher (see appendix
15). Participants were informed of their rights to withdraw from the study at anytime
without giving a reason. They were assigned a pseudonym and were informed that no
material would identify them in the thesis or in any subsequent publications.

Beneficence is another principle that implies, doing good for others (Orb et al. 2001).
In this study it anticipated that the findings may illuminate how best to meet the needs
of overseas black and minority ethnic nurses in the NHS particularly in the south of
England. It is hoped that the findings would further expand the body of knowledge in
this relatively new and unexplored area. Furthermore, it is anticipated that the findings
from this study may help policy makers, NHS Trusts and any other organisation that
employ overseas nurses as part of their workforce, to address the needs of such
nurses. Finally, overseas black and minority ethnic nurses had the opportunity to
express their views about their experiences of working in the NHS in the south of
England and this might have beneficial gains for these nurses.

Critical to this principle of justice is avoiding exploitation and abuse of participants
(Richards and Schwartz 2002 and Normand et al. 2003). This meant that care must be
exercised when conducting research with participants so as to avoid exploitation or
abuse. It was important that participants remained anonymous and felt safe in giving
information, without their identities being disclosed to others. Participants must not be
pressured into disclosing information that they are not happy to divulge to others.
Indeed care was exercised within this study. Participants remained anonymous and
were given pseudonyms to protect their identities. Under no circumstances were they pressured into disclosing information that they were not happy to divulge.

The use of the tape recorder for the interviews was agreed with all participants involved in this study. They were reminded before the interview that should they say anything on the tape that they subsequently did not wish to be included, the tape would be stopped and the offending portion would be recorded over or the information would not be used. This did not happen during either the face-to-face or focus group interviews.

Transcripts were anonymised after they had been transcribed by removing any identifiable personal characteristics such as names and wards. All tapes were coded and stored in a locked cupboard to prevent access by unauthorised persons. Computer files were identified only to the researcher as this protected the participants and complied with the Data Protection Act of 1998 (Data Protection Act 1998). The Data Protection Act aims to protect the rights of the individual(s) from whom data have been obtained. It applies to information which is held on computers and in paper form. Akeroyd (1991) critiques the lack of attention paid to data security by researchers who hold information they have collected from individuals in a textual format on paper. All information collected from the participants was handled securely and stored in a locked cupboard. Tapes were listened to only by the researcher and the transcriber and would be erased on completion of the study. Participants were assured that two supervisors would have access to the transcripts after they had been anonymised.
In undertaking focus group interviews, there might be ethical issues associated with this type of approach. As participants might reveal themselves in a group setting due to its synergistic effect, there might be privacy concerns (Carey 1994). This issue might be greater in a group setting than in a face-to-face interview and would be much easier to deal with such concerns on an individual basis rather than in a focus group setting (Smith 1995). During the focus group interviews participants discussed their experiences with ease and the researcher encountered no ethical issues that needed addressing.

At the beginning of each focus group explicit information was given to all participants that ensuring strict and absolute confidentiality could not be promised. This was due to the fact that the researcher had no control over what participants might disclose after leaving the focus group interviews. It was reiterated at the end of each interview to all participants that they owed a duty of care to each other, and that meant withholding any discussions of the issues covered during the focus group interviews.

The final ethical principle is that of nonmaleficence, that is doing no harm to participants. Although all research carries risks both physical and psychological, it is important that these risks are minimised as much as possible by adhering to the ethical principles laid down by the research governance framework (DoH 2001e). This study did not encounter any concerns about the ethical procedures required. Overall the participants were pleased to assist and had not expressed any concerns involving their right to anonymity. It was important to reiterate the necessity of adhering to the prescribed ethical guidelines as identified earlier within this study. This was to highlight to all participants the responsibilities of the researcher.
It was anticipated that there would be little, if any risk in interviewing overseas black
and minority ethnic nurses about their experiences of working in the NHS in the south
of England. The researcher planned that if participants exhibited any signs of distress
during the interview, the interview would be stopped and no further questioning
would be undertaken unless the participants wanted to proceed. As an experienced
nurse and educator involved in sensitive discussion for many years, felt that the skills
acquired would enable the researcher to reduce or minimise any potential risks to
participants. If the participant appeared to need further counselling, he or she would
be recommended to seek help and advice from his or her general practitioner.

Although these strategies were planned for managing participants’ distress or comfort,
there was one situation where a participant became upset and this was for a short
period of time. In this particular instance, the interview with Person D recalled how
the experience encountered created some anguish for him. Person D recounted the
unpleasantness and the constant undermining brought him great distress. When the
researcher noticed this, the tape recorder was immediately stopped. The researcher
asked if he wanted to discontinue the interview to which he politely stated that he
would prefer to discontinue the interview. Person D was given the opportunity to
discuss his distressing feelings with the researcher if he so wished. He indicated that
he would welcome this. Therefore, the opportunity was given to talk through the
issues and the researcher took the role of a sympathetic listener, which appeared to
have helped Person D.

This interlude provided not only the opportunity to deal with sensitive issues but also
helped to further increase the trust and the degree of comfort enjoyed by both the
participant and the researcher. It must be said that Person D was never left in a state of distress and was informed that should he need to discuss anything further, he should contact his general practitioner for advice and counselling. The following week the researcher was invited back to continue with the interview. This went well and Person D was grateful for the patience and sensitivity shown during his distressful moment.

Nurse researchers have written about the dilemma of the multiple roles and distinguishing between being a researcher and being a nurse whilst doing fieldwork (Rudge 1995). The researcher was well aware of these potential dilemmas prior to conducting this study and felt able to draw on my nursing and educational experience to help Person D cope with such distressing issues.

Many researchers, particularly those working within a feminist framework, have highlighted the potential of an unequal power relationship that might exist between the researcher and the participants (Oakley 1981 and Sherwin 1996). Indeed Oakley (1981) describes the interviewing process as potentially exploitative, with the researcher gaining but not giving information. In building up a rapport in this study, the researcher felt it to be important to both ask questions and share some of his experiences as a nurse, trained in England and worked for the NHS.

According to Nunkoosing (2005) the distribution of power in a voluntary relationship differs from that in which the participants are in a vulnerable relationship with the researcher for example if the participants are employees, patients or clients. In this study, the researcher was not involved in any way with the participants. However, the researcher was aware that there are other aspects of a power differential which may
have been perceived by the participants such as, differences in the education and social class of the researcher. Within the study the researcher attempted to reduce any perception of power inequalities by emphasising the role of the participants as ‘expert’ and the researcher as enquirer into their area of expertise.

A further potential problem for both participants and researcher is one of dependency due to the relationship built up in order to increase rapport and trust. This situation never arose, probably due to the limited time period of the data collection with each participant but could have been more of an issue had the research period been longer. The data collection took place over two visits. The first was, to interview the participants and the second, to verify the data collected by returning to all participants who took part in the study for confirmation as to whether their views were reflected accurately on each transcript.

Participants who took part described the interview as a positive experience, explaining that it gave them an opportunity to discuss something in a way that they would not normally do. Overall, the researcher enjoyed the field work associated with this study and valued the time spent meeting and having a dialogue with the participants. At the conclusion of each interview each participant was thanked for his/her time and involvement in the study. The researcher felt privileged that these participants were willing to share their experiences and endeavoured at all times to convey thanks and gratitude in a suitable and sincere manner to them.
5.6 Rigour

Many of the disputes associated with the different methodological approaches revolve around different perspectives about what counts as reliable or valid evidence. Any research has to demonstrate rigour, where rigour describes the trustworthiness of the research (Koch 1994). According to Sandelowski (1993: 2) 'trustworthiness becomes a matter of persuasion whereby the scientist is viewed as having made those practices visible and, therefore auditable, it is less a matter of claiming to be right about a phenomenon than having practised good science.' Indeed, this view is also echoed by Denzin and Lincoln (2000) asserting that one of the criteria is that of auditability.

Research conducted from a positivist approach uses the criteria of internal and external validity, reliability and objectivity to demonstrate rigour. Internal validity is defined as, 'the extent to which variations in an outcome or dependent variable can be attributed to controlled variation in an independent variable' (Guba and Lincoln 1989: 234). Within the positivist arena, there are several threats to internal validity such as experimental mortality and testing and these must be dealt with in the research situation. In the experimental setting there is an attempt to control variables in order that a causal relationship can be verified between the experimental or independent variable and the dependent variable. Validity is always established in relation to another measure for example the influence of culture on behaviour. Guba and Lincoln (1989) argue that there is no absolute measure for comparison and warn against claims of validity.

The second positivist approach is that of external validity and this is a measure of generalisability such as, can these results be generalised to other populations and
settings in an attempt to predict or explain (Ferguson 2003). There are threats to external validity as highlighted by Guba and Lincoln (1989) such as setting effects and selection effects. If these are addressed then findings from the study should apply to the rest of the sampled population. External validity is generally assumed to be one of the strengths of experimental research and the lack of generalisability as the main weakness of qualitative studies.

Reliability is the third approach and this is concerned with reproducibility and replication such as if the study is repeated will the same data be produced? The validity of a research rests on reliability, that is, if a study is unreliable then it cannot be valid. Reliability may also refer to internal consistency. For a study to be reliable it has to have consistency, predictability, dependability, stability and accuracy. Bloor (1997: 37) argues that 'within the field of sociology, validation cannot occur through subsequent replication, since identical social circumstances cannot be re-created outside the laboratory.'

Finally, objectivity in positivist terms demands that a study is free from biases, values and/or prejudice (Guba and Lincoln 1989). The experiment attempts to fulfil these requirements. Guba and Lincoln (1989), when expounding the problems associated with the assumptions of positivism, argue that within positivism there is an epistemological assumption that it is possible to separate the observer from the observed. They also postulate that there is an assumption that adherence to a methodology is enough to guarantee that the study is free from bias. This is not always the case, there are external factors that might influence the research such as the researcher's background and experience of conducting research.
Positivist researchers generally claim that their studies are embedded in the four approaches as identified above and authors such as Kendall (1997) and Avis (1997) appear to be united in a call for the reconceptualisation of these approaches in post-positivist research. Lather (1991) argues that research in the human sciences is inherently ideological and cannot therefore be scientifically neutral or objective. A positivist approach focuses on measurement, quantification and attempts to categorise, but human behaviour does not fit neatly into this approach. In earlier post-positivist work, one of the major critiques was the neglect of issues of validity and reliability. More recent work has begun to address these areas and there is an expanding body of literature expounding these issues. A post-positivist approach recognises that neutrality and objectivity are not central and other knowledge can remain valid.

Studies conducted with post-positivist paradigm cannot meet the requirements of validity and reliability that positivist research aspires to. Several qualitative researchers have addressed this issue and have argued a case for new perspectives (Sandelowski 1993 and Popay et al. 1998). Although there is disagreement about what the criteria for assessing post-positivist research should be, there is agreement that the criteria should in fact be different.

Reason (1981) and Kirk and Miller (1986) advised that the concepts of reliability and validity be borrowed from the traditional research but cautioned that these should be revised and expanded appropriately. Kirk and Miller (1986: 14) state that, 'the description of reliability and validity ordinarily provided by non-qualitative social scientist rarely seems appropriate or relevant to the way in which qualitative researchers conduct their work.'
Some of the major voices in this area have been that of Guba and Lincoln (1989) and Sandelowski (1993) who have advocated not only for a new approach to discussing these issues, but also for different terminology. Consequently, some researchers have derived their own terms for use within the post-positivist paradigm. As a result of the proliferation of terminology, further confusion has arisen (Brink 1991). There is a case for issues to be similar to the terms used in quantitative research so that they will be understood by positivist researchers and funding bodies. However, this argument is potentially problematic in that it could be extended to limit the methods used by researchers to ones that are familiar to funders and positivist researchers, rather than acknowledging the differences of research and emphasising the importance of these differences.

5.6.1 Rigour related to this study

In using qualitative research methodologies the question of rigour or trustworthiness arises. This is mainly because these methodologies are unable to be assessed using the notion of validity that is aligned with traditional empirical research. However, whatever the chosen approach and line of inquiry, it is necessary to demonstrate that one’s study is rigorous and judged by others as credible. Several authors have offered ways of indicating rigour in qualitative research, particularly when using a phenomenological approach (Koch 1994, Rose et al. 1995, van Manen 1990 and Crist and Tanner 2003).
When using qualitative research methodologies, trustworthiness can be demonstrated by the concepts of

- Credibility
- Transferability
- Dependability or Confirmability

The term credibility is used to refer to truth value or believability of the findings that have been established by the researcher through prolonged contact and interaction with the participants to establish rapport and trust and to understand the culture or context (Leininger 1994). In addition to these there is member-checking and this ought to be dedicated to verify that the constructions collected are those that have been offered by the participants (Guba and Lincoln 1989). In phenomenological inquiry, the truth value lies in the study’s ability to represent the views and experiences as they are lived by overseas black and minority ethnic nurses and these are presented in the findings chapter. Indeed this chapter not only highlights the participants’ lived experiences but also the meaning they attributed to these experiences as overseas black and minority ethnic nurses working in the NHS in the south of England.

Within this research design and method chapter, there is evidence of a systematic approach to the study and details are given on the data collection process. As part of the member checks, the transcripts were taken back to each participant involved in the study to verify that the textual data represented and captured their views and experiences. Participants stated that their views and experiences were accurately reflected within the transcripts. Bloor (1997) found that in his study, participants were
too polite to criticise his data. Although Bloor (1997) revealed this, the evidence from this research highlighted a different mechanism.

In addition to the above, credibility was further enhanced by the skills of the researcher particularly during data collection and analysis (Tobin and Begley 2004). Skills such as interviewing and data analysis were assessed by the researcher’s supervisors and confirmation was made that the researcher had the appropriate skills to conduct this research.

Transferability is a parallel of external validity or generalisability, and refers to whether particular findings from one qualitative study can be transferred to another similar context whilst preserving the particular meanings and interpretations of the original study (Leininger 1994). It is evident from the study’s findings that these have been validated by other studies as illustrated in both the literature review and discussion chapters. The researcher has attempted to provide sufficient and transparent information for the readers to be able to make their own judgements (Miles and Huberman 1994) about the findings and how these were derived. Transferability is further enhanced by the confirmation of the qualitative data through the survey. Furthermore, transferability was also enhanced by tape recording and transcribing each interview. This was important because it allowed the use of verbatim quotes within this study.

The term dependability or confirmability is parallel to the criteria or reliability and objectivity respectively, often taken to mean agreement and reliance of a finding by direct and repeated affirmation (Leininger 1994). Guba and Lincoln (1989) have
argued that qualitative research must be auditable when another researcher can follow the decision trail used by the researcher in the study. Furthermore, comparable rather than contradictory conclusions should be drawn if the study is auditable. Koch (1994) recommends that researchers ought to provide a decision trail in order to establish clearly the trustworthiness of the study. Throughout this thesis I have attempted to describe the processes the research has progressed through, making explicit the decision making process, and providing clear and sufficient information in order that data can be tracked to its sources. Dependability was further enhanced through the development of the interview proforma with the support of the researcher's supervisors. A pilot study was conducted to ensure clarity, suitability and to test the concepts. In view of the participants responses, the interview proforma was further developed to take into account participants views. All interviews were tape recorded as previously stated then transcribed verbatim to give a true account of the participants' experiences of working in the NHS in the south of England.

This research has highlighted the development of the pilot study, tape recording of the interviews, the verbatim transcribing of these interviews and the use of my supervisors, all of which have enhanced the dependability of the study. In addition the use of NUD*IST QSR (N6) computer software to aid management of the data during the analysis phase assists in the establishment of the audit trail and further adds to the dependability of this study.

Lather (1986) also offers some guidelines to increase the credibility of evidence within what she terms open ideological research in a post-positivist context. These are construct validity, face validity and catalytic validity.
Construct validity involves an examination of how preconceptions of the researcher influence the findings and there is a need for reflexivity on the part of the researcher (Whitehead 2004). Koch and Harrington (1998: 886) spoke of reflexivity as, 'the critical gaze turned towards the self', thus examining the personal position, identity and self of the researcher as an ongoing process. The values, assumptions, prejudice and influence of the researcher must therefore be acknowledged and taken into account and even utilised according to Wetherell et al. (2001) and Hammersley and Atkinson (1995). Hermeneutic phenomenology recognises the influence of the researcher on the conduct and presentation of the study. The researcher is aware that his background as a nurse and educator together with his philosophical stance, values and feelings have undeniably contributed to the interest that has developed in the experiences of overseas black and minority ethnic nurses and it is because of these attributes, the findings may be influenced.

Face validity is linked to construct validity. This occurs when the participants can see themselves in the description even though the description may be condensed from the experiences of more than one participant. In order for this to be assessed, the analysis has to be presented to at least a sub-sample of the participants. Reason (1981: 248) stated that, ‘good research at the non-alienating end of the spectrum goes back to the subjects with the tentative results, and refines them in light of the subjects’ reactions.’ Indeed the transcripts were taken back to the participants rather than a sub-sample for verification and the textual data reflected the participants’ views and lived experiences.
Catalytic validity is about empowerment and emancipation of individuals who have participated in the research. It represents the degree to which the research process 're-orients, focuses and energises participants towards knowing reality in order to transform it' (Lather 1991: 68). Participants should gain both self-understanding and self-determination through participation in the study (Lather 1991). This study had no implicit or explicit intention of emancipation but through their participation, the researcher encouraged the participants to express their thoughts and feelings about their lived experiences. Participants indicated that they would hope that this study would identify their needs and would anticipate that their employers would address their identified needs.

Both Draucker's (1999) and Rose *et al*.'s (1995) approaches are underpinned by Heidegger's (1962) philosophy and they identify some criteria that should be considered when evaluating qualitative research. They recommend that Heideggerian research should be evaluated by:

- The extent to which the philosophy informs not only the methodology but the interpretation.
- The extent to which the vantage points of both the participants and researcher(s) merge for a better understanding.
- The extent to which Heideggerian ideas and concepts inform and enrich the research findings.

Throughout this study, it was important to adhere to these criteria and to demonstrate clearly how these had been achieved. Heidegger's (1962) underpinning philosophy
Chapter Five

Research Design and Methods

informs this research and the researcher has attempted to remain as close as possible to this philosophy.

5.7 The survey

This study also utilised a survey to ascertain participants' views of their experiences of working in the NHS in the south of England. The questionnaires were developed following the findings from the focus group interviews and they investigated five areas such as equal opportunity, skill development and training, discrimination, support mechanisms and adjustment to a new environment. The questionnaires were distributed to 15 NHS hospitals in the south of England. There were 208 returned questionnaires and of these 188 were considered eligible for the study [Please refer to chapter 9 for a complete account of the process for the survey].

5.8 Triangulation.

Triangulation may be defined as the use of two or more methods of data collection in the study of some aspect of human behaviour (Risjord et al. 2002). It is a technique of research to which many subscribe to in principle but which only a minority use in practice (Polit and Hungler 1999). Although only a few use this approach in practice, Cook (1983) contends that triangulation is a useful method in assisting the researcher to minimise biases in research.

Denzin (1989) identified four types of triangulation namely: data, investigator, theoretical and methodological. There are three types of data triangulation: time, space and person. Within this study, person triangulation was utilised and this involved the collection of data from individuals and groups. Indeed, participants from
both the face-to-face and focus group interviews told their stories about their experiences of working in the NHS and the data obtained from the focus group was used to validate the face-to-face interview findings.

Both investigator and theoretical triangulation were not used in this study as they were not relevant, however, methodological triangulation was utilised. According to Foss and Ellefsen (2002: 243) methodological triangulation is defined as, 'the use of two or more research methods in one study.' There are two types of methodological triangulations: across-method and within method (Denzin 1989).

Across-method triangulation also called between-method involves combining strategies from two or more research approaches in one study. This usually means researchers utilising both qualitative and quantitative research methods together with the aim of achieving convergent validity (Foss and Ellefsen 2002). This study utilised face-to-face interviews, focus group interviews and a survey to explore the lived experience of overseas black and minority ethnic nurses in the NHS. Although the study utilised both qualitative and quantative approaches to collect data, the intention was not to compare the findings but to highlight the same phenomenon using different research strategies.

Within-method triangulation involves combining two or more similar data collection approaches in the same study to measure the same variable (Kimchi et al. 1991). This study utilised three approaches to obtain information on overseas black and minority ethnic nurses experiences of working in the NHS. Begley (1996) argues that many researchers give the impression that methodological triangulation only implies a
combination of both qualitative and quantitative research approaches in one study. However, it has been argued that the use of two or more research methods from the same tradition can be used, for example, ethnography and phenomenology (Begley 1996), consequently showing the illumination of realities which might not be found when one research approach is adopted.

Methodological triangulation may occur either simultaneously or sequentially (Field and Morse 1994). Simultaneous triangulation utilises both qualitative and quantitative methods at the same time and the findings complement each other at the end of the study. On the other hand, sequential triangulation involves the use of one method followed by the other. In this study, qualitative data was collected and the findings were used to develop a questionnaire which was distributed to participants who had not been involved in the study. The purpose was to ascertain the extent to which the findings from the qualitative data were applicable to the larger study group.

The purpose of using triangulation in this study is to develop a greater understanding of the experiences of overseas nurses who are employed in the NHS where this study was conducted. In addition, the researcher used this approach to enhance the trustworthiness of the study, deepen the analysis and to overcome deficiencies inherent in a single method approach. The findings were drawn from both naturalistic and positivist paradigms. Although these approaches have both strengths and limitations, these were adopted so as to provide the reader with a greater understanding of the experiences of overseas nurses. Although a number of themes emerged following data analysis, the example, discrimination would be used to demonstrate triangulation.
In the face-to-face interviews participants spoke of feeling discriminated against and they could not understand the reason for such treatment. Similarly, participants from the focus group interviews indicated that they had experienced discrimination and were treated differently to that of their UK counterparts. As this theme appeared to be evident within the data, the researcher wanted to investigate the extent to which discrimination occurred within the NHS in general. In attempting to find out about this issue, a questionnaire was devised and it included the concept of discrimination. One of the findings from the survey revealed that participants experienced discrimination in the workplace and this result was highly significant (p=0.000). It is important to say that through triangulation, the researcher was able to develop a better understanding of overseas nurses' experiences and the result of discrimination can be found in both the findings and survey chapters.

5.9 Summary

This chapter has demonstrated the approach utilised for collecting information on overseas nurses' experiences. This method is congruent with the philosophical underpinnings of Heidegger (1962). The method presented allowed the researcher to gather the data in a way that suited the research question. By adhering to this method, relevant data were obtained on the experiences of overseas black and minority ethnic nurses in the NHS in the south of England. The researcher gave an account of how this study was conducted, from entering the field of inquiry to how issues of rigour were maintained in terms of credibility, transferability, confirmability or dependability and triangulation.
Chapter Six

Data Analysis

6.1 Introduction

In order to interpret the participants' stories it was necessary to immerse myself fully in the data, and be mindful of the influence my background had on the interpretation of the participants' stories. This chapter will attempt to give a clear account of the analytical process informed by the philosophy of Heidegger (1962). A description is given of how both face-to-face and focus group interviews were analysed through utilising van Manen's (1990) analytical framework and the hermeneutic circle. I will illuminate how the data were reduced, how important meanings were identified from the raw data and how themes were formed from sub-themes. I will conclude by summarising the main points within this chapter and the pronoun 'I' will be used to avoid the researcher from distancing himself from the analytical process.

6.2 The process

In the literature there appears to be no clear order for analysing data that utilise both face-to-face and focus group interviews. Qualitative data analysis is a creative process with no set 'recipe' to be followed. Koch (1999) advocates, particularly with face-to-face interviews, that researchers may develop their own analytical framework. The methodology utilised within this study is that of Heidegger's. It has been said (Kock 1999) that there is no established method to interpret data when taking this position. Thus researchers using phenomenology have either developed their own methods for data analysis through adaptation or have sought methods that are more closely aligned with the philosophical foundation of their research (Gadamer 1975). With this in
mind, I have decided to develop my own analytical framework but also recognise and adhere to the philosophy of Heidegger (1962). The analysis included elements of a creative and personal nature, which makes it difficult to describe all aspects of the process fully. It also involved elements of Van Manen's (1990) analytical framework. In understanding the data it was important to consider participants' length of time in working in the NHS and living in the UK. In addition, their age, socio-economic position at migration and country of origin [Please refer to chapter 5 more details].

6.2.1 Background of the researcher

My interest in exploring, describing and developing a greater understanding of the experiences of overseas black and minority ethnic nurses in the NHS in the south of England stems from my own ethnic background, media accounts and anecdotal information. I was born in Trinidad and trained as a nurse in England. As previously stated, the location of the researcher within the hermeneutic circle is of prime importance in interpreting hermeneutic phenomenology. It is therefore essential that my background be taken into account when reading and interpreting the participants' account of their experiences of working in the NHS. Moreover, my pre-understanding and assumptions will interact with the whole and part of the interpretive process and my position within the hermeneutic circle will be clearly identified within the data analysis.

I trained in the south of England and worked in a number of surgical settings within a number of hospitals for many years. I possess post-basic qualifications in surgical nursing and held a variety of clinical and managerial positions within the NHS. Currently, I am employed as a Senior Lecturer at the School of Health and Social
Care at Oxford Brookes University and I am responsible for ensuring that the pre-registration undergraduate nursing curriculum reflects issues of inclusion and diversity.

I first became interested in overseas black and minority ethnic nurses when I was a junior ward manager at St Bede's Hospital (pseudonym). Whilst there, overseas nurses highlighted to me that they felt that they were treated differently to that of their white British counterparts. This aroused my interest and I felt that this would be an area that could be explored in the form of a doctoral project. I therefore decided to enrol at the University of Surrey and proceeded to embark upon this relatively new and unexplored area.

6.2.2 Justification for using van Manen's framework

Although a range of established methods was utilised for phenomenological research, this tended to reflect Husserlian philosophical assumptions. For example, methods developed by phenomenological psychologist such as van Kaam (1959), Giorgi (1985) and Colaizzi (1978) incorporate the concept of bracketing one’s assumptions and ideas about the phenomenon. These methods, although helpful in phenomenological studies that take a philosophical stance aligned with the descriptive and epistemological phenomenology of Husserl (1965), are incompatible with the ideas and philosophy of Heidegger. Therefore, they were not appropriate for this research.
As this study uses a hermeneutic phenomenological approach informed by the ideas of Heidegger (1962), it is important that the chosen method is congruent with the philosophical orientation. I chose van Manen's (1990) method because I believed that this particular approach was most suited for this study. Also it reflected the philosophical foundations of the methodology, and enabled me to draw on my own experiences whilst closely interacting with contextual data. Therefore, van Manen's (1990) approach offered me a way of being involved and committed to the interpretive process. As van Manen's analytical framework is aligned with the philosophical thinking of Heidegger, both horizons of the researcher and the participants came together to find a meaningful account of the phenomenon under investigation.

Within phenomenology, van Manen (1990) offered an approach that comprised of seven activities. This approach is flexible in nature as van Manen argues that his analytical framework can be flexibly used to suit the research question. Indeed, flexibility was utilised and the following activities were used to analyse data of a phenomenological nature:
### Table 6.1: Stages of analysis

1. The first stage involved listening to each tape at least twice so as to gain a sense of the participant’s whole story and this was followed by a period of reflection to make sense of the experience.

2. The second stage involved verbatim transcribing of each participant’s interview.

3. The third stage involved reading each verbatim transcript repeatedly and reflecting upon this to achieve a holistic understanding of the meaning of each participant’s experience.

4. The fourth stage involved numbering in the margin each line within each transcript using the package NUD*IST QSR (N6).

5. The fifth stage involved a process of identifying and highlighting descriptive statements within each transcript.

6. The sixth stage involved balancing each descriptive statement by considering its parts and whole in context.

7. The final stage involved coding each descriptive statement across the twelve participants’ stories, and each statement was reflected upon to uncover essential themes.

This analytical framework clearly reflects the philosophical basis of Heidegger’s in many ways and aims to uncover meanings participants attributed to their experience of working as overseas black and minority ethnic nurses in the NHS. It does not attempt to bracket the researcher’s pre-understandings and assumptions, these being important characteristics in the analytical process as also highlighted by Gadamer (1975).

### 6.2.3 Face-to-face interviews

The taped interviews were transcribed verbatim soon after each interview. Twelve tape-recorded interviews were conducted with each lasting no more than ninety minutes. The tapes were listened to and I read and re-read the interview transcripts to get a sense of the whole story. Whilst listening and re-reading the transcripts, I found
that I could relive the interview and participants’ stories and visualise the context in which they had endured their experiences. I was also able to capture the essence of what they had communicated and check for accuracy of the transcripts [see appendix 16 for a copy of an interview transcript for person J].

This initial part of the data analysis process involved trying to reach an initial understanding of the participants’ overall experience. As I listened, read and reflected I entered into a dialogue with the text and this enabled me to attain an understanding of the participants’ stories. The field notes taken assisted me in my analysis and interpretation of the interviews and these became useful prompts for my own recall of events when reflecting on the data.

6.2.4 Hermeneutic circle

Within a hermeneutic phenomenological inquiry, the aim is to obtain and capture the essential meaning of the participants’ stories. In a sense, interpreting and understanding contextual data involves a process whereby the researcher becomes immersed in the data so that meaning emerges. This does not occur in a linear or structured way (Benner 1996), rather it encompasses a circular motion where the researcher moves back and forth between the whole and parts of the text. Moving between the parts and the whole in this circular fashion is known as entering the hermeneutic circle and this allows the researcher to uncover and interpret the meaning embedded in the textual data such as the transcripts (see fig 6.1).

In searching for meaning from the whole and the parts, it was paramount that I looked to the meanings within each participant’s experience of the phenomenon in light of
my background and pre-understanding I brought to the study. In this way I was continually moving towards uncovering the meanings the participants attributed to their experiences. The interpretations I formed and the judgement I utilised were derived from my own horizon of understanding as a researcher, nurse and educator.

**Fig 6.1: The Hermeneutic Circle**

The example below demonstrates how the six-staged hermeneutic circle and the fusion of horizon were used.

**Example: ‘Experiencing fear’**

1. A number of overseas nurses indicated that they were experiencing fear
2. I reflected on what they had said, ‘I could be thrown out with my families.’
3. I engaged with the data and allowed the it to speak for itself
4. What were they really telling me? Were they saying that they were frightened?
5. I re-read the text and immersed myself in the data.
6. A new understanding is achieved as the data confirmed that they were experiencing fear [Fusion of Horizons].
6.2.5 Fusion of horizons

This approach centred on dwelling with or becoming immersed in the data (Gadamer 1975). This interaction with the data and the conscious task of understanding the text by appreciating the views of the participants enabled me to develop a greater understanding of the participants’ experiences. Although this process was lengthy it was hoped that a true and meaningful understanding of participants’ experiences would be achieved.

6.2.6 Computer assisted data analysis

In order to analyse the data, I utilised a qualitative software package known as NUD*IST QSR (N6). There has been some opposition to the introduction of computer technology into qualitative data analysis (Fielding and Lee 1991). However, Seidel (1991) reminds us of similar protestations from researchers when technological advances allowed tape recording to be introduced into fieldwork. Many of the criticisms of computer-assisted qualitative analysis are as a result of a misunderstanding of the software capabilities. None of the various programmes available actually analyses the data, but rather assists the researcher in managing the analytical process.

According to Seidel (1991: 107), there are three forms of research behaviour associated with the computerisation of qualitative analysis, which he refers to as ‘analytic madness’. These are:

- An infatuation with the volume of the data one can deal with.
- Considering the relationship between the researcher and the data.
- Distancing of the researcher from the data.
Qualitative research generates a considerable volume of textual data and the analytic process generates further mountains of information. Unstructured and context-specific textual data obtained from the twelve interviews was voluminous and Fielding and Lee (1998) argue that in order to manage the data, using a computer-assisted package is inevitable.

The use of technology supported this analytic process. The computer was capable of storing a vast amount of textual data in an accessible form and this data was retrievable at a later stage. Dey (1993) contends that data can be analysed more effectively, thus the computer had become a useful tool for data management. In utilising the computer package, scrutinising the data was still required. The line-by-line nature of analysis was still required. This process, along with listening to the tapes as alluded to previously, brought me closer to the data.

In using the computer package, each line of the participant’s text was numbered. Each descriptive statement was highlighted and coded throughout the participants’ stories. I proceeded to do the same at a more focused level, thus I read each transcript individually and continued to highlight and code each specific statement. Throughout the process of interpretation, I was immersed fully in the hermeneutic circle. I continued to highlight and code textual data until all twelve transcripts were coded. During the process, I continued to analyse the data, reflected on it at length and maintained a dialogue with the text. This process was circular and the meaning participants attributed to their experiences began to unfold.
After this initial data analysis, I began to develop some sub-themes through the process of thematic analysis, which refers to the process for recovering the theme or themes that are ‘embodied in the evolving descriptive statement of the coded data’ (van Manen 1990: 28). In the light of van Manen’s descriptions of what constitutes phenomenological themes, and reflecting on the methodological stance for this study, I was aware that these initial sub-themes were superficial and only provided a first stage thematic analysis of the lived experience (see table 6.2).

As I was determined to reveal an understanding, I spent several more weeks reflecting on and analysing the data at a deeper level until several major themes emerged (see table 6.3). By moving between the whole and parts of the stories, I believe I was able to uncover the meanings of ‘being’ overseas black and minority ethnic nurses working in the NHS in the south of England. I believe my final data analysis and interpretation, as confirmed by my supervisors, are true representations of the meanings these participants attributed to their experience.
Table 6.2: Sub-themes

<table>
<thead>
<tr>
<th>Differences in nursing practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusting to a new environment</td>
</tr>
<tr>
<td>Differences in communication [embarrassment and humiliation]</td>
</tr>
<tr>
<td>Absence of support [reduced confidence, resentment and unhappiness and no advocacy]</td>
</tr>
<tr>
<td>Discrimination [invisibility syndrome]</td>
</tr>
<tr>
<td>Lack of equal opportunity</td>
</tr>
<tr>
<td>Bullying</td>
</tr>
<tr>
<td>Separateness</td>
</tr>
<tr>
<td>Challenges to integration [not feeling appreciated, feeling inadequate (lack of trust), unwelcome feeling (experiencing fear) and concept of self-blame]</td>
</tr>
<tr>
<td>Challenges to personal growth and practice [lack of opportunities for skill development and training (performance review) and unfairness in nursing practice]</td>
</tr>
<tr>
<td>Support from overseas black and minority ethnic colleagues</td>
</tr>
<tr>
<td>Proving self</td>
</tr>
<tr>
<td>Building ties</td>
</tr>
<tr>
<td>Reflecting on the experience</td>
</tr>
<tr>
<td>Moving on</td>
</tr>
</tbody>
</table>

Table 6.3: Main Themes

1. Being thrown into an unfamiliar world
2. Encountering marginalisation and experiencing inequalities in the world
3. Surviving in an everyday world
4. Living in an everyday world
5. Making a new world
6.2.7 Focus group interviews

Both Schindler (1992) and Kitzinger (1994) argue that a focus group can provide insight into the experiences of individual participants. For this study, the purpose was to explore, describe and develop a greater understanding of overseas black and minority ethnic nurses in the NHS and indeed a focus group approach was adopted. Carey (1995: 493) states that, ‘analysis of focus group begins in the planning stage and continues during and after the session.’ Both Goldman and McDonald (1987) support this view and add that analysis ought to incorporate the group dynamics, which many researchers seem to have forgotten in their analysis. Carey (1995: 492) further advocates that, ‘the information elicited is very much a function of each group interaction.’

Analysis of focus group is complex and there are difficulties in relation to data coding (Reed and Roskell-Payton 1997). This process is very different from analysing face-to-face interviews. One of the issues with focus group interviews was knowing who was speaking and what contribution that person was making to the group. To minimise this risk, each participant was advised to introduce himself/herself using the number or the number letter given at the beginning of the taped interview. Two compelling reasons for using this process were, firstly, a reduction in anxieties and secondly, it gave the transcriber a point of reference when attributing statements within the interview.

During the interview process each participant would say his/her number prior to speaking. I found this technique very useful, because it enabled the transcriber to identify who was speaking at the time. Although I realised that participants might
have difficulties in remembering their number when discussing their experience, at least, it helped reduce risks when transcribing the focus group interviews. Four focus groups were undertaken [see appendix 17 for sample of focus group interview one]. They were tape-recorded and transcribed verbatim. I listened to the tapes and re-read the transcripts at least twice over two weeks to get a feel for what the participants were saying. By undertaking this process, it brought me closer to the data and I was able to conceptualise these participants’ lived experiences.

The analytical framework utilised was that of van Manen (1990) [see table 6.4]. I was creative in my analysis as the purpose was not to identify individual responses but the group responses. Therefore, my aim was to identify what the group had discussed throughout the interview, and coding these statements with the use of NUD*IST QSR (N6) package. Each statement across all four focus group interviews was intuited upon to uncover themes (see table 6.2). The themes identified were triangulated against those of the face-to-face interviews. As different groups comprised of different members, so to preserve the identity of each group and participant, the recordings were coded as focus group one, participant one A (FG:1:1A) or focus group two participant 10 (FG:2: 10) and so on. Throughout the analysis of the data, the expertise of my supervisors and an expert within the University of Surrey were used. Confirmation was given that the themes developed were similar to those of the face-to-face interviews. However, these new themes emerged following the analysis of the focus groups. These themes include, experiencing fear, concept of self-blame and invisibility syndrome.
Chapter Six

Data Analysis

Table 6.4: van Manen's (1990) Modified Analytical Framework

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The first stage involved listening to each tape at least twice so as to gain a sense of the participant's whole story and this was followed by a period of reflection to make sense of the experience.</td>
</tr>
<tr>
<td>2.</td>
<td>The second stage involved verbatim transcribing of the four focus group interviews.</td>
</tr>
<tr>
<td>3.</td>
<td>The third stage involved reading each verbatim transcript repeatedly and reflecting upon this to achieve a holistic understanding of the meaning of these participants' experiences.</td>
</tr>
<tr>
<td>4.</td>
<td>The fourth stage involved importing the data using the package NUD*IST QSR (N6).</td>
</tr>
<tr>
<td>5.</td>
<td>The fifth stage involved a process of identifying and highlighting descriptive statements within each transcript.</td>
</tr>
<tr>
<td>6.</td>
<td>The sixth stage involved balancing each descriptive statement by considering the context in which it was said and the relationship with the content.</td>
</tr>
<tr>
<td>7.</td>
<td>The final stage involved coding each descriptive statement across the four groups' stories.</td>
</tr>
<tr>
<td>8.</td>
<td>Each statement was reflected upon to uncover essential themes.</td>
</tr>
</tbody>
</table>

6.3 The survey analysis

The package SPSS 12.01 was used to analyse the survey data. A number of different statistical tests such as the chi-squared tests, Fisher's exact, Kruskal Wallis tests, Mann Whitney U tests and Spearman's tests was used throughout data analysis. The level of significance was set at p<0.01 [Please refer to chapter 9 for a more detailed account of the analysis process].

6.4 Summary

In summary, both the face-to-face and focus group interviews were tape-recorded, transcribed verbatim and analysed rigorously for meanings participants attributed to their experiences. The process of the hermeneutic phenomenology and the fusion of horizons between both the participants and myself allowed for the development of a greater understanding of the experiences of overseas black and minority ethnic nurses. There is not much information on the analysis of focus group interviews and therefore
I presented a modified version of van Manen's (1990) analytical framework of how I analysed the data. This framework allowed me to analyse successfully the data obtained from the focus group interviews. I was able to triangulate the data acquired from both the face-to-face and the focus group interviews and was able to give a detailed account of the processes involved in the analysis of such data. In addition, a summary of the different statistical tests used for analysing the survey data were identified. In the subsequent chapter the qualitative findings from both the face-to-face and focus group interviews will be presented.
Chapter Seven

Findings

7.1 Introduction

This chapter presents a thematic analysis of the experiences of overseas black and minority ethnic nurses working in the NHS in the south of England. It encompasses the events from their initial stages of entering the NHS as overseas nurses. The findings will be presented in a way that uncovers the meanings that overseas black and minority ethnic nurses attribute to their experiences (Alexis and Vydelingum 2004)\textsuperscript{1} [see appendix 18] and Alexis and Vydelingum 2005\textsuperscript{2} [see appendix 19]).

The initial analysis revealed words and phrases that stood out as useful to the interpretation of the meanings attributed to the phenomenon. After highlighting these meaningful words and phrases from each participant’s story, it was necessary to relate these back to the whole story and look for shared meanings. Thus, the process of entering and re-entering the hermeneutic circle was evident. Through dialogue with the text (Gadamer, 1975) I asked: What is it like to be an overseas black and minority ethnic nurse working in the NHS? This question has enabled me to reveal the phenomenon under investigation.

The hermeneutic process of reading, re-reading and engaging in a dialogue with the text revealed a number of themes that began to represent the shared experiences of the participants. This process was both time-consuming and arduous and I found myself


continually reflecting, questioning and re-reading the text to ensure that I was being true to participants’ experiences.

Five themes relating to the participants’ experiences emerged following data analysis and these are identified below:

- **being thrown into an unfamiliar world**

- **encountering marginalisation and experiencing inequalities in the world**

- **surviving in an everyday world**

- **living in an everyday world**

- **making a new world**

Each theme has a number of sub-themes that together comprised the main theme (see table 7.1). Throughout the description of each theme, excerpts from the interviews are provided to demonstrate and illuminate the interpretations that I have constructed. These excerpts are a verbatim reproduction of their experiences and this was done to enable the reader to acquire a vivid picture of overseas nurses’ experiences in the NHS in the south of England and to highlight the ‘world’ that they encountered. The term ‘world’ is a concept used to demonstrate participants’ experience of the world that they are a part of.
This chapter will also present the findings from the focus group interviews. The findings from this particular approach within this study yielded valuable insight into the participants' experiences of working in the NHS in the south of England as black and minority ethnic nurses. A thematic analysis was undertaken to reveal the meanings the group attributed to their experiences.

Although many themes emerged which were similar to the results of the face-to-face interviews, however, there were three new emergent themes found and these included, experiencing fear, concept of self-blame and invisibility syndrome.

7.2 The journey

In table 7.1 overleaf, the themes and sub-themes are revealed through a thematic analysis of the participants' stories of their experiences of working for the NHS. In addition, the themes in fig 7.1 illustrate the experiences of 'being' overseas black and minority ethnic nurses in a model that could best be described as a journey. To begin with, participants were thrown into a different 'world', encountered marginalisation and experienced inequalities in that 'world'. They survived in an everyday 'world', they lived through an everyday 'world' and they made a new world for themselves.
<table>
<thead>
<tr>
<th>THEMES</th>
<th>SUB-THEMES</th>
</tr>
</thead>
</table>
| 1. BEING THROWN INTO AN UNFAMILIAR WORLD | ❖ Differences in nursing practice  
❖ Adjusting to a new environment  
❖ Differences in communication  
(embarrassment & humiliation)  
❖ Absence of support (reduced confidence, resentment & unhappiness and no advocacy) |
| 2. ENCOUNTERING MARGINALISATION AND EXPERIENCING INEQUALITIES IN THE WORLD | ❖ Discrimination (invisibility syndrome)  
❖ Lack of equal opportunity  
❖ Bullying  
❖ Separateness |
| 3. SURVIVING IN AN EVERYDAY WORLD    | ❖ Challenges to integration [Not feeling appreciated, Feeling inadequate (lack of trust), Unwelcome feeling (Experiencing fear) and Concept of self-blame]  
❖ Challenges to personal growth and practice [Lack of opportunities for skill development and training (Performance review) and Unfairness in nursing practice] |
| 4. LIVING IN AN EVERYDAY WORLD       | ❖ Support from overseas black and minority ethnic colleagues  
❖ Proving self |
| 5. MAKING A NEW WORLD                | ❖ Building Ties  
❖ Reflecting on the experience  
❖ Moving on |
Chapter Seven

Findings

Data Analysis Emergent Themes

Leaving a familiar world
(start here)

Making a new world

Being thrown into an unfamiliar world

Living in an everyday world

Encountering marginalisation and experiencing inequalities in the world

Surviving in an everyday world

Fig 7.1. The phenomenological journey of overseas black and minority ethnic nurses
7.3 Being thrown into an unfamiliar world

Being thrown into a different world characterised what it meant for the participants to experience a different culture. Participants explained how migrating to and working in the UK, particularly for the NHS in the south of England was not a gradual situation for which they were prepared. Instead, they described how they felt removed from their everyday world into an unfamiliar world, namely the NHS. All participants spoke at great length of their experiences of working in this different world and the difficulties they faced within that environment.

The NHS is a huge organisation with its own culture and sub-culture, and being thrown into, both the NHS and a different culture at the same time, resulted in conflict and difficulties for the participants. It is interesting to note that the concept of throwness for Heidegger (1962) is the environment that one is cast into at the moment of birth and involves the language, culture, ideology and other beliefs that have been constructed within this environment. Heidegger's concept of throwness is relevant to this theme as the participants, as a group of people, have been thrown from their familiar world into an unfamiliar environment.

The aforementioned theme comprised of four sub-themes, namely, differences in nursing practice, adjusting to a new environment, differences in communication and absence of support. Within the sub-theme, differences in communication emerged another sub-theme namely embarrassment and humiliation. The absence of support sub-theme consisted of three sub-themes as identified in fig 7.2.
7.3.1 Differences in nursing practice

During the interviews participants referred to nursing practice in the NHS as being different. They described the way in which care was organised in England and felt it did not reflect what they were accustomed to. All participants were familiar with task orientated schedules rather than individualised and holistic nursing care and found themselves having to provide care which they were not prepared for during their induction programme. Spending time on nursing interventions such as dressing wounds and administering medicine were considered more in line with their usual practice. However, having to wash and dress patients were seen as duties, which they considered to be more appropriate for health care assistants. To be faced with these duties created an initial reaction as highlighted in this exemplar:

*It is quite a total shock for us I believe - the practice because as nurses back home we do just the nursing part we don't usually do the health care part. You know, pushing commodes, washing patients – we never do that because we are too busy to be doing those things. We have far more important things like the*
nursing part, day care, dressing wounds, giving medicines and following orders - doctors orders - but here you seem to do everything which makes the nurses life more stressful, (Interview with Person C).

The extract below provides another similar example of a participant experiencing shock in the nursing environment:

Shocking to say the least. We have health carers who will give patients baths. We don't really toilet our patients or give them a wash. That's what the health carers are there for. I wish we were told this, (Interview with Person K).

As highlighted above, all participants indicated that the physical care of patients would normally be undertaken by health care assistants in their country of origin. They also stated that adopting different roles in the NHS created confusion, frustration and feelings of degradation. To them, nursing was about assessing patients and managing their care not particularly attending to their basic needs as a typical nurse described:

I was frustrated, confused and felt degraded as in the Philippines we don't make beds or wash patients. We don't do all those things. The main thing we do is to assess patients, give medication. We have health carers to make patients' beds and to change linen as and when this is required. We were never told that we would be washing patients, (Interview with Person A).

In another example, a participant referred to the differences in nursing care documentation and how difficult this experience was, as there was little information on what would be acceptable in England. This created frustration and stress and sometimes feelings of apprehension:

Well I think it is more on the difference with the practice. Shall I say the documentation. We use approbation - standard approbations based on the North American legislature for nurses but in England, I had to get used to the documentation and it is - you know a hassle. No preparation is given. The UK doesn't have a standard one or a nationally agreed upon approbations. I found this apprehensive, frustrating and stressful, (Interview with Person C).
For this participant, it was necessary to have standardized abbreviation, which would be acceptable within the nursing culture but found this to be absent within the working environment. This participant referred to approbation to mean recognised abbreviations that are acceptable within the clinical environment. Although there were, it was felt that these were not used consistently within the clinical setting. Although most of the participants recalled their initial shock, and the lack of preparation received to nurse patients in the NHS in the south of England, one participant commented on having worked in a country that contained similar practices to that of the NHS such as Singapore, and was somewhat prepared for the experience of a new culture as exemplified in this extract:

Well, I suppose I have only worked in Singapore, which is a British style of nursing. I thought nursing would be similar to Singapore—unlike back home as I have said it is different. There are no notes and there is a lot of relative involvement. So when I came here I knew that nursing was much you know the same in Singapore, washing the patient, giving bed baths, washing everything. The basic nursing that we learn from the Philippines, (Interview with Person F).

Most of the participants in this study referred to being unprepared for this different culture. Having to adopt different roles in the NHS created distress for some participants. For another, nursing in Singapore was similar to that of the NHS in England and therefore this participant was prepared for this experience. However for others, they felt that they were out of their depth and had experienced stress as a result of this new environment.

7.3.2 Adjusting to a new environment

The unfamiliarity of the NHS environment in the south of England provoked a perception of being displaced. Participants spoke of the difficulties they experienced
whilst working in the NHS and referred to these experiences as frustrating. Hospitals are often busy and stressful places with a variety of uniformed staff and specialist language spoken by health care workers. All these aspects give rise to a culture that is unique to hospitals.

For this participant, the uniqueness of the hospital setting had not enabled her to adjust to a different environment as depicted in this excerpt:

*It was frustrating to adjust, as there was no one to show us what we should be doing. We just watched and observed and that was how we learn what to do and what not to do, (Interview with Person F).*

Similarly, most participants revealed how the pressures were upon them to adjust to a new environment and felt that the clinical setting did not facilitate this. They realised that adapting to a new environment was not an easy undertaking but they were prepared to embrace the new culture and environment. However, their white British counterparts working in this environment were not perceived as facilitators in assisting them in their cultural adjustment and as a consequence they found this difficult to contend with as depicted in this excerpt:

*I suppose the pressure is on us not only are we expected to adjust to their health care system but at the same time we are expected to adjust to their culture but they don't help us to adjust to their culture and the NHS. I mean I have had a lot of training back home in my family in our culture and in order to succeed professionally I have to embrace the culture as well and that's not an easy thing to do. I mean I've got my set ways and it might be disrespectful or respectful for them but these are my ways so I mean that's doubly hard for us because as I've said in order to succeed professionally you have to like embrace their culture and at the same time embrace their work ethics which is really a far cry from what I am used to back home, (FG:2: 15).*

In another example, one participant described the attitude of staff as being unhelpful in the initial stage of adjustment to the ward environment. They do not explain or share information as depicted in the extract below:
Some of them are not willing to help you and it is difficult to adjust. Some of them don't give you...They don't explain things to you not much, you know when you ask they don't explain much. And I think it is the attitude of them being experienced in this area and not showing me what I should be doing. They have been there for ages and you are new and they know better than you and instead of them sharing their experiences they don't. I sometimes feel like I am just thrown in to get on with the job, (Interview with Person E).

For others, adapting was physically tiring and information on the health care system in England would have helped in making the transition easier in many ways:

We should have been prepared more for the British culture. We were not given enough information on what to expect and had they told us then adapting would have been easier, (FG:4: 3E).

In addition, the absence of information about the ward routine made the adjustment process more difficult as highlighted in these excerpts:

Adapting is quite physically tiresome. I believe when we go onto the ward, we just go on and get on with what is necessary with little help from staff, (Interview with Person C).

You know, it is different and difficult to adjust to the ward culture and no preparation is given to us to help us adjust to this new environment, (Interview with Person D).

For another participant, a description of the process of adjusting was illustrated as going with the flow and in this way things were picked up as highlighted in this extract:

I think you have to go with the flow even if it is against what you want to do but you need to follow the way they do the nursing here in order to adapt. Umm of course you have to study and learn and observe what they are doing. I would only wish staff would be more accommodating and helpful, (Interview with Person A).

In the above extracts, many of the participants commented on their difficulties in adjusting to a new environment. It would appear that these difficulties arose from a lack of preparation, limited information about the health care system in England and
what to expect from staff. They referred to their experiences as being thrown into a different world with limited input from their white British colleagues. Yet, they were expected to deliver a high standard of individualised nursing care despite relatively little help, and communication differences.

7.3.3 Differences in communication

Communication is undoubtedly one of the fundamental message systems in health care (Arakelian and Magnall 2002). For many participants, English was not the first language spoken in their country of origin and arriving in the south of England to work for the NHS created some communication difficulties for both the participants and their white British counterparts. Yet, despite English not being the first language for some, they were thrown into a different world to communicate with patients, relatives and members of the multidisciplinary team. Consequently they experienced embarrassment and humiliation.

7.3.3.1 Embarrassment and humiliation

Whilst working on the wards, communication difficulties were an everyday occurrence. Many of the participants described their experiences as somewhat humiliating and embarrassing as described below in this exemplar:

*When I do my sentences, my grammar. It is like they do check me right there and then, they don't wait for.... They say let's talk about how you should say it. I felt embarrassed and humiliated, (Interview with Person E).*

Many participants spoke of the differences in pronunciation of words and felt that they were ridiculed if they had not pronounced words correctly. The differences in communication resulted in some overseas nurses’ feelings of being ostracised and let
down by their contemporaries. The findings revealed that participants were perceived as stupid if they had not pronounced words correctly as highlighted in this extract:

*England is very different... The spelling is different. When I began working I was looking for cefuroxime I say it couldn't be "K" because it's "CE" the spelling is "CE" it couldn't be "K" it should be "Q" anyhow I was arguing with this white colleague. I didn't realise that's the way it's being pronounced here. It's cefuroxime. So it's very different so it seems like the problem is instead of just correcting you they would tend to really put you down. Say you are dumb, you don't even know how to pronounce words, (FG:2: 12).*

In another example, one participant referred to the difference in terminology used which at times was difficult to understand. But as time went on, understanding of such term(s) was inevitable:

*It was the language and some phrases that I didn't understand. Back home we are more familiar with American English and not British English so I think saying things in an American way [...] here. The nursing term like NBM - nil by mouth was different. I supposed because we always said NPO - nothing per oral. I had staff repeating to me that it was NBM and not NPO and this was done in a condescending way. The thing is, no one bothers to be supportive to us to tell us the correct things. I found the whole experience humiliating and frustrating at times. But by listening and observing I soon caught on, (Interview with Person F).*

In a similar vein, another participant described her experience of working in a particular environment. The staff commented on her different accent:

*They always say to me can you do the handover like this, or can you tell her to do the handover in such a manner, which I thought was insulting. I mean we don't speak the way they do, we have some difficulties sometimes speaking the language because we are not used to it. I only wish we were given help in this area. You continue to speak in the way you are used to not in the way that my English colleagues want me to speak. You just try to do what you can that will make them understand what you are talking. It does make me feel bad really when they say, oh your accent is American, (Interview with Person L).*

Participants commented on the differences in language and the expectations from staff to be able to communicate fluently in English with patients and members of the multidisciplinary team. Although they may have had some exposure to English, they stated that knowledge of local colloquial terms would have facilitated their
understanding of patients and members of the multi-disciplinary team. As a result of
the lack in language, particularly colloquial terms, many participants at times avoided
staff for fear of having to communicate with them and the following extract
illuminates this:

When I came here we were not given any help with the language, especially
locally colloquial terms. I was expected to speak to patients, relative and
doctors but was too shy to do so. Some of the white nurses were not helpful.
They used to constantly say they did not understand me. I used to avoid them
until I became fluent in communication, (Interview with Person I).

Communication goes beyond knowing the grammar. It includes being sensitive to the
accent and non-verbal characteristics (Arakelian and Magnall, 2002). Such examples
as identified above have illustrated some difficulties experienced by overseas nurses.

Despite the aforementioned comments, two participants commented on the one-day
course they attended on how to communicate with patients, how to face people and
what to say. They stated that this prepared them to some extent for the real world.
However, they would have valued a few more sessions on how to answer the phone,
and commonly used colloquial terms, as these would have enabled them to
communicate better with patients, family and their work colleagues. Nevertheless, the
experience of being thrown into a different world created some anxieties and
difficulties not only with communication differences but also the absence of support.

7.3.4 Absence of support

Support is undoubtedly an important attribute that is necessary when working in the
NHS (Beishon et al. 1995). Overseas black and minority ethnic nurses encountered
minimal support during their everyday working practices in the NHS in the south of
England. Being immersed into a different environment caused anxieties for many
participants and these were compounded by the lack of support they had received from their white British counterparts. Participants also revealed that they encountered the following: reduced confidence, no advocacy, resentment and unhappiness. For some, working in an unfamiliar environment with different equipment created some uneasiness and this was compounded by the decrease in support within the ward environment.

7.3.4.1 Reduced confidence

One of the important attributes of nursing is confidence. This, with assertiveness, is essential if overseas nurses are to develop further clinical skills in a new practice environment. However, for some, their confidence appeared to be eroded because the support promised had not materialised and as such they became frustrated and annoyed with staff in the clinical setting and this is illuminated in the following statement:

There was no support in this new area where I am working. I found this daunting. Whenever I asked for help from my white colleagues, they were always too busy to help me. This can be really frustrating and annoying. I thought as an overseas nurse I would be given support but it never happened. This affected my confidence, (Interview with person B).

Similarly, the focus group participants reported that despite a significant number of overseas nurses recruited, the provision of support was limited and the following extract sums up the group experience:

There was no support and this affected my ability to work. I felt that they recruited us from overseas and they should provide us with the necessary support but no they didn't. We were just thrown in the deep end, (FG:3: 2A).

The following verbatim descriptors highlight how overseas black and minority ethnic nurses' confidence had been affected by the inadequate support given whilst
managing an acute ward. Having little experience of managing an acute ward accounted for feelings of being a failure:

Well, the lack of support that I got affected my confidence. I was assigned to manage a ward and this was very new to me. There were no clear policies of how this ward was run. People were just asked to run the ward and it didn't matter whether you had what it takes to run the ward or not. I mean that is something that I always remember. I was always asked to run this ward and I didn't know a thing of how this ward ran. All I knew was to be really patient centred in my care. I didn't know anything about management, organisation or asserting myself. They never sent me somebody who could help me. Lots of things were happening and I was expected to run the ward with no back up, (Interview with Person J).

Although it was noted that support would be accessible within the clinical environment, this never happened as shown in the following verbatim extract:

I don't even know how to use some of the equipments, as they are different to the ones I am used to and I am expected to know how to use these. I didn't have the confidence to use them so I voiced my concerns to the senior nurse and said I didn't have a mentor. How did that happen? When I applied you said you were going to give me all support I would need and I have received no support from you or from my colleagues, (Interview with Person G).

Some participants commented on the support they received from their work colleagues. The fear of something going wrong created feelings of uneasiness. They questioned whether their work colleagues appreciated their efforts as highlighted in the following extract which, is representative of what these participants experienced:

No one will back you up, it's always your mistakes that they really notice and they will blow it out of proportion and this can sometimes affect your confidence, (FG:1: 1C).

Another theme that emerged from the main theme titled, the absence of support, was that of no advocacy.
7.3.4.2 No advocacy

In another case, a participant stated that an incident occurred on the ward that appeared to have been handled in a non-effective manner. The participant revealed that the ward manager dismissed the allegation and felt that it could have been dealt with in a different way. The following extract sums up the participant’s experience as:

I told my manager about this and she just dismissed it and said that this HCA was always like that. I was not happy as I felt that something should have been done but I supposed this is their country and this is the way things are dealt with. I just would like to know if it was a white colleague whether the ward manager would have dismissed what the HCA had done to me. Please don’t get me wrong, I have nothing against my ward manager but I felt at times she could be just that bit more supportive to me, (Interview with Person H).

Nursing is a stressful job and support from senior nurses is essential in retaining as well as recruiting staff (Seccombe and Patch 1995). In supporting staff, it was fundamental that senior nurses and ward managers should act as advocates for junior colleagues, particularly if health care professionals became intolerant of the care given (Webb et al, 2002) as depicted in the following excerpt:

It is very sad to say that our managers and senior nurses cannot stand by our side during such difficult times. I mean I would expect them to speak to these professionals and tell them that you know you don’t have to remind me of this because I am capable of carrying out care, instructions and procedures, (Interview with Person I).

The aforementioned excerpts have shown that senior managers were unsupported towards and many participants shared this view. In addition to feeling unsupported, the experience of resentment and unhappiness were issues expressed in some participants’ stories.

7.3.4.3 Resentment and unhappiness

In nursing, feeling comfortable and happy in the job are attributes necessary for productivity (Shields and Price 2002). Participants stated that they became frustrated
Chapter Seven Findings

and unhappy in their working environments. They revealed that they came to England to work and were expecting to be supported by their work colleagues but instead they experienced feelings of resentment. As a result, they felt the need to move to another environment where they perceived that feelings of happiness and acceptability might ensue:

*I say there was hardly any support from the white nurses. We came there as an outsider coming into the place and okay I am not saying that we did know all the work, but we all had basic nurse training but I still think that we needed that support from someone. So we could work better rather than struggling and feeling resented and unhappy and wanting to move on to somewhere else. I think that would have helped a great deal*, (Interview with Person K).

Although a number of negative experiences dominated the face-to-face interviews, one participant revealed how supportive the environment had been and felt that this resulted in a positive experience. However, such a positive description was rare and was an isolated case:

*I think they are treating me fairly well. They tend to give me responsibility. It is not just giving responsibility but they tend to ask me, are you happy with what you are doing? If I am not happy about any work, we try to compromise. That is good. Also I am given more opportunity now. If I want to learn something they give me a mentor whom I can turn to for support. So it is okay*, (Interview with Person F).

Similarly, one participant from the focus group interviews revealed that support was always available and stated that this made delivering nursing care extremely easy. However, it was felt that this support depended on which staff nurse was on duty:

*Most times my work colleagues are supportive but this support depended on who I was on with*, (FG:4: 3D).

These statements as supported by participants B, G, H, I, J and K reflected the common experiences many participants encountered during their everyday practices. Having being thrown into a different world had created some discomfort and
unsettling experiences for overseas black and minority ethnic nurses. Although many of the participants reported that they received minimal support, in contrast, both participant F and 3D felt comfortable and found the support to be available whenever they needed it within their clinical environments.

The aforementioned sub-themes provide an account of the initial journey that participants encountered while working in the NHS. Being thrown into an unfamiliar world characterised what it meant for the participants to experience a culture that was very different to what they were accustomed, the world of the NHS. Within their world, participants revealed that they also encountered marginalisation and inequalities and therefore the theme encountering marginalisation and experiencing inequalities in the world will be the focus of the subsequent section.

7.4 Encountering marginalisation and experiencing inequalities in the world
This theme, encountering marginalisation and experiencing inequalities in the world highlights participants’ lived experiences. This theme also revealed the difficulties and the conflict they encountered in their everyday practices whilst working in the clinical environment as overseas nurses with patients, staff and members of the multidisciplinary team. For these participants, encountering marginalisation and experiencing inequalities in the world were new experiences and difficult to conceptualise. These experiences were in the form of discrimination, lack of equal opportunity, bullying and separateness. Within the theme discrimination, invisibility syndrome was an emergent category that captured overseas nurses’ experience of the NHS (see fig 7.3).
Chapter Seven

Findings

Encountering marginalisation and experiencing inequalities in the world

Fig 7.3: Theme 2: Encountering marginalisation and experiencing inequalities in the world

7.4.1 Discrimination

All participants described many situations where they felt discrimination blighted their experience. Discrimination involves adhoc decisions that are not based on clearly defined standards or rules of general applicability. It also refers to differential treatment of otherwise equally qualified persons (Coker, 2001). Many participants recalled that discrimination in the form of racism was an everyday experience.

Although discrimination can sometimes be difficult to determine, particularly covert discrimination, some participants perceived that they were discriminated against whilst working within the NHS environment as staff nurses. A number of overseas nurses highlighted examples of discrimination but for the purpose of this section different examples of discrimination will be presented. One participant in particular
recalled how the surgeon refused to allow the procedure to begin unless the sister was available to assist:

_Umm, when I was new in theatre, the surgeon asked if I knew the procedure. Although the sister had already told him that I was new to this procedure but had experience in theatres, the surgeon did not want me to 'scrub'. He refused. He said to the sister that if she was not going to scrub then he would not be operating today. This surgeon could be racist…. I am not sure. I felt upset. He made me feel as though I knew nothing and I found this really difficult to accept, (Interview with Person A)._  

The quotation above highlights the participant’s perception of discrimination, however, the surgeon may not necessarily be racist but concerned about the safety of patients. Where clinical governance is concerned, care of the highest standard is paramount alongside safety. Perhaps, it was felt that safety might have been compromised thus resulting in the refusal to allow an overseas nurse to 'scrub'.

Similarly, discrimination occurred in the form of staff using exclusionary practices as exemplified in this verbatim statement:

_Since I came here I have never experienced such open discrimination. White nurses have treated me as stupid and they will not include me as part of the nursing team, (FG:3: 3C)._  

The above examples have highlighted some of the difficulties that these participants endured. Perhaps, such attitudes may have made building relationships difficult. This is because they perceive that both racism and discrimination have been evident in the clinical setting. Although, there is evidence to suggest that racism exists in the NHS (Beishon _et al._ 1995), it is often denied by health care professionals. This is because racism has negative connotations and to be labelled a racist would possible lead to reprehensible actions. This could be a possible reason for the denial of the existence of racism (Miles, 1989).
Some participants noticed that their treatment was very different to that of their white counterparts and wondered why for example they were denied the opportunity to increase their theoretical knowledge. In the UK, nurses have many opportunities for professional development such as obtaining theoretical knowledge to support practice through courses and reflection. However, many participants stated that their development through courses was not apparent in their workplace and this they felt was mainly because they were foreign nurses:

She should have been more helpful by giving us a course. We asked and nothing was done. We went to personnel to inform them that we had not been given a course. We informed personnel that only whites were given courses and we wondered why we were denied the opportunity. We were told that courses were giving on a first come first served. But this did not happen where I work as only the white nurses were given that privilege, (Interview with Person C).

It was suggested by another participant that discrimination was overt in the workplace and this contributed to their disillusionment. The following verbatim extract clearly depicts such feelings:

And having started there was fine at first but I really went against all odds and people being nasty and racist, it was open racism there, you just could not. I mean there wasn't anything that you could do right as far as I was concerned. And there was always people there that were favoured above certain people and that was what really disillusioned me. I could have stayed on longer but I just felt what was the point. If you are not wanted in this area there is no point in getting up and going to work in the morning either because of the way you are being treated. But I just feel there was just petty nastiness in this area, (Interview with Person K).

In one of the focus group interviews a participant revealed that clear differences were evident in the way in which managers treated overseas nurses and their white British counterparts. The following verbatim extract revealed that such differences existed in the form of inequalities in the workplace:

Little things like carer's leave and things like that I remember when I came here my son was still very little and every time he was sick I had to go off sick as well because they won't give me carers leave. I have a white work
colleague who's got a twelve year old girl and because nobody will be looking after her she was given two days carer's leave. My son had measles and I wasn't given any so where's the justice. What I would also like to say is when the ward is quiet they will send home their white colleagues and I would have to stay back because I was not allowed to go home. Do you think this is fair? I don't think it is, (FG:1: 1D).

Rawls' (1999) principles of a just society include both equality and fairness, and states that these are paramount within any given culture. However, the above extract revealed the opposite to that of Rawls' writings thus indicating that the NHS appears to be unfair in its treatment of overseas nurses.

Another participant revealed how a series of incidences culminated in the development of insecurities and low self-esteem:

*My manager was not very nice to me. He would nitpick at everything I did and he would find fault with almost everything. This was really stressful. This experience was on a daily basis and was traumatic. I plucked up the courage to confront him by seeking help from my union. In a meeting, he said he was having a problem with cultural differences. I just could not believe what I was hearing. My manager said this in front of my union representative that he was prejudiced. Being discriminated, I felt bad. My work was affected, my family, my wife and you know we argued almost every day. I did not speak that much to any of my friends. I was too scared to go to work because of fear of making errors and to be confronted by this person. I develop insecurities and low self-esteem, (Interview with Person D).*

This particular participant made the decision to file grievances only after enduring long periods of escalating conflict and suffering from psychological trauma. This treatment led to disputes and the manager in question had recognised that cultural differences were difficult issues to handle but made no allowances to reconcile these internal disputes himself or with an appropriate organisation. This conflict disrupted the social dynamics and consequently polarized this particular participant, thus isolating him. For this participant, dealing with conflict resulted in social and psychological distress.
Chapter Seven

Findings

It would appear that the act of discrimination was not solely confined to staff but to patients as well. The following extracts as identified below have shown how differences in attitudes have been regular occurrences. Participants described how patients had categorised, stereotyped and discriminated against them while refusing to be treated by them for some nursing tasks. They perceived that their racial features contributed to this:

*I want my catheter to be removed by a white nurse and you feel so bad isn't it. I want my medications to be given by a white nurse. Can you check whether this is the right medication? They tried to question your capacity to understand - to read and you know to administer drugs. I don't see them questioning other white nurses. I wonder whether they had bad experiences with other overseas nurses and felt the need to treat me like this or is it because I am black, I don't know anything. I don't know really, (Interview with Person L).*

*There are times I feel they don't want to talk to you - maybe because of my race. I still find some patients who don't like my colour. They don't say it in front of me but the way in which they speak to me is different. When they do see a nurse of their kind, they are open and will speak to that white nurse and will ignore you. Sometimes they think I am the cleaner and I find this difficult to cope with, (Interview with Person E).*

The extracts as highlighted in the above demonstrated the extent to which racial stereotyping and discrimination was evident and these findings concurred with those of Dreachslin et al.'s (2000) study. The tendency for overseas nurses to perceive both racial stereotypes and discrimination as issues affecting their well-being in the working environment was associated with race and this served to reinforce the racial divide between white British staff, patients and overseas black and minority ethnic nurses.

Although participants revealed that they felt discriminated against during their working lives with British white nurses, they also experienced feelings of invisibility. Therefore the concept of invisibility will be alluded to in the subsequent section.
Chapter Seven

Findings

7.4.1.1 Invisibility syndrome

Participants also referred to their experiences of working in the NHS as being different in comparison to their white British counterparts. They reported that there were times when their managers or health care professionals would ignore them by speaking to the sister or the charge nurse about the patient even though the patient was in their care. The following descriptors illuminate this vividly:

Whilst working on the ward the sister or the charge nurse of the ward will tell us the changes, she will not, or he will not look at me directly. I found this difficult to understand. I noticed this happens quite often and I wondered if this could be because I am different and from another country. I don’t see them treating my white colleagues the same, (Interview with Person B).

There are some consultants sometimes who would do the doctors’ rounds on the wards. They would go round and you are the bedside nurse looking after the consultant’s patients and they would ask for the sister. They won’t ask me any questions but they would ask the sister and sometimes if the sister was not sure she would ask me. Ignoring me sometimes makes me feel that I am not worth it. I will tell you this, although they will ask the sister, when she is not there they will look for a white nurse to do the rounds with, (Interview with Person G).

In a similar vein, a participant commented on the differences in treatment between her white work colleagues and her as noted below:

The doctor will see me at the patient bedside but instead of asking me about the patient I have been caring for they prefer to speak to my white colleagues. This happens so often that I have become used to it. We are just as capable as our white colleagues to answer questions about our patients. I sometimes wish that my white colleagues would say, speak to the nurse who is looking after the patient but they don’t do that because they are just as bad as these doctors. This place is really prejudiced, (Interview with Person J).

The quotation above highlights staff attitudes to difference and it clearly shows that being an overseas nurse in the UK is not always a pleasant experience. Being white in the NHS signifies power and privileges and as this participant was not white, she was therefore by-passed. Equally, it could be argued that British nurses are socialised to
accept and validate certain discourses without the capacity or motivation to challenge their legitimacy (Puzan 2003). While it might be the intention of British nurses to raise concerns that may be pertinent to overseas nurses, their voices might be silenced because of hegemony inherent within the medical profession.

Participants in the focus group interviews described that any medical/nursing procedures that needed to be carried out should be directed at them and not through their managers or their white British colleagues:

*I sometimes feel that when orders are given, these should be given to nurses and not through the ward manager or a white nurse. I feel that the manager’s role should be to confront the doctor and tell them that this nurse is qualified to carry out orders. They are as capable as we are to do the things that you want done for the patient. I mean to care for the patients so don’t talk to me you should speak to the nurse who is looking after the patient. Most times the manager and the consultants would discuss those patients and I will be ignored even though the patients are cared for by me, (FG:1: 1E).*

*In the end you are the one who have to carry out the orders and care for the patient so the orders should be directed at us, (FG:1: 1D).*

Similarly, it was stated in the focus group interview that relatives would often bypass overseas nurses, though they had been caring for their family members. They would seek the help of white nurses to inform them of the progress of their relatives:

*Some relatives would by-pass me and look for a white nurse to enquire about their family member although I am the one caring for that patient, (FG:4: 3A).*

It is interesting to note that the concept of prejudice which Beishon et al (1995) allude to is identified in the above excerpts in that, health care professionals and patients’ relatives have pre-conceived ideas of overseas nurses and these may have originated from their background and past history. These may have negatively affected the relationship between the participants and their white British counterparts in this study which may have affected their opportunity to fulfil their roles as nurses.
7.4.2 Lack of equal opportunity

Within this sub-theme participants described their experiences of working on the wards. For them, the lack of equal opportunity manifested itself in terms of what they encountered and saw during their everyday practices and this was described as frustrating. Participants were of the understanding that opportunities should be based on equality of worth and merit but not on the colour of their skin. Encountering discrimination in the form of inequality of opportunities was difficult for some to contend with.

One participant stated that opportunities to be promoted were extremely limited despite having undertaken the appropriate training courses:

> Opportunities are not given to us equally as I have been on this ward for three years. Promised by my manager that the next available vacancy, I should apply. Went for the job and it was given to someone far junior to me. Another vacancy came up and I was unsuccessful. I just could not understand what I had done wrong on both occasions. I just could not help but think that I was denied this promotion because I am an overseas nurse and promotion is blighted because of my skin colour, (Interview with Person L).

Despite the exhortation of equal opportunity policies in the NHS, participants felt that these were not truly reflected in practice. They commented on their chances of promotion and stated that their racial features could have contributed to their present positions as exemplified in the following focus group extracts:

> Promotion is very slow. If you are white or an English nurse even if you are a newly qualified graduate, after two months or three months you can become an "E" grade. Unlike us foreign nurses you are stagnant at a "D" grade, (FG:2: 14).

> This particular hospital will give you a lot of reasons why they are not going to promote you and I think this is unfair. Other staff will be recruited from outside and they will be promoted very quickly, (FG:1: 1F).
Additionally, participants felt that they would have liked to be treated equally to that of their white British counterparts and be recognised for their efforts. However, this did not happen as highlighted in the following extract:

    But for management, they should treat us equally I mean equal opportunity. They should recognise our effort and treat us as equals not as second-class citizens. We are doing a job just as our white colleagues and we deserve to be treated the same, (FG:1: 1B).

Similarly, many participants commented on equal opportunity policies as having little impact on their lives. They described their experiences of such policy implementation as a mere paper exercise in which managers appeared to have failed to follow through and action accordingly:

    Well in this Trust I am working you could see how many who are on the management level or junior management level, you could see one, two or three. Probably just 1% or 2% of the personnel in the Trust are in managerial positions. One is I think South African, Indian, Mauritian. They are all blacks. It is only a few of them you can see in the Trust because I work on all the different floors and I could see that only a few are in a higher position. Equal opportunity, I think it is just on paper to make it good. Just for government's sake. It is not really equal. In terms of promotion or giving courses because we have to fight our way to get a course, you know, it took me two years on this particular acute ward to get a course, (Interview with Person C).

Furthermore, participants reported that there was no point in having equal opportunity policies if these were not going to be implemented appropriately:

    I have waited and waited for a course and this never happened. Why have equal opportunity policies if you are not going to implement them as such you know people do put down policies on paper but nobody is there to read them and see that they are properly implemented. I just think you know someone has to oversee this kind of thing. It is all well and good to have something on paper but is it been done, (Interview with Person K)?

A number of participants revealed that white nurses were promoted despite relatively little experience:

    I have been here for 3 years and am still a D grade staff nurse. Other white nurses have come after me and have been promoted. I just do not know what's
Chapter Seven

Findings

going on. This is really frustrating to see others with little experience getting promotion when I know I can be as efficient as them and as just as good, (FG:4: 3C).

In the above statement it could be interpreted that overseas nurses were used to, in their country of origin, to be promoted following many years experience as a nurse. However, working for the NHS with a different culture and ethos, they commented on how quickly some British nurses were promoted despite relatively little experience. Despite what participants had been used to in their country of origin, the lack of equal opportunity in the workplace resulted in some participants feeling disillusioned and frustrated. These participants stated that they had little hope of getting promotion. This is because they perceived the working environment to be one that appeared not to accept readily differences in terms of racial features and this is depicted in the following exemplars:

I have given up on this whole thing you know. I am not into the grade thing any more because I have had enough. I mean when I used to work on an acute ward, I could understand there were no positions, but on the day I left, there were several positions and they were convincing me to stay. I moved on to another acute ward and thought it was a good move. A change of environment, change of workplace meant I had a chance to get promoted but the politics in this environment was so different. It was very tense. Because imagine for two years as an overseas nurse and I am still a D grade. They are hiring E grades from outside which with all due respect I know they have experience elsewhere but it is a new environment and you end up teaching them first for the first couple of weeks, show them the ropes and then in paper they are E grade, (Interview with Person B).

They would not give me the opportunity to advance. Other white British nurses were given the opportunities but I was not. To be honest I didn’t think there was equal opportunity in that area, (Interview with person E).
Similarly, some participants described their opportunity for promotion as being limited. This is because they saw overseas colleagues to be static in their current positions despite years of experience. The following verbatim statement illuminates this:

*Judging by my other colleagues, I don't hold much hope as many of them have been here for a few years and they are still D grade. Some are E grades but that's the highest in this hospital as far as I can see, (Interview with Person H).*

Another participant felt that being of a minority ethnic group within a white dominant culture was perceived to be a factor that played a role in not getting promoted in the workplace:

*Because I know they want to educate people but only the whites. I feel that coming from a minority background it is not very easy to actually climb the ladder really, (Interview with Person I).*

Regardless of colour, creed, race and ethnicity, equality of opportunity is a moral principle that can often be neglected in the NHS in the south of England as illustrated in the above extracts. Participants were not convinced of their chances of promotion within their workplaces. They commented on their treatment by management as being different to that of their white British counterparts. For example, if a vacancy arose, it appeared that white British nurses would be first to hear of it, unlike overseas black and minority ethnic nurses. They felt that unfair treatment was not in the best interest of the organisation, but more importantly, it contravened the foundation on which equal opportunity policies was based. Studies conducted by Beishon *et al.* (1995) and Culley (2001) found similar results in that black and minority ethnic nurses had been denied promotion on the basis of their racial features.
Whilst experiencing the lack of equal opportunity, participants encountered bullying as well. Therefore the following section will highlight the participants’ accounts of experiencing bullying in the clinical setting as overseas nurses whilst working in the NHS in the south of England.

7.4.3 Bullying

According to Einarsen et al. (1994; 381) bullying is, ‘where a worker or supervisor is systematically mistreated and victimized by fellow workers or supervisors through negative acts like insulting remarks and ridicule, verbal abuse, offensive teasing, isolation and social exclusion or the constant degrading of one’s work and efforts.’ Encountering bullying in the workplace was a difficult experience for some participants. They described the uncomfortable feelings it created and felt unable to speak to their managers because they feared reprisals. The following extract illustrates this:

*With the higher grades, there are some people who bully you. Well there are some charge nurses who have bullied me. I think it was more on the way they spoke to me. They raised their voices and sometimes shouted at me in front of my colleagues for no apparent reason. You could say that there was a sort of anger or something like that, but I didn't know if it was just..., but it didn't only happen to me, it happened to other overseas colleagues as well. I was uncomfortable and embarrassed by this, (Interview with Person C).*

A further participant described both the humiliation and unequal treatment he encountered. He spoke of what had happened whilst working in that environment:

*A pilot study was carried out in my clinical area and my manager did not know about this. Several times he would complain that I had not filled out the fluid balance chart when in fact if he would check the off duty he would notice that I was not on duty on the day the fluid chart was not filled out. This was happening too often, constantly blaming me and picking on me for no reason. One day whilst I was on duty he shouted at me in a loud voice in front of the doctors and my work colleagues. This manager did not feel the need to treat me as an equal but to constantly humiliate me, (Interview with Person D).*
Similarly, another participant observed bullying in the workplace and the ridiculing of overseas nurses by managers and this is alluded to in the following verbatim extract:

*I have noticed sometimes a lot of this, I will call it bullying in the workplace. Managers and work colleagues have constantly ridiculed other overseas colleagues in front of patients, family and health care members. I don’t think there is a place for bullying. It is not appropriate,* (Interview with Person G).

One of the issues highlighted in focus group discussions was that of bullying. Participants felt unable to report such incidents for fear of reprisals. The following extract exemplifies this:

*I can say that I was bullied in this environment. I was expected to do things that I was not happy to do and one or two colleagues were bullied as well. I could not speak to my manager because she was the one who was bullying me. I did not speak to my husband about it. The bullying soon stopped because I said that if it continued I would go to my union or her manager about this,* (FG:1:1A)

The statements as identified above demonstrated the power differential between the participants and their work colleagues in authority. Bullying created uncomfortable feelings to the point at which some participants wanted to leave the working environment. The stress and the low levels of job satisfaction induced by bullying resulted in unhappy feelings. Quine’s (1999) study on workplace bullying found comparable results. It is important to note here that more than half of the participants from the face-to-face interviews and four out of twenty four participants from the focus group interviews reported experiencing, encountering and seeing bullying in the work place. The rest made no report of this kind. In addition to experiencing bullying, a number of participants revealed how they felt isolated in the workplace.
7.4.4 Separateness

This sub-theme captured what it was like to be an overseas nurse of black and minority ethnic origin working in the NHS. Participants described their feelings and what they encountered in the workplace. They were seen as the ‘other’ mainly because their racial features and cultural identity were different to that of their predominantly white British counterparts. The following exemplar highlights this:

I felt as not belonging to this group. Out of place, lonely and at times wanting to go home. Kept asking myself why am I here? (Interview with Person B).

One participant commented that team members tended to gather by race. In other words, Filipino and ethnic minority nurses would sit together whilst British white nurses would sit on the other side of the room during coffee breaks. This participant stated that this did not reflect good teamwork:

I have observed in the coffee room. I say this [...] In the coffee room you will see my, you know people with the same colour sitting together. There are the overseas nurses and on the other side of the room are the white nurses. They don’t mix. I don’t know what is wrong with that. I don’t know if it is wrong. I don’t know as well if it is right but you will see white nurses here and overseas nurses there, not mixing together. I think we should be mixing but we don’t, (Interview with Person D).

There was also a need to reduce social isolation and communication differences across culture as exemplified in the following extract:

Knowing about another culture is useful as you get to understand and appreciate differences. Having noticed overseas nurses on their own and white nurses sitting together at break times do not help us to feel integrated but further separate us. Mixing and integrating at work will help in reducing barriers. I feel if we don’t mix it is so rude but I have tried and I was ignored, (Interview with person C).

The following verbatim descriptor highlights the inability to express oneself has been seen as a deterrent to the full integration of the team:

The thing is I feel that they normally - that is my feeling anyway - when you can’t express yourself very well it means that you can’t perform well, so may
be the language can be a problem. I sometimes feel isolated from the rest. The language itself can be a drawback and, you can be ignored by work colleagues, if you can't speak the language, (Interview with Person I).

Participants in the focus group interview recalled how they felt whilst working in the clinical environment. The following verbatim descriptor clearly highlights these participants' feelings:

As much as I live in this country I will always feel like an overseas nurse. They don't allow you to integrate even if you want to. I tend to keep to myself because I know that is best for me. I feel like an outcast at times, (FG:4: 3C).

Encountering marginalisation in the form of separation created both a feeling of alienation and, to a certain extent, being alone in a crowd. In the nursing profession care and working together as a team are believed to be two guiding principles and are the unified core of the profession (Leininger, 1995). Yet, in this study, these participants felt isolated and separated from their contemporaries because they were seen and treated differently. These issues may have contributed to a number of participants feelings of 'otherness'.

In summary, participants revealed how encountering marginalisation and experiencing inequalities in the world affected their everyday lives. Although they encountered these problems in practice a number of participants felt that they needed to survive these experiences by tolerating such treatment. Therefore, the subsequent section will highlight another main theme, surviving in an everyday world. This theme will explore the treatment participants experienced whilst working in the NHS in the south of England.
7.5 Surviving in an everyday world

In the second theme outlined earlier, participants described what it meant and what it was like to have encountered marginalisation and experiencing inequalities in the world. Feelings of uncertainty, despair and disillusionment seemed to arouse the need to move away from the working environment. The third theme is surviving in an everyday world and this encompassed challenges to integration and to personal growth and practice. Emanating from these sub-themes are: not feeling appreciated, feeling inadequate, unwelcome feeling, experiencing fear, the concept of self blame, the lack of opportunities for skills development and training, performance review and experience of unfairness in nursing practice as identified in fig 7.4. The findings from this study revealed a number of problems experienced by these participants during their working lives in the NHS. Yet, despite these, they were able to survive in their everyday world and this will be illustrated in this section.

![Diagram: Surviving in an everyday world]

Fig 7.4: Theme 3: Surviving in an everyday world
Chapter Seven

7.5.1 Challenges to integration

This main sub-theme identifies a number of challenges that overseas nurses face during their clinical working experience as overseas black and minority ethnic nurses. These challenges may have impacted on their full integration in the NHS. Many overseas nurses indicated that in order to survive they needed to tolerate those unpleasant experiences as indicated below.

7.5.1.1 Not feeling appreciated

In the theme surviving in an everyday world, participants expressed their feelings of being unappreciated despite having worked extra hours and helped in the delivery of health care. A couple of the participants perceived that their racial features contributed towards their different treatment and felt that in order to survive in their everyday world they had to endure such experiences as depicted in the following extract:

I remember there was a time when my English colleagues on an evening shift would get together and spoke about the number of overtime shifts Filipino nurses had done. They are working so many hours blah blah blah blah. They don't appreciate the hard work you do. They would only talk about all the extra shifts we did. I found this very disconcerting. Consequently I decided not to do any extra shifts and my colleagues did the same, (Interview with Person B).

Both respect and appreciation were issues participants highlighted as well in the focus group interviews. Many of their work colleagues, particularly health care assistants, did not value their contributions within the workforce. A number of participants stated that they wanted to feel valued and appreciated but these were not apparent in the clinical setting. It would appear that staff had not been adequately prepared for understanding cultural differences. Yet, despite this, participants felt that in order to
survive in such a harsh everyday world, accepting their different treatment was inevitable:

\[ I \text{ wished I knew what's his basis for his accusation but I didn't. I consider him as an equal. He is not a staff nurse he is only a health care assistant. I don't think that this person realises how hard I work because if he did such comments would not be made. It is really sad to say this but we are not given the respect we deserve. Surviving in this world is so difficult you know but I have to put up with it, (FG:1: 1F). }\]

\[ Everyone \text{ should be respected. Each and everyone should be respected. Each and everyone should be valued as important however that is not always the case, one is always favoured than the other, (FG:2: 15). }\]

Similarly, one participant from the face-to-face interview described the working environment as being difficult. It was felt that the appreciation was lacking despite all the efforts and energies invested in patients' care:

\[ But I \text{ just feel there was just petty nastiness in this area and there was also no recognition of what you do. No praises for the good work that you do, you never got that you know, it was just oh well, you know. The attitude to your work was, what are you doing here from another country, you know? Why don't you go back home kind of attitude? That is how I felt. Really I could have been wrong but that is exactly how I felt. I don't think I was appreciated, (Interview with Person K). }\]

In a similar vein many participants revealed in the focus group discussions that their white British colleagues claimed that one of the attributes necessary for effective patient care was that of team spirit. However, participants felt that despite this claim, the working environment did not reflect this as identified in the following extract:

\[ They \text{ talk about team spirit but I am not treated as a team member. I am aware that I am a foreign nurse but all I would ask of them is to treat me as someone who deserves respect, (FG:2: 12). }\]

A significant number of participants from the face-to-face interviews described their experience of not feeling valued by staff. They stated that, during their time spent in
the clinical environment, no incentives were given. However, this soon changed when they were about to leave. They were offered the opportunity to undertake a project:

*That health care team where I worked, I did not feel valued there at all. When I was about to leave they began motivating me and offered me a project but this was too late as I had already made my mind up to leave. While I was there, I was not valued. I was just used as another pair of hands. I found this frustrating. You were not given the choice to use your initiative, expertise or to make changes to the environment, so I thought this place is stifling me and I got to get out, (Interview with Person E).*

*I was on this ward for three years and they did not appreciate what I was doing. I was becoming unhappy. I have not been treated well nor been recognised for my work so therefore, I had to say good-bye to that place. I was there but I was not if you see what I mean. I was not given the chance to be involved in any projects, (Interview with Person L).*

In the above extracts the value of being appreciated was eroded and some participants felt the need to change jobs. Alexis and Chambers (2003) noted that valuing the contributions that overseas black and minority ethnic nurses brought to the NHS would inevitably retain staff. In contrast, not all participants felt unappreciated. Others felt happy that their contributions were well received within their workplace.

*Actually, I have no problems. My manager is really nice to me and she appreciates all of my work colleagues and my hard work, (Interview with Person A).*

*Well as a person, as a colleague and a nurse. They don't see me as a foreigner. They appreciate what I can do and they know my capabilities and limitations, (Interview with Person F).*

Although not all participants referred to their lack of appreciation by their white colleagues, two nurses felt that their experiences were in contrast with participants B, E, K, and L as identified above. The findings from the focus group interviews revealed similar results to that of participants A and F as highlighted in the following extracts:
Chapter Seven Findings

There was this patient who kissed me and said thank you for the help I gave. I was so happy that this patient appreciated all the help I gave. She also said that if it was not for people like me, the NHS would not be able to function. I really felt proud to be part of the NHS. To be honest I do not need my manager to give me credit because I know it would not come but at least my patients are appreciative, (FG:1:1A).

Some patients are really thankful for the help you give them and that would sometimes make my day. They appreciate the things that we do for them, (FG:2:12).

Participants in the focus group interviews revealed that despite the lack of appreciation for their skills and contributions, they were appreciative and thankful for being in England and the following extract depicts this:

The only thing that we are grateful for is the experience because you cannot buy the experience, can you? But you have to go through the whole of the experience to learn and I did learn a lot, (FG:1:1D).

7.5.1.2 Feeling inadequate

In addition to experiencing feelings of being devalued, many participants also reported that they felt inadequate at times. This feeling was a regular occurrence for nine participants. Surviving in an everyday world and feeling inadequate created some discomfort, anger and sometimes frustration:

I was with the doctor who wanted to know the fluid input and output of the patient in my care. I had informed him earlier that there were discrepancies in the fluid management of the patient but he did not bother to check, only to realise that the patient was acutely ill. He saw my patient in the presence of one of the senior nurses. This senior nurse commented by saying that this was poor fluid management. Although I had already drawn this to the doctor’s attention, and he refused to see the patient, this senior nurse did not want to know. She made me feel so inadequate. I am very upset now thinking about it but you just tend to get used to it, (Interview with Person J).

Participants also spoke about the difficulties they faced with junior members of staff. For example, one participant described how he was constantly questioned in the presence of the patient and this was perceived to be a form of belittling:
This health care assistant insisted that the patient face mask should be worn a certain way. I said to her that it should be measured from this area down to this area and not go beyond that but she kept arguing with me in front of this patient. I think she was trying to prove that she was better than me. I said ... and she made me feel that I didn't know what I was doing. Sort of underestimation - probably she was just trying to impress the patients, (Interview with Person C).

Another participant commented on the initiative used by a junior member of staff to call the night practitioner without consulting the nurse in charge:

I mean they really treat you differently, for example, there was this health care assistant whom I was working with just took it upon herself to contact the night practitioner without informing me. When the night practitioner came I was not sure why she was here as I thought I would have been able to solve the problem without her help. I was really ashamed when she came. I apologised and explained that I had not called her and I think it was the health care assistant who did. All I needed was some respect from her. She could have let me know she was going to call the night practitioner. I was really angry when this incident happened but I suppose, I am in their country and I need to go along with their thinking and their behaviour, (Interview with Person H).

Another sub-theme that emerged from within the theme feeling inadequate is a lack of trust and this will be described in the subsequent section.

7.5.1.2.1 Lack of trust

Some participants described their account of experiencing lack of trust from their health care colleagues. They stated that such experience sometimes created feelings of inadequacy and this is depicted in these exemplars:

There is a lack of trust. It makes me feel very bad especially when I know that I can do a job but they make you feel inadequate. That makes me feel very bad. But sometimes I am just philosophical about it. Staff do assume that because of your colour you don't know anything and this can cause me great anger and frustration. I really do not know what I need to do to prove that I am a competent person, (Interview with Person I).

Initially, all eyes were on you when you first arrived. I don't know if they were waiting for you to make mistakes. You feel like you are being watched all the time. This was uncomfortable and this continued until now. You cannot really
ask for their help without feeling stupid. Well that's the way I feel anyway, (Interview with Person J).

In describing their experiences, participants revealed that the lack of trust coupled with the feeling of being watched at all times as well as being made to feel awful following mistakes contributed to their low self esteem and reduced confidence. The following descriptors clearly highlight the feelings of the group:

In this country you are followed so much you are looked at so much, you are watched so much and you are put down so much and you are not allowed to do anything. Whenever you make mistakes you are made to feel awful. This made me lose my confidence and I felt so low that I was on the verge of going back because I never thought I would be able to live up to their expectations. The way things are done, the way I was followed, the way I was watched it's like I had no rights. I sometimes feel it's difficult to be honest to be comfortable here. I think if you are a softie and don't have enough strength to survive it can be quite difficult here, (FG:2:10).

It is important to note that the findings from the above descriptors from the focus group interviews confirm those of the face-to-face interviews cited earlier, in that participants highlighted that their experiences of mis-trust within the clinical setting have been a regular occurrence.

From a phenomenological perspective, the human body is the beginning point for understanding and interpreting experience (Madjar, 1997). In the NHS, participants had experiences of ‘living in the world’ and these were interpreted as feelings of inadequacy. The NHS can be a stressful environment and this, coupled with a lack of trust contributed to participants’ feelings of even more stress. In the working environment trust is so fundamental in teamwork. However, this notion had been eroded and replaced by distrust and many participants’ feelings of inadequacy led to feelings of not being part of the ward team.
7.5.1.3 Unwelcome feeling

As previously stated, the NHS is an organisation with its own culture and is characterised by the presence of a multi-cultural group of individuals. The Vital Connection (DoH, 2000d) clearly states that, ‘welcoming and building on the great diversity amongst the people who work in the NHS’ (DoH, 2000d: 7) thus presumably making the NHS a better place to work. Yet, despite this recommendation, many participants felt unwelcome as highlighted in these excerpts:

*I was disappointed as the people were not nice to me and they did not make me feel welcome. I kept asking myself why am I here. I was always of the feeling that the UK was a nice place to work but working with some of my colleagues has changed my viewpoint about the NHS, (Interview with Person H).*

*They should just chill out and make people feel welcome when they start work. I don't think it is just in this area - I think the whole hospital because I could remember talking to other colleagues working in other areas in the Trust and they were very unhappy. A lot of them were really unhappy, (Interview with Person K).*

Another participant stated that her work colleagues would not acknowledge her presence and this created some uncomfortable feelings at times:

*In this new environment when I first came into it, some of them would not say good morning when they first saw you. So I never felt that warm welcome when I was on the acute ward. I never felt it, (Interview with Person B).*

Similarly, throughout the focus group discussions, participants spoke of their feelings of being unwelcome and said that in order to survive they needed to prove to their white British colleagues that they were tough. The following verbatim extract highlighted this:

*You are made to feel unwelcome and to feel that you should not be here. But as I have said that I had to survive this and to prove to them that I am tough, (FG:1: ID).*
Chapter Seven

Findings

Thus the unfamiliar world that participants had experienced and lived, created unpleasant feelings. Although some participants commented on their feelings of being unwelcome, one participant spoke of the experience of feeling welcomed and accepted:

_Umm they welcome you and they will show you around the ward, (Interview with person G)._ 

Many participants described their 'feelings of being unwelcomed' which were regular occurrences in the clinical settings. Surviving in an everyday world with such feelings was difficult for many participants. However, in contrast, interview with participant G provided a slightly different picture. Participant G felt that some British white nurses were welcoming and this at times contributed to a positive and pleasant experience.

7.5.1.3.1 Experiencing fear

Participants described their account of working in the NHS and stated that in order to survive in their everyday world, experiencing fear was a regular occurrence. All revealed that being temporary residents in the UK meant that they needed to be cautious of what they say or do because of fear of being asked to return to their country of origin:

_Because number one we are just temporarily here. They are here no matter what happen to them they won't lose anything. But for us we would be thrown out with our families and we would have to start all over again. So we have to consider this at times, (FG:1: 1A)._ 

_We are just careful of what we have to say you know what I mean. They are permanent here and no matter what happens they can stay here but we are temporary nurses here and if we say something that they don't like we could be thrown out of the country, (FG:2: 13)._ 

213
7.5.1.4 Concept of self-blame

All spoke of being the wrong colour and stated that had they had similar racial features to that of their white British counterparts, their treatment would have been different. In surviving in their ‘everyday world’ participants experienced guilt and revealed that this was a feature they had to endure in the NHS in the south of England as described in these extracts:

*It's because our skin colour is different and I suppose our hair as well and there is nothing I can do about this, (FG:1: 1C).*

*Well, I sometimes feel it's my fault for the way I am treated but I just can't change my skin colour. I am from overseas and there is nothing I can do about the colour of my skin, (FG:2: 14).*

7.5.2. Challenges to personal growth and practice

This sub-theme encapsulates the difficulties that a number of overseas nurses experienced towards their personal growth, and in clinical practice. These challenges created some conflict for overseas black and minority ethnic nurses. Although this ensued, they indicated that tolerating such experiences was pivotal for surviving. The following themes as identified below capture some of the difficulties overseas nurses encountered as employees of the NHS in the south of England.

7.5.2.1 Lack of opportunities for skill development and training

Training and development opportunities for nursing staff are issues of increasing importance within today’s NHS. Of course the need for nursing staff to undertake further training and development is of significant value to the organisation. Investment in the regular update of staff’s clinical skills is likely to lead to the delivery of a high quality of patient care/service. Such regular training and
development are important to nursing staff as their chances for further career development would be enhanced.

Many participants revealed that both training and development were not easily available for a number of reasons. The first was, there were financial constraints in the NHS and priority was often given to patient care needs. Therefore both training and development were perceived to be low priority. Secondly, once training was offered, it was perceived that the acquired skills might be used elsewhere. Finally, these participants perceived that their racial features played a significant role in their lack of skill development, thus resulting in the denial of both training and development as illustrated below:

I have been in the Trust for four years and I am still a D grade. In this area I am presently working if you want to do a course you are denied because the courses were given to people the manager likes, English people. I applied and was told that I would need to wait my turn. But I could not understand this when white nurses who joined the team after me were given courses. If you speak to any of my colleagues of the same ethnic group they will say the same thing, (Interview with Person B).

Another participant reported that filling the gaps seemed to be one of the reasons for being an employee of the NHS and this is clearly depicted in this extract:

It makes us feel that we are just filling the gaps. You go to work, do your job, go home, we will pay you and that is it. There is no development out there. That is how I feel. And there is no career pathway, I just wonder in five years time where will I be heading. Probably still the same, still the same doing all the jobs, (Interview with Person C).

Similarly, another participant felt that despite having asked for a course to develop appropriate skills as this was perceived to be paramount for both development and for evidence based health care, this was refused. In nursing, the development of skills through training is fundamental for advancement. Therefore, this participant was
unable to develop skills and this meant that opportunities for advancement as well as providing evidence based health care were constrained:

*It is my line manager who got all the powers to do that. Even though if I ask for a course to develop myself - you know my professional growth - he will not give this to me and this means I can’t advance,* (Interview with Person D).

The findings from the face-to-face interviews concur with those of the focus group interviews. Many participants in the focus group interviews commented on the unfairness they endured in terms of skill development and training and would only tolerate this because of family commitments. They stated that their skills and qualifications were not recognised. They revealed that suggestions were made to their managers such as in order to continue providing the highest standard of nursing care, they needed to develop professionally. This opportunity was denied to them, yet, they felt that their white British counterparts were not, as illustrated in the following extract:

*What I found to be unfair was that the courses I came with were not recognised here. We are highly skilled professionals. The thing is we are not given the opportunity to do courses. When we ask we are denied but our white colleagues aren’t. I don’t think this is fair but I am in their country and I need to support my family and survive so I put up with it,* (FG:2: 13).

It was stated that new British recruits were offered opportunities to undertake courses unlike overseas nurses who were not:

*Where I work in this department some of my colleagues applied for the university courses but the manager said there were no funds. Here comes the new staff and of course the English staff and they got the course. In fact if you are saying that there is a queue for getting on courses how come the new staff got the course and we were not given the chance to take the courses if there is a queue,* (FG:2: 12).

A number of participants described their experiences as ‘being left out’ and their education had suffered as a result of no training and development and this is alluded to in the subsequent extract:
I feel really left behind. I just felt the ward nurses are not considered as important. Although we are giving patient care, no one seems to want to develop our skills. We should be updating ourselves regularly. I feel that my education is suffering. And I was thinking of my loyalty to this ward. I have been there and I don't seem to be doing any courses. I don't want to be stagnant in this area. I suppose because I am a foreigner that I don't get the chance to do courses.

OA: What do you mean you are a foreigner?

Well, I get the feeling sometimes that they will be happy with me just working and not updating myself. This can be frustrating as I said earlier I need courses to help me to grow in my area of work and if I don't have these courses I feel left out, (Interview with Person F).

Umm, now I accept it that they won't send me on those training courses but I am expected to continue to give up to date care to my patients, (Interview with Person A).

The group identified how frustrating it was for them to be unable to undertake courses. They stated that they had waited for a considerable amount of time and to no avail. The following verbatim extract highlights the feelings of the group:

Well, I have been here and have not been able to do a course and this is upsetting at times. I have waited a long time and still no success with courses or career advancement. This situation is not good for the NHS, (FG:3: 2A).

In the NHS, as in any organisation, developing skills through knowledge acquisition is fundamental. In order to provide care of the highest standard underpinned by evidence based knowledge, participants would be required to undertake appropriate courses. However, accessibility to these courses was not apparent and therefore such nurses were unable to develop sufficient theoretical knowledge to underpin practice and enhance their skills. The paradox is that many of these participants are skilled practitioners in their country of origin however, the bureaucratic environment of which they are part of, has constrained their opportunities to utilise those skills. Many participants stated that they became frustrated and unhappy because their
comprehensive set of skills was not utilised and this was further compounded by the fact that access to courses was denied and they perceived this experience to be based on their racial features.

Training and development are important because an organisation that trains and develops its nursing staff will be less dependent on external resources and will consequently retain nurses. Furthermore, staff will feel valued and appreciated if their training needs are met, as discussed earlier in the sub-theme based on, 'not feeling appreciated.' To have lived in the 'everyday world' with no training and development meant that participants might seek alternative employment, which some had done. This is because both training and development are considered to be valuable assets to recruiting and retaining staff. In order to survive in such world there is a need to develop skills and knowledge through training.

7.5.2.1.1 Performance review

One of the recommendations made in the Griffiths Report for the NHS was the introduction of individual performance review. This was made compulsory for all managers in the NHS in 1986 as it was deemed important in motivating staff to achieve their potential (NHS Training Directorate 1986, Institute of Health Services Management 1991). Although appraisal is instrumental in developing staff potential, its introduction is considered to be somewhat patchy (Institute of Health Services Management, 1991). Many participants revealed that there were instances when appraisals were introduced haphazardly and they perceived this process as having no benefits to them:
If we have this appraisal, I think we should know what the appraisal is all about. I have had two appraisals already and I think they just do appraisal for the sake of doing them. I remember what I wanted at my first appraisal and I haven't done it yet, (Interview with Person B).

You know I don't even have my appraisal for eighteen months and we should have one every six to twelve months. My manager wanted to appraise me despite all the problems I had with him. I did not attend my appraisal because I felt that I would not benefit from this. I felt it would just be destructive rather than constructive, (Interview with Person D).

Equally, another participant stated that the adhoc implementation of appraisal resulted in no goals being set:

I have not been appraised formally. There was a time when my ward manager asked me a few questions but I would not call that appraisal as no goals were set for the following year, (Interview with Person H).

Throughout the focus group discussions, some participants revealed that they had not achieved their previous goals and questioned the purpose of the appraisal system. The following extract clearly captures the experience of these participants:

Whenever I have my appraisal my manager will get the feedback from my work colleagues which is very sad because if your work colleagues do not like you then you can have an unfair appraisal. From my last appraisal, I don't think I have achieved the goals set. My manager is good at setting goals but when its time for me to achieve these goals, there are no opportunities. Sometimes I wonder what is the point, (FG:1: ID).

The above extracts clearly identified an existing problem that is evident in the NHS. Beishon et al. (1995) noted that black and minority ethnic staff experienced helplessness and felt that they could do nothing to change the ethos of the working environment of the NHS. In this study, in order to survive in the world of the NHS, staff needed to accept the status quo and this meant acknowledging the work ethics and the unfairness in the working environment.
7.5.2.2 Unfairness in nursing practice

This study revealed many unpleasant aspects experienced by overseas nurses such as unfairness in nursing practice and this created unpleasant experiences during their everyday working lives:

Many a times I will finish my day-to-day duties and will have to help my colleagues but I don't see them helping me when I do need it. What I have noticed is, they will delay their clinical work so that the nurse who will be taking over from them will need to complete what they have finished. I found this so unfair. Most of the times overseas nurses are the ones who have to finish these tasks. I know it is 24-hour care but they will wilfully leave their work behind for others to do. This ward predominantly has overseas nurses, so guess who will be doing the unfinished job? I say no more, (Interview with Person E).

Well I can remember an incident where one senior staff nurse was always picking on me, you know, and when I confronted her, I said you know can you tell me what is it that I am not doing right. She couldn't tell me. You have got to do that and she will always give me the worst patients, the worst of the patients and as much as you try and do your best. Sometimes you would like to complain but you couldn't even go to the person in charge because you knew she wouldn't take our side at all, you knew that, so there was no point in doing it, (Interview with Person K).

The findings from the focus group discussions support the above extracts in that many of the participants revealed how they would be involved in ‘doing the dirty jobs’. They did not mind having to do such but they would have liked their white British colleagues to be involved as well. The following verbatim extract encapsulates this:

Where I work it is very different. All the dirty jobs you would end up doing. They will go have their cups of tea and they will leave me to clean up after them. They certainly don't ask me to join them. I feel that discrimination is rife where I work. My reason for saying this is, I do not see any of my white colleagues doing the dirty jobs. It is always the foreign nurses, (FG:1: 1D).

Similarly, the focus group participants described their experiences of unfair treatment whilst in clinical practice. These participants stated that they were given the heaviest patients and if they needed help this was not available. The following extract captures the feelings of the group:
You are given the heaviest patients and there is no help from my colleagues. If you do ask for help they will say in a minute and they will never come to help you, (FG:4: 3B).

Within the focus group discussions one participant commented on being left alone with no support to take charge of the ward particularly on nights. It was felt that managing the ward at such times only occurred at the manager’s convenience and this was perceived to be exploitation:

*I think as a foreign nurse I am used especially on nights. I am left alone to run the environment with no support. I am only a D grade and I think I should have an E grade on with me. On hand they do not trust me but when it suits them they want me to manage the ward. I sometimes say I am unable to even though I know that I can. I really do, (FG:1: 1C).*

Equally another participant from the face-to-face interview highlighted the increasing workload and felt that managing the ward with a health care assistant did not reflect good skill mix:

*I would say that I could count many times when I had been on my own with a health care assistant managing the ward. I could have had sixteen or fifteen patients. And you are the only one with a health care assistant. So I don’t think that works effectively. I can do the job but at the end of the day you try to do what you can to do to manage the ward and everything else. I didn’t think it was really very effective and safe. I became frustrated and tired as I have been used at their convenience, (Interview with Person L).*

It is clear from these findings that participants have experienced unfairness in nursing practice and this affected both their physical and psychological well-being. These participants’ lives were characterised by not feeling appreciated, feeling inadequate, a lack of trust, feeling unwelcome, experiencing fear, the concept of self-blame, the lack of opportunities for skills development and training, ineffective performance reviews and unfairness in nursing practice. Yet, despite these negative characteristics, participants were able to survive in their everyday world and recall their stories of working in the NHS as overseas black and minority ethnic nurses. Not only did they
survive in their everyday world but participants felt that they needed to live through these experiences by developing strategies. The subsequent section will focus on living in an everyday world.

7.6 Living in an everyday world

This theme relates to the ways in which participants sought to develop strategies to cope with their experiences of working in the NHS as black and minority ethnic nurses from overseas. The following sub-themes comprise of support from black and minority ethnic colleagues and proving self as alluded to in fig 7.5.

7.6.1 Support from black and minority ethnic colleagues

Living in an everyday world such as the NHS, support was necessary. Many participants sought support from other overseas black and minority ethnic colleagues whilst working in unpleasant situations in the NHS. However, for some participants conflict and difficulties ensued because the support promised was not available from their white British counterparts. Despite this, they were able to develop coping mechanisms to live in an everyday world as exemplified in the following extracts:
Because of the boundaries I tend to stick to my own ethnic group. We discuss it among ourselves if there is an issue. We tend to be very close and very supportive because we are in the same boat. But don't ... I have never talked over an issue with an English person because it is difficult, because you don't know who you can trust, (Interview with Person B).

More or less with our colleagues, those of the same nationality we speak about what the problems are. We seldom go to our manager or to our F grade because they are white and we don't know how loyal they are. We don't know if they could keep information. They might just pass it on to everyone on the ward you know. So you don't know their loyalty or their professionalism so we just talk with our own colleagues and our families that is how we cope with our problems, (Interview with Person C).

Participants continued by describing the support they received from other black and minority ethnic colleagues. They stated that this support helped them maintain a life of 'normality' and contributed to their adjustment to a different environment:

People of my kind have helped me to understand the new culture, acculturating myself and adjusting to the new environment I find myself in, (Interview with Person J).

Nurses of our colour, we support each other. You know we encouraged ourselves to continue to rise above all the problems that we met. We helped each other to adjust to a new culture and we discussed our problems with each other, (Interview with Person K).

The findings revealed many participants’ stories of ‘living in the world’ in the NHS. They stated that the support of their overseas colleagues was integral throughout their difficulties and conflict they experienced whilst working in the NHS in the south of England. Many participants experienced difficulties during their everyday practices and these no doubt impacted on their everyday lives. In order to overcome some of the difficulties encountered, they sought support from other colleagues of black and minority ethnic origin. This is because these participants could identify with those individuals with similar cultural identity but perhaps could not with their white British
counterparts, particularly as support in the clinical environment was not readily available.

In the nursing profession, caring meant to be concerned about someone or something. Participants cared for each other by supporting one another throughout their experiences. They spoke of their difficulties and were able to give peer support to each other. Despite these difficulties that these participants experienced during their everyday practices, they were able to live through and overcome these by obtaining support from other overseas nurses of similar racial features. Despite the peer support received, they needed to prove themselves to their white colleagues.

7.6.2 Proving self

Another sub-theme to emerge was proving self. Some participants described how they had to prove themselves in order to live comfortably in the world. In the following extract participants commented on having to prove themselves so as to gain recognition in their workplace:

*Prove to them that I can do it. To show them that I can be better than what they are doing. We are never given the chance. We always have to prove ourselves, to others that we can do bedside nursing, better than them, (Interview with Person A).*

*I have to think that I will one day be right there. I have to prove myself that I can be one of them. I think more of the future now. Unlike before, I didn’t care but now I have to. Because I notice if you don’t think of what you want to be in here they won’t help you much, (Interview with Person E).*

In another example, a participant reported on having to prove herself in order to work comfortably in the clinical setting:
Chapter Seven

Findings

I am always out there to prove myself to my white colleagues that I am here to help out in the same way an English nurse would be there to help out, (Interview with Person J).

Participants talked about being the best nurses and how important this is to them. They stated that patient care is paramount and the following extract from the focus group discussion highlights the views of the participants:

I think the ability to prove that our race isn’t just anybody underdog or something like that. For me I can make patient a lot better than anybody can then I think that this is my contribution to humanity itself and it is not just for myself but for the patients. Having the ability to be the best nurse that I can be would be the thing that I value the most, (FG:3: 2A).

The above statements indicate participants’ motivation to prove to their white British counterparts their capabilities. In order to be accepted in the world, participants had to prove themselves. This defence mechanism adopted, gave them the impetus to continue in their everyday activities in the working environment. Living in an everyday world meant developing coping strategies and these enabled some participants to maximise their effort to work and live comfortably, as well as maintain their self-esteem. Equally, participants needed to make a new world in order to gain personal satisfaction. The next section will explore making a new world. It will highlight these participants’ experiences and what they did in order to make a new world.

7.7 Making a new world

This final theme relates to the way in which participants sought to develop and establish a new world. This main theme, making a new world, comprises of the following sub-themes: building ties, reflecting on the experience and moving on as illuminated in fig 7.6.
7.7.1 Building ties

Participants spoke of making new friends and this helped not only in their adjustment to the NHS but also with their understanding of the NHS culture, which they were not accustomed to. Working for the NHS in the south of England meant that some participants were able to engage themselves with different cultures and it was this socialisation that enabled them to form friendships as depicted in the following extract:

_I am happy here to be honest. A lot of my friends I have met through working for the NHS. We will meet and socialise and I think I have learnt a lot from them about the NHS and the British culture, (Interview with Person G)._ 

Another participant echoed a similar experience and described how useful it was to be able to build ties with other overseas nurses. It was perceived that this friendship had enabled this participant to survive and this is depicted in the following excerpt:

_I am surviving with the help of my friends in the NHS. They are so useful to me. Without them I don't think I would be here today. I am happy to call them my true friends, (Interview with Person L)._
In addition to building ties, participants revealed that throughout their journey they were able to reflect on their experiences in order to devise strategies that would facilitate their development.

7.7.2 Reflecting on the experience

Almost all of the participants reflected on their experiences of being overseas black and minority ethnic nurses working in the NHS in the south of England. They described how the experience had enabled them to become more aware of the culture within the NHS as well as the culture of their white British counterparts. Participants stated that the experience gained from working in the NHS had prepared them to work in any part of the world as reported in the following exemplar:

*I must say, this experience has enabled me to develop personally as an individual and has taught me lessons about the NHS and the British culture. I believe I could now work in any clinical environment in the world, (Interview with person K).*

As a result of reflecting on their experiences, some participants revealed that moving on would be an appropriate option.

7.7.3 Moving on

Experiencing the unfamiliar world, compounded by difficulties in the world meant that participants were able to rationalise what was happening and this resulted in the participants moving on. Not all participants took this option but some felt that their skills and expertise would be appreciated in an alternative environment:

*Well right now, because I don't know, I still do not see myself staying here for a very long time. I have moved from another environment to here and I would*
like to move on to another hospital to see what the culture is like - the work ethics and how management is like, (Interview with Person J).

Another reported that:

_That is why I think I was just so disillusioned with the whole thing. I just thought to myself well it is either I have the choice and fight this thing but if I do then I am going to be ostracised by everybody there. And I chose to move on which is sad because I really liked working in that area but I wasn't happy, I really wasn't_, (Interview with Person K).

Discussions from the focus groups revealed that many participants stated that pastures new were inevitable because their experiences of the NHS in the south of England were not what they had anticipated:

_Because I am not appreciated and recognised for what I do I can't see myself staying in this country_, (FG:1: IS).

Another stated that:

_You work hard you put your heart in it and you get nothing in return. I will certainly move on_, (FG:1: IC).

As a result of the difficulties that many participants encountered, they stated that moving on was an option they were considering:

_I mean the earliest chance that I get to leave I will take the opportunity pack my bags and say good bye_, (FG:1: IE).

_They have employed lots of foreign nurses but they do not recognise our effort we are putting into the system. Many of us will move on. Although we are still surviving their treatment, there is only so much you can take. So moving on is definitely an option for me_, (FG:2: 12).

Moving on was a coping strategy that participants adopted. Heidegger (1962) refers to engagement with the world as involvement in the world. Also, Heidegger contends that humans are self-interpreting beings and these perspectives have significance to moving on. Throughout their experiences, participants were constantly engaging and interpreting and re-interpreting the world. Whilst engaging and interpreting the world,
some participants came to an understanding that moving on was an appropriate option. This was because they were unable to seek satisfaction for their needs in the current clinical environment, so moving to alternative workplaces, presumably would improve their working lives and experiences.

7.8 Summary

Five main themes emerged from the data analysis of the experiences of overseas black and minority ethnic nurses working in the NHS. The first theme centred on being thrown into a different world and what it was like to be in that world. In this theme, participants described the difficulties they experienced in this unfamiliar world and the discomfort it created for them.

The second theme describes what it was like for the participants to encounter marginalisation and inequalities in the world. In this theme, participants described the difficulties and conflict they experienced during their everyday practices in the NHS. They referred to discrimination, lack of equal opportunity, bullying and separateness to explain the different experiences they encountered.

Participants spoke of their experiences of surviving in an everyday world in the third theme. A number of concepts emerged from the initial interpretation of these experiences. The following themes emerged: not feeling appreciated, feeling inadequate, unwelcome feeling, experiencing fear, concept of self-blame, lack of skill development and training, performance review and finally unfairness in nursing practice. By interpreting their world, participants generally felt that to some extent
their racial features played a significant role in their difficult experiences of surviving in the everyday world of the NHS.

The fourth theme relates to the way in which participants develop strategies to live in an everyday world. They sought solace from other black and minority ethnic colleagues. They also had to prove to their white British colleagues that they were capable of performing to the highest standard that was expected of them.

Making a new world was the final theme. Participants indicated that they were able to reflect on their experiences and were able to build ties with friends. For others, moving on to an alternative environment was necessary, as this was perceived to 'hold the key' to their personal satisfaction.

Emergent themes from the thematic analysis of the lived experience of overseas black and minority ethnic nurses working in the NHS have been presented. Throughout these themes, the meanings participants attributed to their experiences were revealed and made explicit to the reader. Presenting the data in this way provided the means to derive a meaningful ontological phenomenological description of the essence of being overseas black and minority ethnic nurses working in the NHS in the south of England.
Chapter Eight

Discussion

8.1 Introduction

The research question asked: What are the experiences of overseas black and minority ethnic nurses working in the NHS in the south of England? Using a phenomenological approach informed by the tenets of Heidegger (1962), this study seeks to examine the lived experience of overseas nurses of black and minority ethnic origin who have been working for a period of at least one year but no more than ten years in the NHS.

This chapter discusses the overall findings of this research, compares and contrasts the study participants’ perspectives with the relevant research and makes explicit the unique findings of this study.

8.2 Discussion of the findings

This research provides a rich description and interpretation of the meaning the participants attributed to their lived experience of being overseas nurses and the findings will be discussed under the following sub-headings, ‘being thrown into an unfamiliar world’, ‘encountering marginalisation and experiencing inequalities in the world’, ‘surviving in an everyday world’, ‘living in an everyday world’ and ‘making a new world’. The insights derived from this study confirm and extend the findings of previously published studies in a number of ways.
8.2.1 Being thrown into an unfamiliar world

The results of this study show that the participants were being thrown into a different world and experienced differences in nursing practice, adjusting to a new environment, differences in communication and the absence of support. Although no previous study identifies being thrown into a different world, several studies have reported that participants experienced differences in nursing practice (Allan and Larsen 2003, Buchan 2003, Withers and Snowball 2003 and Daniel et al. 2000). Participants in these particular studies experienced obstacles in terms of documentation and medical and nursing abbreviations and these created stress and frustration.

This research also found that participants reported being displaced in a new environment and the difficulties experienced in adjusting to this new environment. The findings described in this study are consistent with previous studies that featured descriptions of adjustment to a new environment (Yi and Jezewski, 2000, Omeri and Atkins, 2002 and Withers and Snowball, 2003). The data obtained about overseas nurses’ experiences of nursing in the NHS revealed important differences both in the organisation and delivery of health care to patients. In the UK, the nursing environment was significantly different to that of overseas nurses’ previous clinical setting and as such, the findings of this study revealed the difficulties they experienced as a result of being thrown into a new environment.

Undoubtedly, moving into a new environment created some challenges in many participants’ lives. For some, they had experienced helplessness, uncertainties and stress and needed to regain control of their everyday world. Nevertheless, this was not
an easy undertaking as they were placed into a new environment. When changes occur and can be easily accommodated, adjustment is relatively stress free (Berry, 1992). However, being thrown into an everyday world with limited support and then having to adjust created insurmountable problems, as had been the case for some participants. These findings affirm those that Berry (1997) identified in his study on the adjustment and acculturation of individuals to a new environment.

For a number of participants migrating to another country to work usually involves encountering challenges to their experiences and these appear to vary according to cultural norms and values (Buenza et al. 1994). Cultural norms and values are not static but are learned and shared and are characteristics of the behaviour of a society and in order to adjust to these support is required. Indeed, adapting to the cultural norms and values within a given society such as the NHS in the UK is viewed as a dynamic process that is part of the experience of any individual and those values can change markedly over a period of time (Brislin, 1993). As identified in this research it would appear that many overseas nurses found adapting to the norms and values that underpin the NHS to be challenging and this is because of cultural differences and inadequate support.

Participants also indicated that they experienced humiliation and embarrassment related to their differences in communication. Although English was not their first language in their country of origin, it appears that some participants were thrown into a different world with minimal support and were being ridiculed by staff. This produced uncomfortable feelings of fear and anxiety for a number of participants.
This present study's findings reflect those of previous studies (Allan and Larsen 2003, MORI 2002)

In attempting to address these findings, it is important to draw on Taylor et al.'s (1999) work. They identify two types of sociological concepts that are inherent within the social world of individuals these being primary and secondary socialisation. In terms of primary socialisation, this involves learning basic lessons for life from family members such as language. Therefore for overseas nurses they acquired their language from their countries of origin. However, moving to work in another country such as the NHS in the UK created some difficulties as the accent and colloquialisms were different to what they were accustomed. Although understanding such differences in language posed problems for some participants, it is important to say here that everyone has an accent and this can possibly create problems for whoever the receiver might be (Pekerti and Thomas 2003).

On the other hand secondary socialisation includes individuals moving into the wider world such as the working environment. In this world individuals learn and continue to develop social skills. Although overseas nurses were attempting to socialise into the world of the NHS, they were not fully socialised or integrated. This is because their communication skills were perceived to be different and this could have contributed to the way in which they were treated. Matiti and Taylor's (2005) study confirm these aformentioned findings.

The lack of support as reported in this study also concurs with findings of previous studies (Allan and Larsen, 2003, MORI, 2002 and Davidson, 1997). However, in
contrast, the findings from Withers and Snowball’s (2003) study revealed the opposite. Participants realised that in order to survive in the environment in which they were placed, support was necessary. However, this was not apparent and they perceived that the reason for this inadequate support was partly due to their racial features. They felt that staff had little time to explain, accommodate and to assist them in their adjustment to a new environment. Although they felt this way it could be that the working environment in the NHS was [and have always been] busy and stressful and these factors may have contributed to the absence of support. Although Webb et al.’s (2002) study does not specifically explore the support surrounding overseas black and minority ethnic nurses however, they highlight a pertinent issue surrounding support in the NHS in general. They found staff to be unsupportive of each other and this resulted in low morale and poor recruitment and retention of nurses. Similarly, Arnold et al. (2003) found comparative results in that British based staff felt unsupported in their workplaces. Therefore, the limited support overseas nurses received may have been a cultural dimension inherent within the NHS.

Reduced confidence, no advocacy, resentment and unhappiness were aspects affecting their experiences in the NHS. They felt that the limited support in particular affected their confidence. Although not all participants reported this, one participant’s description in particular encapsulates the feelings of many by indicating that the support received while working in the clinical environment could have been much better. The results also found that participants’ expressed feelings of unhappiness and resentment and these were compounded by a lack of advocacy consequently affecting their experiences of working in the NHS. These findings are consistent with those of Allan and Larsen (2003).
8.2.2 Encountering marginalisation and experiencing inequalities in the world

Several studies examining the experiences of overseas nurses in the NHS have reported that participants experience racial discrimination (Taylor 2005, Alexis and Vydelingum 2004, Allan et al. 2004, Allan and Larsen, 2003, MORI, 2002, Shields and Price, 2002 and Hagey et al. 2001). This current study confirms these findings and extends the knowledge and understanding of this aspect of the participants’ experience. This result illustrates the difficulties participants encountered while working in the NHS. Studies conducted by Kyriakides and Virdee (2003), Coker (2001), Sawley (2001), Vydelingum (2000), Esmail and Carnall (1997) and Beishon et al. (1995) have demonstrated the disadvantaged position of minority ethnic groups in the NHS. Although these studies have concentrated on minority ethnic groups, they highlight the extent to which this problem is prevalent in the NHS.

This study also revealed irretrievable breakdown in the relationship between employer and participant resulting in the participant’s decision to file grievances. Such a desire to have grievances dealt with in a comprehensive manner is consistent with the principles of a just society (Hagey et al. 2001). Holding the employer accountable for the consequences of its actions is paramount to the good relationship of the employer and participant. In a diverse society like the NHS, the principles of justice to restore equity and procedures to ensure accountability are needed to bring about fairness which is envisioned as one of the principles of the NHS. Achieving equality and fairness is therefore fundamental in any egalitarian society (Rawls, 1999).

Similarly, Peter and Morgan (2001) concur with Rawls’ seminal work in that the basis of the principles of justice has been described as embracing values of social justice,
freedom from exploitation and oppression and the maintenance of relationships. Equally, Peter et al. (2004) address the abuse of power such as those that are associated with race, class and ethnicity within health care. The findings from this study support the evidence suggested by Peter et al.'s (2004) account in that participants referred to their unequal positions in relation to their white British counterparts.

According to Puzan (2003), whiteness signifies power and being white allows individuals to include or exclude people of non-white races. This hegemony influences how individuals might socialise and integrate within the lifestyles of whiteness. How this inclusionary or exclusionary power is exercised will depend on whom white individuals might consider worthy. Parallels can be drawn from this in that overseas nurses might be included if they are considered worthy or excluded if they do not conform to the expectations of the culture of the NHS and therefore this exclusionary power can be exercised in the form of racism, discrimination, lack of equal opportunities and invisibility.

The concept of invisibility in relation to nurses is unreported. Bjorklund’s (2004) discussion of the concept of invisibility relates much more to the unseen work of nurses, rather than nurses themselves feeling invisible. Much of the literature on the concept of invisibility is in the United States and relates to black peoples’ experiences and the way the white dominant group expressed their social superiority by not perceiving those they dominated as equal and this is illustrated in Ralph Ellison’s (1999) work, The Invisible Man. Invisibility involved not only a physical non-present, but also a rather non-existence in a social context. What the nurses in this
study were describing were how doctors, managers and relatives were ‘looking through’ them, an active form of intentional invisibility, which demonstrated the capacity of the other agent to disregard the nurses’ presence. Such intentional practices that ‘looks through’ the black and minority ethnic nurses, not only shows dominance and power, but at the same time reinforces a form of invisibility that emphasises humiliation by white people.

Allied to these experiences of racism, discrimination and invisibility were participants’ perceptions about the lack of equal opportunity for them in the NHS. This finding affirms the results of previous research and extends knowledge and understanding on overseas black and minority ethnic nurses in the NHS (MORI, 2002 and Taylor 2005). Many studies specifically highlighted the disadvantages nurses faced within the NHS, particularly in terms of the lack of opportunities to advance in their chosen careers (Beishon et al. 1995 and Culley and Mayor 2001). Much of these studies concentrated on British based minority ethnic nurses rather than overseas black and minority ethnic nurses.

The Vital Connection (DoH, 2000d) highlights three integrated values as fundamental to its core and these are equality, fair treatment and social inclusion. However, in this current study, these values appeared to be eroded and replaced with unfairness, social isolation and inequalities in opportunities in the NHS. The perceptions of the participants illustrated concerns about the rhetoric and reality of such a policy. Despite the formal commitment, the policy was perceived to have had limited impact on the organisation with the resultant effect on participants. Against this background,
such a policy was perceived to lack management commitment to its implementation resulting in participants experiencing unfair treatment.

Almon (2002) identified two approaches to equity: horizontal and vertical equity. Horizontal equity refers to treating everyone equally. This may lead to inequity as everyone is not equal or the same. In contrast, vertical equity may appear contradictory at first but this refers to giving unequal but appropriate treatment or care to individuals or groups who are unequal in specified respects, therefore meriting different provision. Such an approach is similar to the affirmative action initiatives operated in some areas of the United States. Therefore, vertical equity may need to be considered by senior managers in order to address the unequal treatment of overseas nurses.

Despite the introduction of the Race Relation Amendment Act [2000](Home Office, 2000) it would appear that such an act seemed to have had little impact on the lives and well being for some overseas nurses. As identified in this study, many participants referred to their disadvantaged positions and recalled that their white British counterparts were promoted despite their relatively limited experiences. Kanter (1993) claims that participants are empowered when they perceive that their work environments provide opportunity for growth. In these circumstances participants would feel empowered. However, as participants were not given the opportunity to advance, they felt powerless and this threatened organizational productivity, leading to some participants becoming disillusioned with management.
The lack of promotion, exclusionary practices and limited chances of promotion are all examples of discrimination though such discriminatory practices are covert and hard to prove or disprove. However, prejudice and discrimination are negative manifestations of integrative power and are suggestive of some sort of employee/employer relationships (Boulding, 1989). In this study, such a disintegrative power relationship seems to be manifested in the way negative stereotypes are held about black and minority ethnic staff and they are discriminated against by British staff due to such held stereotypes. Whilst open discrimination is illegal, covert discriminatory practice might be endemic within the organisation, where minority ethnic staff might be treated as if they do not exist.

The formal interpretation of equal opportunities has inspired anti-discrimination in the UK for example Equal Pay Act (1970), the Sex Discrimination Act (1975), Disability Discrimination Act (1995), the Race Relations Amendment Act (2000), the Special Educational Needs and Disability Act (2001) and Equal Opportunities Commission (2001). In addition to these, there is the Universal Declaration of Human Rights (1948) that promotes equality for all involved. Although these legislations pertained to different aspects of equality within the UK, they have relevance in this study. This is because the concept of equality signifies that every member of a given society has equal status and indeed opportunities (Rawl 1999, Walzer 1985, Humana and Harrison 2003).

Equality is a guiding principle within any egalitarian and liberal society (Singh 2002, Miller 1999, Young 2001 and Sen 1999). However, the findings suggest that overseas nurses expression of the lack of equality and indeed opportunities meant that their
opportunities to advance were constrained and therefore they were not able to progress as they would have liked to in the NHS in the south of England.

This study also provides a further dimension that no other study on this topic has found. For example, bullying in the workplace was not reported in any of the studies based on overseas black and minority ethnic nurses. In this research, participants referred to encountering bullying and feeling unable to speak to their managers for fear of reprisals. According to Adams (1997) bullying is the persistent demeaning, degrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem. Rayner (2002) identifies five categories of bullying such as belittling, professional humiliation and failure to acknowledge good work. The individual receiving such derogatory treatment is commonly described as the ‘victim’ and usually experiences poor psychological health and dissatisfaction with work (Royal College of Nursing 2005 and Cowie et al. 2002).

The RCN (2002) report also indicated that one in six nurses had been subjected to bullying from a colleague in the last year but only six percent of those who had experienced bullying went on to report formally incidents of such nature. Equally, a study based on workplace bullying specifically explored this issue in relation to NHS staff (Quine 1999). Although this study examined bullying from the perspectives of NHS staff, it demonstrates that bullying occurs in the NHS and overseas black and minority ethnic nurses are not immune to such practices.

The results of this study indicate that overseas nurses who were identified as being different to that of their white British counterparts remained as participants who were
marginalized and seen as the other. The findings from this research concur with more recent studies, which indicate that little has changed with participants continuing to feel excluded and marginalized in the workplace (Allan and Larsen 2003, Omeri and Atkins 2002).

Allied to this is the idea of social identity theory that suggests that individuals’ self-concept is based on distinguishing characteristics of their own ‘in-group’ (Tajfel and Turner 1979). However, both ‘in-group’ and ‘out-group’ are characterised by their different identities and as both groups have distinct features from each other, it has been suggested that ‘in-group’ such as British nurses see the ‘out-group’ such as overseas nurses in a less favourable light and it is these defining features that determine their treatment in the NHS. This study found that overseas nurses were characterised as the ‘other’ and these findings showed that they perceived themselves to be treated in a less favourable light. This study also illuminates both the social and cultural distances that are inherent between overseas black and minority ethnic nurses and their white British counterparts. This study confirms the findings of Matiti and Taylor’s (2005) study.

Given that overseas nurses are intrinsically different and it is because of this difference, they are marginalized and treated as the other (Mason, 2000). Marginalisation affected the relationship between overseas black and minority ethnic nurses and their white British counterparts and this was further compounded by the participants’ inability to communicate fluently. Similar findings were observed in Canales’ (2000) study by emphasising that racial features played a significant role in
Chapter Eight Discussion

the relationship between the dominant culture and minority ethnic groups, resulting in marginalisation of the minority ethnic groups.

According to Leininger (1994) there is a long-standing deficit in nursing education in preparing knowledgeable, competent and responsible nurses for engaging with different cultural groups. Others have suggested that nursing education in general be altered to support more global awareness of cultures and ethnic diversity (Arnold et al. 1998, Davidhizar et al. 1998 and Freda 1998). Such awareness and education is fundamental for building relationships with different cultures, thus reducing social isolation and marginalisation which has been alluded to in this study. Similarly, Carr-Ruffino (1996) offers some insightful information on managing diversity by stating that it involves acknowledging that society comprises of different socio-cultural groups and giving equal respect to all categories and not offering authority to one over the other should be the focus of a multicultural society.

8.2.3 Surviving in an everyday world

Participants in this research felt mistrusted, unwelcome, unappreciated and were considered inadequate and these findings were consistent with the findings of a number of studies (Matiti and Taylor 2005, Allan and Larsen 2003 and Daniel et al. 2001). Participants felt that their cultural differences were factors that prevented them from being valued by their contemporaries and also accounted for the way in which they were treated.

Walker (1994) proposes a valuing difference model with four key principles such as, people work best when they feel valued, they feel most valued when they believe that
their individual and group differences have been taken into account, the ability to learn from people regarded as different is the key to becoming fully empowered and finally when people feel valued and empowered they are able to build relationships in which they work together synergistically and on an interdisciplinary basis. As these principles were perceived as being absent in the workplace, some participants sought satisfaction by moving on as referred to in the main theme such as ‘making a new world’. Allied to this is the notion of value congruence. This may arise as a result of conflict within the organisation and this could lead to job dissatisfaction (Verplanken 2004). Overseas nurses indicated that they felt devalued and experienced a number of challenges to integration and this resulted in conflict. Yet, despite this, they tolerated such experiences in order to survive in the world of the NHS.

Participants revealed that they were temporary residents in the UK and stated that they were living in fear of being deported. So in order to survive they revealed that they needed to be careful in their interactions with their white British counterparts, as they would not want their actions to be mis-interpreted. Symptoms of fear in the workplace have been studied as part of organisational behaviour, but there is no evidence of any work related specifically to minority ethnic nurses. The experiences of fear reported by nurses in this study appear to be perceptions of a personal threat of their employment, status and a fear of ‘being thrown out’. Austin (2000) suggests that employers and employees may see each other as having a great deal of power to control outcomes, and employees’ fear may have something to do with loss, fear of the loss of inclusion, role, the job itself, future opportunities and one’s destiny, as revealed in this study. This study found no other research that identifies this area and this significant finding contributes to knowledge and understanding in this area.
Within this study the concept of self-blame emerged. Participants perceived that their racial features contributed to their different treatment and felt a sense of guilt for being the wrong colour. Such internalisation alongside having to adapt to a new environment could have increased overseas nurses’ stress and this could have affected their relationship with their British counterparts and also undermined their confidence.

There is very little literature on the concept of self-blame, especially in relation to black and minority ethnic nurses though a related study of depression and rape victims classifications have relevance here (Janoff-Bulman’s 1979). She suggests that there are two types of self-blame: behavioural and characterological. Behavioural self-blame relates to attributions to a modifiable source, such as a person’s behaviour is associated with a belief in the future of avoidability of a negative outcome. Whilst behavioural self-blame is control related, characterological self-blame is esteem related and involves attributions to a relatively non-modifiable source such as one’s character (Janoff-Bulman, 1979). Findings from this study would suggest that nurses’ expression of self-blame would be more characterological, mostly attributed to being from overseas, lacking fluency in English and being of the wrong colour or culture, which in themselves could result in discrimination.

Another finding identified in this study was the lack of skill development and training. Participants were questioning why both training and development were not available while surviving in their everyday world. This finding affirms those from a number of previous studies (Beishon et al. 1995 and Gerrish and Griffith 2004). Some participants perceived that their racial features played a significant part in their lack of
skill development and training thus contributing to their present positions. They also felt that their education had suffered because there was limited opportunity to develop skills so as to both continue to meet the needs of patients and to maintain high individualised patient care. Although many overseas nurses required skills, the paradox is that many of the skills that these nurses need to develop have already been acquired in their country however, because of the bureaucracy that exists in the NHS, these participants have been restricted and become frustrated as a result.

Surviving in an everyday world like the NHS that appeared to contain unfairness in nursing practice and performance that was perceived to be inadequately implemented created some difficulties for the participants in terms of building a friendly relationship with their peers. Building a good relationship with colleagues was fundamental to their survival, however, for some this was not possible because the acknowledgement, the value, appreciation and the support were not available. Although, each participant’s experience was unique, these findings are similar to those previously reported by Beishon et al. (1995) and Allan and Larsen (2003).

Performance review was another theme that emerged and training and development are included within this theme. As there was limited support from few managers, some participants understandably questioned the usefulness of the appraisal process as having no beneficial gains for them. Such performance review is a process that involves reviewing how individuals have done over the past six to twelve months with the aim of improving individual performance. As has been identified in this study such process appeared to be futile for overseas nurses.
8.2.4 Living in an everyday world

In terms of the support, overseas nurses felt that they could rely on their ethnic counterparts in order to cope in an 'everyday world.' This current research concurs with the findings of Allan and Larsen (2003). However, several reasons could play a significant part in the support given by similar overseas colleagues. Overseas nurses also recognised a commonality of experience and culture between self and other ethnic minority individuals and this was referred to as empathetic identification (Weinreich 1983).

Second, this relates to the first issue, as these participants were seen as a less dominant group, they felt that their identities might be eroded. Therefore, to maintain their identities in the workplace, they sought support from overseas nurses, as this was fundamental for their well-being. Similar findings were identified by Xenia (2004), who explored people belonging to a non-dominant group moving into new environments. This serves to highlight that in order to cope in the NHS, support is necessary.

Participants also referred to adopting different ways of coping in their workplace. They had to prove to their contemporaries that they could perform their nursing duties with ease. As there are no studies that specifically identified this finding, it can be deduced that this result provided additional knowledge on the experiences of overseas black and minority ethnic nurses. Equally, some participants wanted to prove to their white British counterparts their worth. This strategy adopted was fundamental in facilitating them in their adjustment to a new environment. In addition, it helped them cope and enabled them to live in the world of the NHS.
8.2.5 Making a new world

Finally, the need for participants to build ties and reflect back on their experience enabled them to make sense of the experience and to make a new world. This study also found that moving on was another strategy adopted, as there was a need for some participants to engage in an alternative environment that might inevitably support their needs. The findings from this study provide further understanding to these aspects and they illuminate the ways in which participants sought to make a new world as overseas black and minority ethnic nurses in the NHS in the south of England.

8.3 Summary

This chapter has provided a discussion of the findings and has utilised where appropriate other studies to compare and contrast what have been found. Although this study has found a number of consistent findings with other studies as identified in the discussion, there were many significant findings such as the invisibility syndrome, bullying, experiencing fear, concept of self-blame, proving self, building ties, reflecting on their experiences and moving on that no other studies had found.
Chapter Nine

The Survey

9.1 Introduction

A survey approach was adopted because of its ability to capture the views of a large sample of the population (Oppenheim 1992). This survey was essential because it added to the existing qualitative data on overseas nurses’ experiences. This chapter will provide both a description of the methodology chosen and will present the findings from the survey based on overseas black and minority ethnic nurses in the NHS in the south of England. The findings from both the face-to-face and the focus group interviews informed the design and questions for this survey. This study was conducted both in the South East and South West of England and because of these geographical regions, the term south of England will be used to denote these areas.

This chapter is divided into a number of sections, commencing with the rationale for choosing a survey type approach. The second section will describe the aim and research questions. In section three, the process involved in developing and designing of the questionnaire is elaborated upon. The subsequent sections will discuss the distribution of the questionnaire to participating organisations and will provide information on how the data was collected and analysed. Following this will be the findings section. In the final section, a discussion of the findings will be presented, with conclusions and an overall summary of the key survey findings.
9.2 Rationale

A survey was conducted and the purpose of this approach was to determine the extent to which the findings from both the face-to-face and focus group interviews were applicable to a wider population of overseas black and minority ethnic nurses, particularly in the south of England. By using a survey it is the intention that such approach, would contribute to the body of knowledge that already exists and increase our current understanding on the experiences of overseas black and minority ethnic nurses. Moreover, the findings from the qualitative section of this study will be made more appropriate to a wider section of overseas black and minority ethnic nurses through this survey.

In reviewing the literature, only four published studies utilised a survey type approach to ascertain the experiences of overseas nurses in the NHS (Buchan et al. 2005, Dinsdale 2005, Withers and Snowball 2003 and MORI 2002). These studies explored specifically aspects of living and working in the UK unlike this current study that specifically seeks to investigate five different areas. These are equal opportunity, skill development and training, discrimination, support mechanisms and finally adjustment to a new environment for overseas nurses. The following section will now focus on the aim and research questions for the survey.

9.3 Aim and research questions

In seeking to understand the experiences of overseas black and minority ethnic nurses in the NHS in the south of England, it became therefore necessary to investigate the extent to which the findings from the qualitative phases were important within the larger study group of overseas black and minority ethnic nurses. Following the
completion of the qualitative phases, the findings from both the face-to-face and focus
group interviews informed the design of the quantitative phase of this study. As there
were no specific studies that investigated areas, such as equal opportunity, skill
development and training, discrimination, support mechanisms and adjustment to a
new environment, it was therefore important that this survey should seek to
investigate these specific areas. The following five specific questions were developed
to explore these aforementioned areas:

- How do overseas black and minority ethnic nurses perceive equal opportunity
  in the NHS in the south of England?
- How do overseas black and minority ethnic nurses perceive their opportunities
  for skill development and training?
- Do overseas black and minority ethnic nurses perceive discrimination to be
evident in the NHS in the south of England?
- To what extent is support available for overseas black and minority ethnic
  nurses within the workplace?
- To what extent do overseas black and minority ethnic nurses perceive their
  adjustment to a new environment?

9.4 Development of the questionnaire

The development of the questionnaire was through the collaboration of the researcher,
the researcher’s supervisors, and the literature based on both the findings of the
qualitative methodology. As previously stated, no studies had utilised both face-to-
face and focus group interviews to inform the development of the survey
questionnaire.
Chapter Nine

The Survey

The main advantage of using a postal questionnaire is its ability to survey a large sample of the population relatively cheaply. Participants would be free to complete the questionnaires at a time convenient to them. On the other hand, postal surveys have a number of disadvantages. Generally the response rate can be low and even when questionnaires are completed, participants' answers may be incomplete, illegible or incomprehensible (Oppenheim 1992).

In developing the questionnaire, it was important that the wording was clear and unambiguous, as this would allow for successful completion of the questions (Dillman 2000 and Drennan 2003). However, numerous problems have been documented in relation to understanding and successfully completing the questionnaires. These issues generally include participants' difficulty with interpretation and understanding of the questions, retrieval of answers and judgement and social desirability in relation to how much information is the participant willing to disclose (Goldbloom et al. 1999 and Pasick et al. 2001). As a result of these problems, participants may not follow the instructions given and may provide inappropriate answers. Therefore in order to minimize these issues, questionnaires should be clear, in simple language that is understandable to the study group and jargon free. The questionnaire for this survey utilised the above principles and the researcher elicited appropriate information from overseas nurses who participated in this study.

9.5 Content of the questionnaire

In developing the questionnaire it was necessary to find out what had already been investigated in this area so as to minimise replication (Jarvis and Worth 2005). After careful consideration and using the findings from the qualitative phases, the
researcher found those aspects that needed further exploration and realised that these would hopefully contribute to the existing body of knowledge on the experiences of overseas nurses in the NHS. These were. Therefore, the questionnaire contained six sections and these included the following, biographical profile and the five areas as previously identified. These aforementioned sections will be briefly described in more detail below.

9.5.1 Biographical profile

This section asked participants to provide some information about their background such as their age, sex, current grade, ethnic background, nursing qualification, country of origin, how long they had worked in the NHS in their professional capacity, how many years they had worked in their home country after qualifying, whether they had worked in another country before coming to the UK, the length of their training and whether they had any in-service training in their country of origin.

9.5.2 Equal opportunity

This section asked participants to examine their workplace and to determine whether they were given equal opportunity or not and whether they thought that their colour or race contributed to this. Moreover, overseas nurses were asked to examine whether they perceived equal opportunity to be given only to their British counterparts.

9.5.3 Skill development and training

Overseas nurses were required to provide information about their beliefs in relation to their opportunities for skill development and training as this section wanted to find out whether the findings from the qualitative phases would be applicable to the wider
population. In addition to this, they were asked specific questions based on courses, skill development and training and the opportunities they had for such development.

9.5.4 Discrimination
As part of the questionnaire, they were also asked to examine their experiences in the NHS and to determine whether they perceived that they had been discriminated against or not. This section included questions based on patients and their families, and work colleagues to include doctors, managers and other nurses. Overseas nurses were given the opportunity to indicate whether information had been deliberately withheld and given to their white British counterparts.

9.5.5 Support mechanisms
This section addressed the support mechanisms in their workplaces and the sources of staff they would most likely turn to for support should the need arise. Moreover, they were asked to indicate what strategy or strategies they would adopt should problems arise in the workplace.

9.5.6 Adjustment to a new environment
This final section sought to investigate overseas nurses' perception of the information they had received and whether they had adequate time to adjust to a new environment. Another aspect covered within this section was whether help was available throughout their adjustment to a new environment.

At the end of the questionnaire they were given the opportunity to add comments in the spaces provided if they felt that these would contribute to the research findings. As
this study was very sensitive, the email addresses of two support groups were included for their use should the need arise.

9.6 The questionnaire layout, covering letter and information sheet

In developing the questionnaire, it was considered important to pay particular attention to the lay out. Barriball and While (1999) suggest that conveying the importance and usefulness of a study is the factor which most influences a participant's decision to take part and this was emphasized in the information sheet. In order to increase participants' response rate, the wording of the questions had to be simple, unambiguous and clear (de Vaus 1996). In addition, the cover of the questionnaire utilised coloured paper to attract the participants' attention. Furthermore, each questionnaire contained a code, which allowed the researcher to identify where it came from and the organisation that participated, whilst maintaining participants' confidentiality and anonymity.

De Vaus (1996) points out that both the information sheet [see appendix 20] and the cover letter [see appendix 21] should be printed on headed paper. Therefore, the University of Surrey headed paper was utilised because it demonstrated support and approval and this might motivate them to complete and return the questionnaire. The information sheet outlined a brief introduction and identified overseas nurses' involvement in the study. The cover letter on the other hand gave a brief introduction of the research and outlined how long it would take to complete the questionnaire.
9.7 The consent form

In order to conduct this study consent must be obtained and indeed this was sought from all overseas nurses involved in this study. The consent form was printed on the University of Surrey headed paper and each overseas nurse received two consent forms [see appendix 22]. Participants kept a signed copy and the other was returned to the researcher. In addition to obtaining consent from overseas nurses, this study needed multi-site ethical approval because it involved using a number of hospitals in the south of England.

9.8 Ethical approval

Multi-site ethics approval with no local investigator was sought in order to conduct this survey [see appendix 23]. As stated in the chapter on research design and method, the primary aim of obtaining ethics committee approval was to protect the interests of overseas nurses within the participating NHS Trusts. The ethics committees from both North and Mid-Hampshire and the University of Surrey examined and approved this study [Please refer to pages 135 to 144 for a full account of the ethical principles related to this study].

9.9 Pre-testing of the questionnaire

Pre-testing of the questionnaire was particularly important because it determined how effective the survey instrument was (Reynolds et al. 1993). Both the researcher and his supervisors collaborated to ensure that errors were minimised. Furthermore, the researcher sought the advice of an independent expert in questionnaire design to assess the feasibility of the questionnaire. This proved extremely useful in the
development and efficacy of the questionnaire and the suggestions were incorporated into the final draft [see appendix 24 for final questionnaire].

Ten overseas nurses piloted the questionnaire and the purpose of this was to test the survey instrument and its feasibility (Silverman 2001). All ten participants were given an evaluation form [see appendix 25] to assess the questionnaire, the covering letter and information sheet. These nurses were given the opportunity to give feedback on the following sections, the clarity of the questions, the presentation of the questionnaire, the information provided about the study, the time it took to complete the questionnaire and finally the clarity of instructions given on filling out the questionnaire (Crombie 1996). All ten overseas nurses were selected through personal contacts and did not form part of the main survey. In the light of the participants’ constructive criticisms, the questionnaire was amended accordingly to reflect their constructive views.

9.10 Participating organisations

In order to conduct the postal survey in the NHS in the south of England, it was necessary to contact many hospitals within the study area. Fifty Directors of Nursing within fifty NHS Trust hospitals were contacted by either emails or letters and these outlined the purpose of the study and the research questions. Of these hospitals, 26 expressed an interest in the study and referred the researcher onto their research governance department. This was essential for two reasons, first, for obtaining the appropriate research governance forms and second, for registration purposes. Once received, the forms were filled out and returned to each NHS Trust hospital and following answering any questions, 15 NHS Trusts gave approval for the survey to be
conducted in their hospitals. The remaining 11 indicated that participating could not happen as the study did not include any of the government's priorities so approval could not be granted.

In addition to these participating hospitals, five High Commissions were contacted in writing to explain the purpose of the study and to seek their assistance in the distribution of the questionnaires. This approach was perceived as important because it was anticipated that a large number of overseas nurses could be targeted. Of these, only one High Commission had responded and agreed to participate. The remaining four did not respond and were therefore excluded from this study.

9.11 Distribution of questionnaires

The target numbers for the distribution of the questionnaires were derived from power calculation. The questionnaires were distributed to all 15 NHS Trust Hospitals and one High Commission in the south of England by post. It was anticipated that mailing 1000 questionnaires would be sufficient to achieve the desired sample of 200 as determined by using statistical sampling size test. The High Commission involved received 50 questionnaires and some NHS Trust hospitals received between 6 to 300 questionnaires. These were packaged in several large envelopes and each package included, a participant's letter, an information sheet, a questionnaire, a self-addressed freepost envelope and two consent forms [a signed copy to be returned to the researcher and the other to be kept by the participant]. Participants were asked to return the questionnaire within one month of receiving it. As the desired number of 200 questionnaires had not been received, it was important to send follow up letters. All 15 participating hospitals were sent a number of follow-up letters with the purpose
Chapter Nine  
The Survey

of increasing the response rate. However, despite sending these follow up letters, the response rate had only improved marginally. The questionnaires were distributed in March 2005 and the collecting of data ceased at the end of December 2005.

9.12 Returned questionnaires

There were 208 returned questionnaires and upon receipt, each questionnaire was checked to ensure that it met the eligibility criteria. However, 20 questionnaires did not meet the eligibility criteria and were therefore not included in the survey. The remaining 188 questionnaires met the criteria and were included. The eligibility criteria are as follows, participants must be of black and minority ethnic origin, be working in the NHS for a minimum of one year, be a registered nurse and qualified as an overseas nurse [please see chapter one for a complete list of the eligibility criteria]. Following accuracy checks the questionnaire data were entered onto an Excel spreadsheet before being imported into an SPSS package.

9.13 Analysis

Analysis of the questionnaire data was undertaken using SPSS 12.01. The non-numerical data from the open-ended questions were entered onto an excel spreadsheet and coded accordingly. Analysis of this data was undertaken and the findings were converted to percentages and these contributed towards the quantitative phase of this study. The numerical data were analysed using simple descriptive statistics to summarise responses. Chi-squared tests were utilised to determine significance and this involved using nominal data. Similarly Fisher’s exact tests were employed for analysing discrete data when the two independent samples were small in size. Kruskal-Wallis tests were used for ordinal data in k groups. Mann-Whitney U tests
were employed for testing differences between two independent groups and finally, Spearman’s tests assessed the relationships between ordinal variables. In order to take into account the use of multiple comparisons, the level of significance was set at p<0.01. This indicates that the result is less likely to have occurred by chance.

9.14 Results

The results of the questionnaire are presented in this section. In considering the results descriptive statistics are presented. Throughout this section, both grades D and E were categorised as one group and grades F and G as another. This approach was adopted because useful analysis could be obtained with the numbers involved. Countries that belonged to the continent of Africa were grouped as one category. Both Pakistan and India were grouped as another. The Philippines were grouped as a single category and those countries that did not belong to the African Continent, Philippines, Pakistan and India were classified as a single group as the numbers in the individual countries were too small to permit useful analysis on their own. In order to allow for any form of analyses by ethnicity and to obtain the best outcomes, these four sub-categories were created.

Additionally, the organisations involved in this study were categorised into two groups. Hospitals located in London were categorised as one group and those that did not belong to this geographical area were classified collectively as out of London. This was done because the numbers in each organisation were too small to permit useful analysis on their own. Characteristics such as ethnicity, sex, grades, age, organisations and their relationships between the five questionnaire categories were explored.
There were 900 questionnaires distributed to overseas nurses and of these 208 were returned. However of this number, only 188 met the eligibility criteria thus giving a response rate of 21%. Based on this number, 154 females and 34 males (81.9% and 18.1%) respectively participated in this survey. The majority of overseas nurses were aged between 31 to 35 years (31.9%) and those between 21 to 25 years were the fewest (1.1%). A number of grades were included creating a clearer picture of overseas nurses who participated in the survey. The results showed that over 50% of the participants were D grades with only 3.2% being G grades (see table 9.1 below).

**Table 9.1: Characteristics of overseas nurses**

<table>
<thead>
<tr>
<th>Sex</th>
<th>F</th>
<th>154 (81.9%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>34 (18.1%)</td>
</tr>
<tr>
<td>Age</td>
<td>21 – 26</td>
<td>2 (1.1%)</td>
</tr>
<tr>
<td></td>
<td>26 – 30</td>
<td>34 (18.1%)</td>
</tr>
<tr>
<td></td>
<td>31 – 35</td>
<td>60 (31.9%)</td>
</tr>
<tr>
<td></td>
<td>36 – 40</td>
<td>45 (23.9%)</td>
</tr>
<tr>
<td></td>
<td>40 and over</td>
<td>47 (25.0%)</td>
</tr>
<tr>
<td>Grade</td>
<td>D</td>
<td>103 (54.8%)</td>
</tr>
<tr>
<td></td>
<td>E</td>
<td>57 (30.3%)</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>22 (11.7%)</td>
</tr>
<tr>
<td></td>
<td>G</td>
<td>6 (3.2%)</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

This study utilised a number of hospitals in the south of England and to protect the identity of each hospital, pseudonyms were therefore used. This ensured that confidentiality was maintained (Data Protection Act 1998) and that hospitals did not feel threatened by the findings. Data obtained showed that St Augustine Hospital had
the majority (50%) of overseas nurses who returned the questionnaires and St John, St Elizabeth and Prince Charles had none returned (see table 9.2 below).

Table 9.2: Returned questionnaires as a percentage of each organisation

<table>
<thead>
<tr>
<th>Organisations</th>
<th>Percentage of questionnaires returned</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Christopher Hospital</td>
<td>11%</td>
<td>London</td>
</tr>
<tr>
<td>St Phoenix Hospital</td>
<td>46%</td>
<td>Non-London</td>
</tr>
<tr>
<td>St Finbar Hospital</td>
<td>38%</td>
<td>London</td>
</tr>
<tr>
<td>St Augustine Hospital</td>
<td>50%</td>
<td>Non-London</td>
</tr>
<tr>
<td>St Michael Hospital</td>
<td>10%</td>
<td>London</td>
</tr>
<tr>
<td>St Thunderbird Hospital</td>
<td>5%</td>
<td>Non-London</td>
</tr>
<tr>
<td>St Swithun’s Hospital</td>
<td>6%</td>
<td>Non-London</td>
</tr>
<tr>
<td>St Andrews Hospital</td>
<td>13%</td>
<td>London</td>
</tr>
<tr>
<td>St Rock Hospital</td>
<td>31%</td>
<td>Non-London</td>
</tr>
<tr>
<td>St Xavier Hospital</td>
<td>17%</td>
<td>London</td>
</tr>
<tr>
<td>St John Hospital</td>
<td>0%</td>
<td>London</td>
</tr>
<tr>
<td>St Elizabeth Hospital</td>
<td>0%</td>
<td>London</td>
</tr>
<tr>
<td>Prince Charles Hospital</td>
<td>0%</td>
<td>London</td>
</tr>
<tr>
<td>St Ravens Hospital</td>
<td>10%</td>
<td>London</td>
</tr>
<tr>
<td>High Commission</td>
<td>0%</td>
<td>London</td>
</tr>
<tr>
<td>St Catherine Hospital</td>
<td>14%</td>
<td>London</td>
</tr>
</tbody>
</table>
Table 9.3 below presents the number of years overseas nurses have been working in the NHS in their professional capacity at the time of participating in this study. The findings revealed that there were more nurses with less than five years experience who participated in this study than those with more than five years but less than ten years experience. There are a couple possible explanations for such findings. The first is, overseas nurses with less than five years experience perhaps felt more inclined to participate than those with more than five years. Second, due to the geographical areas where this study was conducted perhaps there were not as many overseas nurses with more than five years who could participate and therefore the numbers obtained in these areas reflected this.

Table 9.3: Number of years spent working in the NHS

<table>
<thead>
<tr>
<th>Number of years</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>34</td>
<td>18.1</td>
</tr>
<tr>
<td>2</td>
<td>37</td>
<td>19.7</td>
</tr>
<tr>
<td>3</td>
<td>37</td>
<td>19.7</td>
</tr>
<tr>
<td>4</td>
<td>26</td>
<td>14.9</td>
</tr>
<tr>
<td>5</td>
<td>30</td>
<td>15.9</td>
</tr>
<tr>
<td>6</td>
<td>14</td>
<td>7.4</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Mean = 3.30 and SD = 1.972
Overseas nurses involved in this survey were asked to specify the number of years they had worked in their country of origin. The results showed that of those who participated, most were nurses with at least 5 years experience in their home country and the least were from the category of nurses with eleven years or more experience as indicated in table 9.4 below.

Table 9.4: Number of years spent working in their country of origin

<table>
<thead>
<tr>
<th>Number of years in country of origin</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 5</td>
<td>101</td>
<td>53.7</td>
</tr>
<tr>
<td>6 - 10</td>
<td>46</td>
<td>24.5</td>
</tr>
<tr>
<td>11 - 15</td>
<td>18</td>
<td>9.5</td>
</tr>
<tr>
<td>16 - 20</td>
<td>11</td>
<td>5.9</td>
</tr>
<tr>
<td>21 - 35</td>
<td>12</td>
<td>6.4</td>
</tr>
</tbody>
</table>

Mean = 7.55 and SD = 6.824

The NMC (2004) suggested that a number of nurses from overseas were recruited to work in the NHS and this study found at least twenty-one different countries from where nurses were recruited to work in the NHS. The results revealed that the majority of overseas nurses who participated were from the Philippines and the minority were from six different countries as indicated in table 9.5 overleaf.
### Table 9.5: Participating countries

<table>
<thead>
<tr>
<th>Countries</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Botswana</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>China</td>
<td>3</td>
<td>1.3%</td>
</tr>
<tr>
<td>Ghana</td>
<td>5</td>
<td>3.7%</td>
</tr>
<tr>
<td>Guyana</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>India</td>
<td>23</td>
<td>12.2%</td>
</tr>
<tr>
<td>Jamaica</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Kenya</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Malawi</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Malaysia</td>
<td>11</td>
<td>5.9%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>7</td>
<td>3.7%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Philippines</td>
<td>94</td>
<td>50%</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Singapore</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>South Africa</td>
<td>12</td>
<td>6.4%</td>
</tr>
<tr>
<td>Thailand</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Trinidad</td>
<td>4</td>
<td>2.1%</td>
</tr>
<tr>
<td>Zambia</td>
<td>4</td>
<td>2.1%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>7</td>
<td>3.7%</td>
</tr>
</tbody>
</table>
Of the nurses who were recruited to work in the UK, at least 44% had worked in other countries such as Saudi Arabia and Oman and the majority classified themselves as belonging to the Asian category. Over fifty percent of overseas nurses were degree educated with one nurse having obtained a Master of Science in the Philippines.

In addition to the above, this research also elicited information about the length of their training in their home country. All overseas nurses had undertaken between three to five years training before qualifying as a nurse. Of these 56.4% had undertaken some form of in-service training in their country of origin with 43.6% having undertaken no in-service training. This study also found that 20% of overseas nurses indicated that the NHS offered good job prospects and 6% felt that they were able to undertake clinical procedures though they did not state what these were.

The following section will highlight the results for equal opportunity and the different characteristics used in this study.

9.14.1 Equal opportunity

The table 9.6a overleaf presents the significant statistical findings for the relationship between equal opportunity and ethnicity. Overseas nurses were asked to indicate whether they had been refused jobs based on their colour. The Kruskal Wallis test was used and the results showed a significant difference of (p=0.000) with African nurses being more likely to perceive that overseas nurses were refused jobs based on their ethnic backgrounds and Filipino nurses were less likely to perceive this as highlighted in table 9.6a overleaf.
Table 9.6a: The relationship between belief about applicants being refused jobs and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/ Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Believe that applicants from overseas black and minority ethnic countries are refused jobs based on their ethnicity</td>
<td>Africa</td>
<td>43</td>
<td>125.24</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>105.16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>83.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>80.07</td>
<td></td>
</tr>
</tbody>
</table>

In order to examine the promotional aspect of overseas nurses in the NHS, this study asked these nurses to indicate whether they had applied for promotion and whether they had been successful. Chi-square test was used to analyse the data and significant differences were found for promotion (p=0.03) and success (p=0.000) respectively as shown in table 9.6b. Clearly these findings indicated that nurses from India and Pakistan were more likely to perceive to be promoted than any of the other group of nurses. However, African nurses were more likely to perceive that they had been refused promotion for reasons based on the colour of their skin as indicated in table 9.6b overleaf.
Table 9.6b: The relationship between applying for promotion, success and ethnicity

<table>
<thead>
<tr>
<th>Questions</th>
<th>Country/ Ethnicity</th>
<th>Participants (N)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever applied</td>
<td>Africa</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>for promotion</td>
<td></td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>55</td>
<td>39</td>
</tr>
<tr>
<td>Did you get the job</td>
<td>Africa</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>37</td>
<td>18</td>
</tr>
</tbody>
</table>

The Mann Whitney U test revealed a significant result. Overseas nurses employed with NHS hospitals in non-London areas were more likely to perceive that they had been refused promotion based on their ethnicity in comparison to those in London (p=0.008) as shown in table 9.6c.

Table 9.6c: The relationship between refused promotion and organisations

<table>
<thead>
<tr>
<th>Question</th>
<th>Organisations</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refused promotion</td>
<td>London Hospitals</td>
<td>29</td>
<td>21.10</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>21</td>
<td>31.57</td>
<td></td>
</tr>
</tbody>
</table>

Overseas nurses were also asked whether they perceive themselves to have been bypassed for promotion for reasons based on their ethnicity and using the Kruskal Wallis test the results showed a significant difference between all four ethnic categories (p=0.001). It is interesting to note that African nurses perceived that they
had been bypassed for promotion for reasons based on their racial features unlike nurses from both India and Pakistan who were less likely to perceive this as indicated in table 9.6d.

### Table 9.6d: The relationship between bypass for promotion and racial features

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>By-passed for promotion</td>
<td>Africa</td>
<td>21</td>
<td>38.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>10</td>
<td>32.23</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>1</td>
<td>15.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>19</td>
<td>20.19</td>
<td></td>
</tr>
</tbody>
</table>

Further analysis of the data was undertaken and this involved using the Mann Whitney U test. This test was conducted in order to determine whether any differences existed between overseas nurses being bypassed and the different organisations in London and non-London regions. The findings showed that overseas nurses in London perceived themselves to be less likely to be bypassed for promotion (p=0.001) for reasons based on their race as indicated in table 9.6e.

### Table 9.6e: The relationship between being bypassed for promotion and organisations

<table>
<thead>
<tr>
<th>Question</th>
<th>Organisations</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bypassed for promotion</td>
<td>London Hospitals</td>
<td>29</td>
<td>20.00</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>17</td>
<td>29.47</td>
<td></td>
</tr>
</tbody>
</table>
Moreover, this study investigated whether overseas nurses knew if their employers had a policy of ensuring that equal opportunity was available for all employees regardless of their ethnicity. This study utilised the chi-squared test and found a significant difference between all four categories (p=0.000) with more African nurses unaware of their employers operating an equal opportunity policy. Only a small number of nurses from the Philippines and the rest of the world indicated that their employers had no such policy as highlighted in table 9.6f.

Table 9.6f: The relationship between equal opportunity policies and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/ Ethnicity</th>
<th>Participants (N)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal opportunity policy</td>
<td>Africa</td>
<td>Yes: 33, No: 10</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>23, 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23, 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>91, 3</td>
<td></td>
</tr>
</tbody>
</table>

Further analysis was conducted to determine whether there would be any differences in organisations involved in this study. Following the use of the Fisher’s exact test, the findings revealed that overseas nurses employed in London hospitals perceived that equal opportunity policies were more effective in comparison to those nurses in non-London hospitals as indicated by this significant difference (p=0.000) as shown in table 9.6g overleaf.
Table 9.6g: The relationship between equal opportunity policies and organisations

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/ Ethnicity</th>
<th>Participants (N)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal opportunity</td>
<td>London Hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>103</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

A Kruskal-Wallis test showed a significant difference (p=0.000) between the different countries in their perception of opportunity in the workplace as highlighted in table 9.6h. Again African nurses perceived that opportunities were only given to their white British counterparts whilst Indian and Pakistani nurses were less likely to perceive this.

Table 9.6h: The relationship between the perception of opportunities to be given to white British nurses and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/ Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception that opportunities for advancement in the workplace is only given to white British nurses</td>
<td>Africa</td>
<td>43</td>
<td>124.69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>94.36</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>67.74</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>87.28</td>
<td>0.000</td>
</tr>
</tbody>
</table>

This study also found no significant differences in the perception of equal opportunity for gender and age. However, the chi-squared test was used for both applying for promotion and success and the findings showed that there were significant differences for both promotion (p=0.000) and success (p=0.000) for grades. The subsequent
section will present the findings for skill development and training and the different characteristics used within this study.

9.14.2 Skill development and training

The findings revealed no significant differences between overseas nurses from different ethnic groups and their satisfaction with the number of training courses they had attended in comparison to that of their white British nursing counterparts. However, a significant difference was found between skills acquired from overseas and ethnicity following the use of the Kruskal Wallis test (p=0.002). Filipino nurses indicated that their skills were more likely to be used than that of their African counterparts. Again African nurses perceived themselves to be experiencing the greatest difficulties in the NHS in the south of England when compared to the other ethnic groups involved in this study (see table 9.7).

Table 9.7: The relationship between skills acquired from overseas and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilised acquired skills from overseas</td>
<td>Africa</td>
<td>43</td>
<td>73.07</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>86.61</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>91.13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>107.48</td>
<td></td>
</tr>
</tbody>
</table>

This study revealed that a number of skills that overseas nurses arrive with were not utilised and these skills would be highlighted as percentages of those nurses who responded. Of those 10% indicated suturing, 39% intravenous cannulation, 15% phlebotomy, 3% electro-cardiography, 22% intravenous administration of drugs and
finally 12% catheterisation. These findings have clearly demonstrated that a number of skills have yet to be utilised by overseas nurses’ employers.

This research asked overseas nurses to specify in what way they perceived that they were more qualified than their British nursing colleagues. The results showed that 45% of overseas nurses indicated that they were more qualified than their British counterparts. Although they indicated that they were more qualified, they had not specified in what way they perceived this to be. This study also undertook further analysis of the data and the findings revealed that 70% of overseas nurses pointed out that they perceived their experience to be much better than their British nursing colleagues. They indicated that their exposure to a number of different health care services throughout the world, had given them more experience. Although 70% indicated this, the remaining 30% of overseas nurses made no such comments.

Table 9.8 overleaf presents a number of significant values for the relationship between skill development, training and grades. The results of Mann Whitney U and chi squared tests revealed no statistical significance. However, following the use of the Mann Whitney U test a significant difference was found for grades. Nurses of Grade D and E differed significantly from nurses of F and G grades in terms of their dissatisfaction with the number of training courses attended in comparison to their white British counterparts (p=0.001). Not surprisingly, grades D and E were more dissatisfied with the number of training courses they attended in comparison to grades F and G. This is because grades F and G have already been promoted. A significant difference was also found between the lack of opportunity to go on training courses based on colour or race and grades (p=0.002). Again grades D and E perceived
themselves not to have been given the opportunity to attend training courses in comparison to grades F and G as indicated in table 9.8.

Table 9.8: The relationship between training courses and grades

<table>
<thead>
<tr>
<th>Questions</th>
<th>Grades</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissatisfied with the number of training courses</td>
<td>D and E</td>
<td>160</td>
<td>99.60</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>F and G</td>
<td>28</td>
<td>65.36</td>
<td></td>
</tr>
<tr>
<td>Lack of opportunity to go on training courses based on colour or race</td>
<td>D and E</td>
<td>160</td>
<td>99.14</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>F and G</td>
<td>28</td>
<td>68.00</td>
<td></td>
</tr>
<tr>
<td>Encouragement by managers to attend training courses</td>
<td>D and E</td>
<td>160</td>
<td>89.61</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>F and G</td>
<td>28</td>
<td>122.45</td>
<td></td>
</tr>
</tbody>
</table>

In addition to the above, grades D and E perceived that they were less likely to be encouraged by their managers to attend training courses whereas grades F and G were given more encouragement to pursue courses as indicated by this significant result (p=0.002) as highlighted in table 9.8.

The subsequent section will report on the results between discrimination and different characteristics utilised within this research.

9.14.3 Discrimination

This research also explored the relationship between perceived discrimination and ethnicity or country of origins and the findings showed a number of significant differences and these would be highlighted in this section. Overseas nurses were
Table 9.9a: The relationship between perceived discrimination and ethnicity

<table>
<thead>
<tr>
<th>Questions</th>
<th>Country /Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced discrimination in the workplace</td>
<td>Africa</td>
<td>43</td>
<td>122.00</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>94.39</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>69.87</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>87.98</td>
<td></td>
</tr>
<tr>
<td>Aggressive patients and their relatives</td>
<td>Africa</td>
<td>43</td>
<td>124.63</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>90.96</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>84.72</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>82.46</td>
<td></td>
</tr>
<tr>
<td>Aggressive white British nurses</td>
<td>Africa</td>
<td>43</td>
<td>128.97</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>85.54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>84.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>82.93</td>
<td></td>
</tr>
</tbody>
</table>

The Mann Whitney U test was utilised to analyse the data to determine whether any differences were apparent between the organisations involved and that of white British nurses being aggressive towards overseas nurses for reasons based on their racial features. The findings revealed that overseas nurses from NHS hospitals in London felt that their white British counterparts were less difficult and aggressive to them as opposed to nurses from hospitals outside of London as indicated by this highly significant result (p=0.001) as shown in table 9.9b overleaf.
asked to indicate whether they perceived that they were discriminated against in their workplaces and using the Kruskal Wallis test to analyse the data, the results revealed a highly significant difference (p=0.000) as shown in table 9.9a overleaf. African nurses were more likely to perceive themselves to be discriminated against in comparison to nurses from India and Pakistan.

The Kruskal Wallis test was used to analyse the data and this test demonstrated that overseas nurses perceived that discrimination was apparent in the workplace in the form of patients and family members behaving in a difficult and aggressive way towards them as indicated by this highly significant result (p=0.000). Having looked at the mean rank (see table 9.9a overleaf), it could be deduced that Filipino nurses felt that patients and their relatives were less aggressive to them in comparison to African nurses who were more likely to perceive the behaviour of both patients and relatives as being more aggressive towards them.

In addition to the above, this study also investigated whether white British nurses behaved in a difficult, aggressive or hostile way towards overseas nurses for reasons based on their ethnicity and using the Kruskal Wallis test a highly significant result was found (p=0.000). Again African nurses and the rest of the world felt that they were discriminated against more so than nurses from India, Pakistan and the Philippines (see table 9.9a overleaf).
Table 9.9b: The relationship between aggressive white British nurses and organisations

<table>
<thead>
<tr>
<th>Question</th>
<th>Organisations</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive white British nurses</td>
<td>London Hospitals</td>
<td>104</td>
<td>85.63</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>84</td>
<td>105.49</td>
<td></td>
</tr>
</tbody>
</table>

In addition to obtaining statistical data, this study also acquired qualitative data on discrimination and these were categorised and then coded. Following this process the data were converted into percentages. The findings revealed that 45% of overseas nurses perceived themselves to be discriminated against in a number of ways such as, being denied promotion, courses not being offered equitably and having too heavy a workload in comparison to their white British counterparts. Furthermore, 8% of overseas nurses indicated that a lack of acknowledgement was evident and this they considered to be a form of discrimination.

In attempting to determine whether any differences in treatment were apparent, it was therefore important to find out from overseas nurses whether their managers treated them differently to that of their white British nursing colleagues. The Kruskal Wallis test was utilised and a highly significant result (p=0.001) for different ethnic groups was found and this is presented in table 9.9c overleaf. Nurses from India and Pakistan were less likely to perceive that their managers treated them differently than their white British nurses. In contrast, African nurses were more likely to perceive that their managers treated them far differently in comparison to that of their white British counterparts.
Table 9.9c: The relationship between being treated differently by managers and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country /Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated differently by managers</td>
<td>Africa</td>
<td>43</td>
<td>118.69</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>99.80</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>73.33</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>87.04</td>
<td></td>
</tr>
</tbody>
</table>

Table 9.9d overleaf presents the findings of overseas nurses on the extent to which they considered whether white British doctors treated them differently from their white British colleagues. The Kruskal Wallis test was conducted and the findings revealed a significant difference of p=0.008 for the different ethnic groups involved in this study. Interestingly, nurses from the Philippines felt that they were treated differently in comparison to India, Pakistan and the rest of the world. Nurses from Africa were more likely to perceive that their treatment was far less favourable than their overseas counterparts.

Table 9.9d: The relationship between different treatment by doctors and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country /Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated differently by doctors</td>
<td>Africa</td>
<td>43</td>
<td>114.49</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>88.89</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>70.63</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>92.87</td>
<td></td>
</tr>
</tbody>
</table>
The Kruskal Wallis test was utilised to analyse the data based on the relationship between the different ethnic groups and the deliberate bypassing of patient information from them. The findings showed a highly significant result ($p=0.000$) as shown in table 9.9e below. Nurses from India, Pakistan and the rest of the world were less likely to perceive that their ethnic backgrounds contributed towards information being deliberately bypassed. On the other hand, African nurses were more likely to feel that their ethnic backgrounds contributed to the difference in treatment in terms of information being deliberately bypassed and offered to their British counterparts.

Table 9.9e: The relationship between deliberate bypassing of overseas nurses of patient information and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country /Ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient information deliberately by-passed overseas nurses</td>
<td>Africa</td>
<td>43</td>
<td>124.28</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>79.29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>75.78</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>89.99</td>
<td></td>
</tr>
</tbody>
</table>

In order to determine whether any significance differences were apparent, this research investigated the relationship between discrimination, gender and grade, and the findings revealed no significance differences. However, data analysis was also conducted by using the Mann Whitney U test, and the findings revealed a highly significant result ($p=0.005$) for both age and being treated differently by managers and this result is illustrated in table 9.10 overleaf. This perception was higher for those nurses who were aged thirty-six and above but lower for nurses aged thirty-six and under. There were no significant differences found between age and the following aspects, patients or relatives behaving in a difficult or aggressive way to overseas
nurses, white British doctors treating them differently to that of their white British nursing colleagues and the deliberate bypassing of important information which was given to their white British counterparts whilst on duty.

Table 9.10: The relationship between age and perceived discrimination

<table>
<thead>
<tr>
<th>Questions</th>
<th>Age</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated differently by managers</td>
<td>Under 36 years</td>
<td>97</td>
<td>84.26</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>Over 36 years</td>
<td>91</td>
<td>105.42</td>
<td></td>
</tr>
</tbody>
</table>

In addition to presenting the findings for discrimination, the subsequent section will present the findings for the relationship between support and the different characteristics employed in this study.

9.14.4 Support

The significant values for the relationship between support and country of origins/ethnicity will be presented in a number of tables. The support section of the questionnaire investigated the support mechanisms available. Those who were involved in this study were asked whether they felt supported in their workplaces. Data analysis involved the use of the Kruskal Wallis test and the findings revealed a highly significant result (p=0.001) as highlighted in table 9.11a overleaf. The perception for Indian and Pakistani nurses was strong, however for African nurses this was much lower.
Table 9.11a: The relationship between feeling supported and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling supported</td>
<td>Africa</td>
<td>43</td>
<td>66.50</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>102.70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>112.26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>100.52</td>
<td></td>
</tr>
</tbody>
</table>

This study conducted further data analysis by using the Mann Whitney U test. The results revealed a significant result (p=0.005) as illustrated in table 9.11b. Overseas nurses employed in London hospitals were more likely to perceive that they had been supported in their workplaces than those employed outside London. Despite this significant finding, this study also found that a small minority of work colleagues had indicated that they felt bullied by other overseas nurses (6%).

Table 9.11b: The relationship between feeling supported and organisations

<table>
<thead>
<tr>
<th>Question</th>
<th>Organisations</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling supported</td>
<td>London Hospitals</td>
<td>104</td>
<td>104.15</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>84</td>
<td>82.55</td>
<td></td>
</tr>
</tbody>
</table>

In determining any significance differences between the quality of support, guidance and ethnicity, the Kruskal Wallis test was employed. The results showed that the ethnic categories differed significantly (p=0.001) in their perception of the quality of support and guidance they received from their white British colleagues. This significant finding would seem to suggest that African nurses were more likely to perceive that the quality of the support and guidance was markedly different to that of
nurses from India and Pakistan who were less likely to perceive this (see table 9.11c below).

**Table 9.11c: The relationship between the quality of support, guidance and ethnicity**

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of support and guidance is excellent</td>
<td>Africa</td>
<td>43</td>
<td>70.20</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>88.27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>123.04</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>100.49</td>
<td></td>
</tr>
</tbody>
</table>

In attempting to determine whether any differences were apparent between NHS hospitals in London and non-London NHS hospitals, this study utilised the Mann Whitney U test. Again a significant result was found (p=0.003) as shown in table 9.11d below. Overseas nurses employed in NHS hospitals in London were more likely to perceive that the quality of support and guidance received was better in comparison to nurses from non-London NHS hospitals who were less likely to perceive this.

**Table 9.11d: The relationship between quality of support, guidance and organisations**

<table>
<thead>
<tr>
<th>Question</th>
<th>Organisations</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of support and guidance is excellent</td>
<td>London Hospitals</td>
<td>104</td>
<td>100.15</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>84</td>
<td>87.50</td>
<td></td>
</tr>
</tbody>
</table>
The Kruskal Wallis test was used to determine whether the systems and processes to support overseas nurses work would differ in terms of ethnicity. This study found a significant difference (p=0.003) as shown in table 9.11e. African nurses were more likely to feel that the systems and processes to support their work were inadequate unlike nurses from India and Pakistan who were less likely to perceive this. Overall, the finding demonstrated that African nurses felt less supported in their working environment in comparison to Indian, Pakistani and Filipino nurses.

Table 9.11e: The relationship between support systems, processes and ethnicity

<table>
<thead>
<tr>
<th>Question</th>
<th>Country/ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems and processes are inadequate</td>
<td>Africa</td>
<td>43</td>
<td>119.33</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>91.16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>76.35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>88.58</td>
<td>0.003</td>
</tr>
</tbody>
</table>

In addition, further data analysis was conducted using the Mann Whitney U test and the findings revealed that overseas nurses perceived the processes and systems to support their work in non-London NHS hospitals to be inadequate as indicated by this significant result (p=0.001). However, overseas nurses from London hospitals were less likely to perceive this as illustrated in table 9.11f overleaf. This finding is important because it has implications for recruiting and retaining overseas nurses in the NHS particularly in non-London NHS hospitals in the south of England.
Table 9.1f: The relationship between support systems, processes and organisations

<table>
<thead>
<tr>
<th>Question</th>
<th>Organisations</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems and processes are inadequate</td>
<td>London Hospitals</td>
<td>104</td>
<td>83.55</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>84</td>
<td>108.06</td>
<td></td>
</tr>
</tbody>
</table>

Given that significance differences were found for the quality of support and aspects related to support, this study also conducted further analysis by employing the chi-squared test. The results revealed a significant difference between distancing self when problems had arisen (p=0.001) and for different ethnic groups. This result indicated that African nurses were more likely to distance themselves from their workplaces and work colleagues. On the other hand nurses from India and Pakistan were less likely to do this.

This study asked overseas nurses to indicate which strategy or strategies they would most likely use should problems arise in the workplace. In analysing the data, the chi-squared test was employed and the results revealed a significant difference between problem solving and ethnic groups (p=0.008) with nurses from India and Pakistan being more likely to perceive to resort to problem solving. However, African nurses were less likely to adopt this strategy. These significant results demonstrated the two different strategies that overseas nurses might adopt in order to cope should problems arise in the workplace. However, despite these significant results, this study has found no significant differences in the following categories, confrontation, accepting responsibility, self-control, seeking support from colleagues and re-appraisal.
In attempting to determining if there were any differences between age and support, the Mann Whitney U test was used and following data analysis the findings showed that overseas nurses aged thirty-six years and under were more likely to perceive themselves to be supported than nurses above this age as indicated by this highly significant finding (p=0.005).

In order to determine whether any differences existed between age and work related problems, this study utilised the Mann Whitney U test to analyse the data. This revealed a significant result (p=0.002). It would appear that should work related problems arise in the clinical environment, nurses aged thirty-six and over would tend to seek help from similar overseas nurses or family members. In contrast, nurses aged thirty-six and under were more likely to seek the help of their work managers or white colleagues. Overall 60% of overseas nurses indicated that they would seek help from another family member or overseas nurse in comparison to 40% who felt that they might obtain help from their ward managers or their white British counterparts.

Given that the preceding section highlighted the results for support, the subsequent section will report the findings between adjustment to a new environment and the different characteristics utilised in this study.

9.14.5 Adjustment to a new environment

The Krushal-Wallis test was utilised to determine if there were any significance differences between adjustment to a new environment and ethnicity/country of origins (see table 9.12a overleaf). The finding revealed a highly significant result (p=0.000) for nurses of different ethnic groups and their relationship between receiving
satisfactory information on how to adjust to a new environment. It would appear from the results that nurses from the Philippines, India and Pakistan perceived that they had been offered satisfactory information on how to adjust to a new environment. However, African nurses and the rest of the world felt that the information given on how to adjust to a new environment was relatively less than the other two ethnic groups.

Table 9.12a: The relationship between satisfactory information on adjusting and ethnicity

<table>
<thead>
<tr>
<th>Questions</th>
<th>Country/ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given satisfactory information</td>
<td>Africa</td>
<td>43</td>
<td>69.45</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>79.29</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>108.17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>107.14</td>
<td></td>
</tr>
</tbody>
</table>

In seeking to develop a greater understanding of overseas nurses’ adjustment to a new environment a survey type approach was conducted. This study utilised the Kruskal Wallis test to analyse the data and the results revealed a significant result between overseas nurses from different ethnic groups and their perception of the help they received from their white British colleagues whilst adjusting to a new environment (p=0.001) as shown in table 9.12b overleaf. Again, data interpretation suggested that Filipino, Indian and Pakistani nurses were more likely to perceive that their white British colleagues facilitated them in their adjustment to a new environment unlike their African counterparts whose perception on this issue was the weakest.
Table 9.12b: The relationship between adjusting to a new environment with assistance from white British nurses and ethnicity

<table>
<thead>
<tr>
<th>Questions</th>
<th>Country/ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted with the help of white British colleagues</td>
<td>Africa</td>
<td>43</td>
<td>73.29</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>90.45</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>103.37</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>103.24</td>
<td></td>
</tr>
</tbody>
</table>

This study also investigated whether overseas nurses were given sufficient time to become acquainted with methods and procedures of working in the NHS. The Kruskal Wallis test was used and the findings revealed a highly significant result (0.000). This indicated that there were variations within all four ethnic groups in their perception of the time given by white British nurses to become acquainted with the methods and procedures in the NHS in the south of England. It would appear that Filipino nurses perceived that they were given adequate time to become acquainted with the procedures and methods of working in the NHS unlike African and the rest of the world nurses as highlighted in table 9.12c below.

Table 9.12c: The relationship between sufficient time to adjust to procedures, methods and ethnicity

<table>
<thead>
<tr>
<th>Questions</th>
<th>Country/ethnicity</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficient time to become acquainted with the procedures and methods of the NHS</td>
<td>Africa</td>
<td>43</td>
<td>68.08</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The rest of the world</td>
<td>28</td>
<td>84.86</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>India and Pakistan</td>
<td>23</td>
<td>99.76</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
<td>94</td>
<td>108.17</td>
<td></td>
</tr>
</tbody>
</table>
Again, the Mann Whitney U test was employed to determine whether any differences existed between the organisations involved and overseas nurses being given sufficient time to adjust to a new environment. The findings revealed a significant difference of \( p=0.001 \) as shown in table 9.12d and this would indicate that overseas nurses from London felt that they were given more time to adjust to a new environment in comparison to overseas nurses from NHS hospitals outside of London. Again this important finding has implications for the NHS particularly for non-London hospitals in the south of England.

Table 9.12d: The relationship between sufficient time to adjust to procedures, methods and organisations

<table>
<thead>
<tr>
<th>Question</th>
<th>Organisations</th>
<th>Participants (N)</th>
<th>Mean Rank</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficient time to become acquainted with the procedures and methods of the NHS</td>
<td>London Hospitals</td>
<td>104</td>
<td>105.56</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Non-London Hospitals</td>
<td>84</td>
<td>80.81</td>
<td></td>
</tr>
</tbody>
</table>

In addition to reporting these findings, this study will also present some significant results based on correlation analyses.

9.14.6 Correlational analyses

This section utilises the Spearman’s rank correlation to analyse the data. Therefore statistical analysis of the data was conducted to determine whether any correlations were apparent between support mechanisms and adjustment to a new environment. Support in the workplace strongly correlates to adjustment to a new environment \((r=0.48, p=0.000)\). This finding suggests that having satisfactory information about
adjusting to a new environment would enable overseas nurses to feel supported in the workplace.

Sufficient time and help from white British nurses \( (r=0.60, p=0.000) \) were perceived to be important factors in facilitating overseas nurses' adjustment to a new environment. It would appear that these factors have contributed to their feelings of support in the clinical environment. However, it is important to note that although these two factors correlate, not all overseas nurses felt supported in their clinical environment. Some indicated that they had experienced difficulties in adjusting to their working environment.

Stress, the quality of support and guidance were important correlates of adjustment to a new environment \( (r=0.63, p=0.008) \). This indicates that the more information and support overseas nurses receive and the more time allowed to become acquainted with NHS procedures \( (r=0.54, p=0.002) \) the more likely they are to perceive to be adjusting to their new environment.

Interestingly this study also found a strong correlation between satisfactory information about adjusting to a new environment and satisfaction with the number of training courses \( (r=-0.36, p=0.000) \). This appears to be suggesting that the more information overseas nurses are given about adjustment to a new environment the more satisfied they are with their training courses. Satisfaction with training courses also correlates with help from white British colleagues \( (r=-0.49, p=0.000) \) as well as having sufficient time to adjust to a new environment \( (r=-0.43, p=0.000) \). These findings are interesting as they indicate that as long as overseas nurses are given help
from their white British colleagues, have sufficient information and time to adjust to a new environment the more likely they are to perceive to be satisfied with their training courses.

Another important finding was skills utilisation and its relationship correlate with sufficient time to become acquainted with a new environment. A highly significant result was found \((r=0.26, p=0.000)\) indicating that the more adjusted overseas nurses are to their new environment the more likely they are to perceive that their skills will be utilised in their clinical environments.

A strong correlation between sufficient time to adjust to a new environment and experiencing discrimination \((r=-0.46, p=0.000)\) was found. This result would seem to suggest that if overseas nurses are given sufficient time to adjust to a new environment they are less likely to perceive that they have been discriminated against.

**9.15 Discussion**

This survey has found a number of significant results relating to overseas black and minority ethnic nurses in the NHS in the south of England and these will be discussed within this section of this chapter.

**9.15.1 London and non-London NHS hospitals**

This study found that African nurses were generally perceived to be dissatisfied with their experiences in comparison to Filipino, Indian and Pakistani nurses particularly if they were working in NHS hospitals outside London. They also perceived that discrimination was more likely to occur in NHS hospitals outside London than in
London. In addition, the survey revealed that overseas nurses employed in NHS hospitals in London were more likely to be promoted, supported and less likely to have aggressive behaviour directed at them compared to those in NHS hospitals in non-London regions.

In attempting to explain these findings, it would be fundamental to draw on ethnic data for nurses in these areas. According to the Department of Health (2001g) there are approximately 19,000 white nurses employed in a number of NHS hospitals in London in comparison to 17,000 black and minority ethnic nurses. So this ethnic mix in London is fairly evenly distributed and this may have somewhat influenced overseas nurses’ in London hospitals perception of their experiences in their clinical environments.

In contrast, figures obtained from the Department of Health (2001g) indicate that, of 48,000 nurses employed in non-London hospitals, 44,000 are white and 4,000 belong to either black or minority ethnic backgrounds. Therefore, in explaining this difference it would seem likely that the greater the numerical dominance of white British nurses over their black and minority ethnic counterparts the more likely inequalities are perceived to be apparent in the workplace. In other words, what this study appears to be suggesting is that, overseas nurses are less likely to be satisfied with employment practices in NHS hospitals in non-London regions in the south of England where white British nurses are the majority culture.

Another but interesting point that could be considered to explain such differences is that, hospitals in London may have been ‘quick off the mark’ to recognise the
legitimate differences in characteristics and needs of overseas nurses. As historically (Abel-Smith 1960) black and minority ethnic nurses have always been part of the workforce in a number of major cities such as, London, Manchester and Birmingham and because there has been an influx of overseas nurses to these hospitals, particularly in London, catering for their needs may not necessarily be a new phenomenon. This is because it is widely believed that these employing organisations are more likely to be equipped with the necessary skills to address the needs of overseas nurses unlike NHS hospitals in non-London regions in the south of England where employing large numbers of overseas nurses is a new trend. It is therefore unlikely that these hospitals would have either the necessary skills or the infrastructure available to cater for such a diverse workforce. Such explanations may account for the differences in experiences as revealed in this survey.

9.15.2 Equal opportunity

Overseas nurses revealed that in their perception differences in opportunities and treatment existed. Such differences in treatment may reflect the lack of consistent application of equal opportunity policies in the NHS in the south of England and this may have resulted in some groups of nurses faring better than others. So while there are equal opportunity practices in some places within the working environment that have equal opportunity policies (Buchan et al. 2005), there remains a proportion of workplaces that have not introduced the expected supporting practices as revealed in this study.

In addition to the above, the result suggested that African nurses perceived that their racial features contributed negatively towards gaining promotion in the NHS in
comparison to that of their overseas counterparts. Given these perceived differences in experiences, it was difficult to determine specifically why some overseas nurses, particularly those from the Philippines, Indian and Pakistan, perceived this to be less of an issue than that of their African colleagues. However, in attempting to explain this, it would be useful to draw on ideas from America. Cox (1993) argues that individuals who do not feel valued because of their ethnic backgrounds may have difficulties in adjusting to a culture to which they are not accustomed. Furthermore, he suggests that these individuals are more likely to feel disenfranchised and would generally have difficulties in progressing in their chosen careers. Similar findings have been echoed in this study. Of the four ethnic categories identified in this study, African nurses were more likely to perceive that their adjustment was difficult. Therefore, it would be fair to say that because of their circumstances in terms of their difficulties in adjusting to a different environment, their career progression might be constrained.

Another possible explanation is that, there is a widely held view that Asians are generally regarded as model minorities (Cheng and Thatchenkery 1997). This minority perception is based on the beliefs that some groups are successful, hardworking, loyal and do not complain, and therefore their career progression is unlikely to be affected. Given this widely held view, it would seem likely that managers may have been influenced by such beliefs either consciously or unconsciously and this may have affected their decisions to the detriment of African nurses.
There is also evidence to suggest that black and minority ethnic nurses have been disadvantaged in gaining promotion (Beishon et al. 1995), however, there are no survey type studies that specifically investigate the career progression of overseas nurses in the NHS. A qualitative study conducted by Mensah et al.'s (2005) showed that African nurses had some difficulties in adapting and gaining promotion in the NHS in the UK and the authors appeared to be suggesting that African nurses' racial features were contributory factors. The findings from this present research concur with that of Mensah et al.'s (2005).

In examining the data, the results also revealed that of the sixty-one nurses from India, Pakistan and the Philippines who applied for promotion, more than half were successful in gaining promotion. In contrast, of the thirty African nurses who applied for promotion, only ten were successful. Clearly, these findings suggest that differences in opportunities for overseas nurses are apparent within the clinical environment.

Given such differences in treatment, the analysis leaves open to question whether having substantive equal opportunity policies is improving outcomes for all overseas nurses. As has been identified in this study, there is a perception that racial features appeared to have influenced decisions in the NHS particularly for African nurses in non-London NHS hospitals in the south of England. Yet, despite the underpinning principles of equal opportunity policies, it would therefore be reasonable to argue that these policies and practices do not always secure equal treatment on their own unless the NHS develops an environment and culture that enables equality of opportunity to flourish. However, an important precursor to the development of such an environment
is having formalised equal opportunity policies that are supported wholeheartedly by managers (Flatman 1973, Phillips 1999 and Young 2001).

This study also focuses on the issue of bypass for promotion and the findings revealed that overseas nurses particularly African nurses perceived themselves to have been bypassed for promotion. One possible explanation for such differences could be that African nurses might not have fully understood the 'micro-rules' required at interviews and this could have affected their chances for promotion. In contrast, nurses from India, Pakistan and the Philippines may have grasped the rules of engagement much more quickly and this may have resulted in the differences in outcome as seen in this survey. It is important to note that Cox's (1993) theory suggests that individuals who have difficulties in adjusting are less likely to progress in their careers, and this perspective may help to explain why African nurses were less likely to advance in comparison to their overseas counterparts.

Despite no known studies exploring the concept of bypass in relation to overseas nurses, Beishon et al.'s (1995) qualitative and quantitative study found that black and minority ethnic nurses had been bypassed for promotion more often than their white British counterparts. It is important to note that this study's main focus was on British black and minority ethnic nurses rather than overseas nurses. However, despite this, the concept of bypass is not a new phenomenon in the NHS particularly for black and minority ethnic nurses. This current study has found that differences in perception to bypass is evident and as no quantitative or qualitative studies based on overseas nurses have found this, it is fair to say that this study contributes to the body of knowledge in this area.
9.15.3 Training and development

The findings from this research also revealed variations in overseas nurses utilisation of skills. Although they had skills, such as catheterisation and administration of intravenous drugs, these were constrained in their clinical environments due to the bureaucracy inherent within the NHS in the south of England. There were variations in skills utilisation and this indicated that the Scope of Professional Practice (NMC 2003) might have been instituted quicker in some workplaces than in others. Although no studies have reported this, several other studies have revealed that overseas nurses were unable to utilise their skills in their clinical environments (Taylor 2005, Dinsdale 2005).

Perceived differences were evident in this study in relation to grades. Overseas nurses of grades D and E appeared to be dissatisfied with the training and development opportunities available in comparison to grades F and G. Although there is a widely held view that the lower grades of nurses would normally have less training and development opportunities, this study has been one of the major contributors to document this evidence, particularly for overseas nurses. This is because managers in the NHS are required to curtail their spending and resulting from resource constraints the outcome is expected to have a negative impact on the lower grades of nurses compared to grades F and G. In Beishon et al.'s (1995) study they found that black and minority ethnic nurses in the NHS were generally dissatisfied with their training and development opportunities, particularly the lower grades of nurses. The findings from Beishon et al.'s (1995) study are congruent with those of this present research.
9.15.4 Discrimination

One of the challenges that overseas nurses faced was perceived discrimination. Although discrimination in the form of racism is difficult to define because of its fluidity and context specific, overseas nurses interpretation of their experiences of discrimination could be caused by factors other than their racial features (Goldberg 1993). However, in a recent study Taylor (2005) found that discrimination was evident in the NHS and this present study revealed that overseas nurses perceived that they had been discriminated against within their working environment. Despite revealing this significant finding, this current study was unable to determine whether institutional racism was the key contributory factor for their experiences of discrimination (Anthias 1999).

A number of overseas nurses interpreted their experiences as being different to that of their UK counterparts. They perceived that patients, relatives and staff were aggressive towards them and they felt that their racial features contributed towards such experiences. The concept of aggression is difficult to define (Duffy 1995). However, according to the Webster’s Dictionary (1989) aggression is an attack, a harmful or offensive action, an inroad or encroachment and an aggression upon one’s rights. According to Duffy (1995) the health service is rife with aggressive and destructive behaviour perpetrated by nurses on nurses and nurses on patients and vice versa. It could be argued that because nurses and patients are dominated by a patriarchal system of doctors and marginalized managers, white British nurses lower down the hierarchy target their aggression towards overseas nurses but not necessarily because they are racially different.
9.15.5 Support

The results suggest that support overseas nurses received varied in the clinical environment. However, this study was unable to specify the extent to which they had received support since the design did not allow for drawing of such conclusions. In Webb et al.'s (2002) study, they revealed that support for nurses in general was lacking in the NHS. Similarly, a survey by Dinsdale (2005) reported that overseas nurses in general felt unsupported in the NHS. However, this present study found variations in support, with nurses from Pakistan and India indicating that they were more satisfied with the support they received as well as the processes and mechanisms in comparison to their African colleagues.

Support in any organisation is important because it can protect individuals from both stress and burnout (Coffey and Coleman 2001, Piko 2003). According to Melchior et al. (1997) supervisor support and support from colleagues were very important in reducing and preventing stress in individuals. This study found that some overseas nurses felt more supported than others particularly if they were aged thirty-six and under. This important finding would seem to suggest that of those nurses who felt supported, their stress levels may have been markedly reduced in comparison to those overseas nurses, particularly for African nurses aged thirty-six and over, who felt less supported while working in the NHS in the south of England. This meant that African nurses were more vulnerable to increase stress and as a consequence they were more likely to experience poor job satisfaction and difficulties in adjusting to a new environment.
In a recent survey, Buchan et al. (2005) found that more than four in ten overseas nurses were considering moving to another country to work because of poor job satisfaction and limited support. Given these findings, it is fair to say that this present study’s findings are congruent with those of Buchan et al.’s (2005). Allied to this are distancing self and problem solving. The degree to which overseas nurses espoused these strategies could have been influenced by age, gender and the support mechanisms in their working environment. These strategies have been unreported in any other studies and therefore they add to the body of knowledge based on overseas nurses in the NHS.

9.15.6 Adjusting to a new environment

In attempting to explain these findings in relation to adjustment to a new environment, it would be useful to draw on the sociological dimension of the cultural identification model, as this would assist in providing some insightful information into the differences in experiences as perceived by overseas nurses.

The cultural identification model (Oetting et al. 1998) suggests that individuals may identify with cultures other than the ones to which they belong without losing their identity whereas others may find it difficult to socialise and develop relationships with different cultural groups. Thus it would appear that nurses from India, Pakistan and the Philippines were more likely to identify with a different culture yet retain their cultural identity. In contrast, African nurses appeared to be less likely to adapt, and according to Oetting et al. (1998) this may have influenced and even heightened their perception of their experiences. This present research is consistent with that of Sanchez and Fernandez’s (1993) study which showed that Africans were more likely
to experience social isolation and had more difficulties in adapting to a new environment than their Asian counterparts. It is therefore important to say that the use of this theory adds a new understanding to the body of knowledge based on overseas nurses.

It has also been suggested (Adler 1997) that throughout the years, individuals’ cultural values may remain constant throughout their lives and this cultural context may lead to individuals acquiring their own socio-cultural identity and characteristics. Therefore, individuals’ perceptions, feelings and attitudes are grounded in their social cultural identity (Lewin 1948). Given these perspectives they offer insights into why overseas nurses experienced variations in treatment in practice particularly in relation to adapting to a new environment.

Adjusting to a new environment may be influenced by a number of key factors such as support, information, and a welcoming and friendly environment. For some overseas nurses, these factors may have been present, for others, absent. Despite the impact that these factors might have on overseas nurses who came to the UK to work in a culturally different environment, they were expected to adjust. This adjustment was not the same for all overseas nurses as indicated in this study. The variation in adjustment depended on the environment that they were a part of and overseas nurses’ readiness to adapt to a culture that was alien to them. (Pilette 1989).

Many overseas nurses face challenges to their adaptation to a different environment and these may vary according to the norms and values of the host country (Brislin 1993 and Buenza et al. 1994). The adaptation process involves recognising the
cultural norms and values of a given society such as the UK, and this process can be viewed as dynamic for some but for others as a slow and arduous task. Given these circumstances faced by overseas nurses in the NHS, particularly African nurses, it would appear that adjusting to a different environment was not easy. This is because the findings indicate that some overseas nurses experienced limited support, discrimination and a lack of equal opportunity and these perceived factors could have influenced their adjustment to a new environment. The findings from this study also revealed that overseas nurses such as Indians, Pakistanis and Filipinos were able to adjust much more quickly because the support and help had been available in their workplaces.

This research has also identified that adjustment to a new environment takes time. Unfortunately, this study was unable to identify how long it would take for each ethnic group to adapt but it was able to reveal that overseas nurses needed time to adjust. The findings suggest that the more time they are given the less likely they are to perceive that they have been discriminated against. Time could be seen on a continuum where all ethnic groups would adjust depending on the support available, the environment and information given.

9.16 Summary

This chapter commences with the rationale for choosing a survey as the method for investigating the extent to which the findings from the qualitative phases were applicable to the wider population of overseas black and minority ethnic nurses. It outlines the process involved in designing and developing the questionnaire and
Chapter Nine

The Survey

discusses the process involved in obtaining approval as well as of how the data were collected and analysed.

The fact that this study utilised a sample size of 188 nurses and to generalise to the national population would need to be treated carefully, even though the sample characteristics are fairly typical of the national population of overseas nurses. It is important to note that the responses elicited in this study reflect the views and perceptions of overseas black and minority ethnic nurses in the NHS in the south of England at the time this study was conducted.

This study specifically investigated five main themes such as equal opportunity, skill development and training, discrimination, support mechanisms and finally adjustment to a new environment. This study revealed variations in the findings for all four groups involved in this research with African nurses being more likely to perceive that they were being disadvantaged in comparison to their overseas counterparts. This study has found many significant results which have been alluded to in this chapter. Overall, overseas black and minority ethnic nurses employed in NHS hospitals in London were more likely to perceive that their experiences were better than those in NHS hospitals in non-London regions in the south of England.
Chapter Ten

Discussion

Implications and Recommendations

10.1 Introduction
This chapter discusses the findings related to the literature for all phases of the study. Following this, the implications and recommendations based on the findings from both phases will be addressed. The researcher will also highlight the strengths and limitations of this study and will present a number of recommendations for future research. This chapter will conclude with an overall summary by emphasising the importance of these implications and recommendations.

10.2 Discussion
The mixed method approach to this study provides an insight into the experiences of overseas nurses that are working in the NHS in the south of England. Within this section the concepts of power, social closure and transitory theory will be explored in an attempt to explain and offer interpretations of the findings for the qualitative and quantitative phases.

10.2.1 Power
Both phases have highlighted the difficulties that some overseas nurses faced whilst employed in the NHS and they revealed that migrating to a different country created some conflicts between the two different cultures. It has been established that the greater the dissimilarities between two cultures, the greater will be the conflicts and
problems with adjusting (Lopez 1990). Therefore, in seeking to understand the conflict and differences in the relationship between overseas nurses and that of their white British counterparts, it is important to draw on the sociological theory of power.

As many white British nurses were in positions of power, they had the authority to decide on those nurses who should or should not enter their ‘world’. This resulted in some overseas nurses feeling powerless and marginalized. Furuta et al. (2003) referred to three types of marginalisation such as, cultural, social role and structural however, cultural and structural marginalisation will be addressed. Cultural marginality is defined in terms of individuals assimilating, however, in this process there can often be an imbalance of power where individuals feel isolated and rejected. Indeed, this study found that some overseas nurses felt isolated and marginalized and it is this marginalisation that defines their cultural identity. Allied to this is the perspective of structural marginality and this refers to groups that are disadvantaged, powerless or disenfranchised within society. This notion is particularly important within this study as it demonstrates that some overseas nurses perceived that they were disadvantaged in terms of promotion and support. Although this is a relevant point, it is fundamental to say that, not all overseas nurses should be aligned with this perspective as the experiences from the survey was mixed. Some nurses felt more supported than others and this has been alluded to in the quantitative phase.

Although power may have influenced some overseas nurses’ relationships with their white British counterparts, this study found through the qualitative phase that they were experiencing difficulties in adapting and adjusting to a different environment because the support mechanisms were limited. Similarly, the quantitative survey
found that African nurses were more likely to perceive that they had difficulties in adjusting because the support was not apparent unlike nurses from India, Pakistan and the Philippines. They indicated that the support, its processes and systems were more readily available and it is likely that these play a role in facilitating overseas nurses in adapting and adjusting to a new environment.

Power was displayed in the form of discrimination and bullying. Both the quantitative and qualitative phases of this study found that overseas nurses felt that they were discriminated against and bullied. A number of studies, such as Taylor (2005), Alexis and Vydelingum (2005) and Allan et al. (2004), found either discrimination and or bullying. Therefore, this present research concurs with those previous studies. These exclusionary powerful covert practices though inherent and perceived by overseas nurses to be apparent, might be difficult to prove or disprove. Despite the difficulties in proving and disproving discrimination, the questions that remain unanswered are: what purposes do equal opportunity policies serve and who are protected by these policies?

As indicated previously the concept of bullying was reported in both phases. Rayner and Hoel (1997) referred to bullying as unbalanced power, social exclusion, destruction of self-esteem and confidence. The qualitative phase revealed that some overseas nurses indicated that their white British colleagues had bullied them. Although everyone did not share this view, those who indicated this, felt that their self-esteem was affected as a result. The survey also revealed that 6% of overseas nurses indicated that bullying was apparent. Although authors such as Cowie et al. 2002 and Randle (2003) have explored issues surrounding bullying, there is limited
research that specifically investigates bullying experienced by overseas black and minority ethnic nurses.

10.2.2 Social closure

In attempting to explain what this study found, it was also important to draw on the sociological theory of social closure that Weber (1970) developed. Social closure in the workplace is a process by which social groups seek to restrict opportunities for other groups that have distinct characteristics such as language, race and social origins. Indeed this monopolisation is directed at such groups in order to exclude them from the opportunities within the dominant group. These social markers such as ethnicity and culture, distinguish the minority group from the dominant majority group. As with this study, there were elements of social closure in both the qualitative and quantitative phases. In the qualitative phase, some overseas nurses felt isolated and unwelcome and had limited opportunities for skills' development and training. These aspects identified were largely due to social closure. The dominant group of nurses had the power to disregard those nurses whom they felt should be excluded from their social group. By restricting their opportunities, in a sense barriers and boundaries are being created in the labour market (Carter 2003).

In the quantitative phase the concept of social closure emerged in the form of discrimination with variations in both support and adjustment to a new environment. Such variations in experiences were partly attributed to the dominance of the majority culture in exercising social closure principles and these may have contributed towards the differences experienced by overseas nurses. In the qualitative phase of this study, there were a number of ways in which some overseas nurses attempted to resist social
closure. These included, proving self, building ties and moving on. In these circumstances they were attempting to avoid the monopolisation by the dominant group. Therefore, in order to resist such exclusionary practices, they began to build ties and prove to others that they would not passively accept their present positions. Similarly, for others, moving on was another way in which social closure could be defied and therefore seeking alternative employment was a way forward in overcoming such social closure.

10.2.3 Transition theory

In seeking to explain what this study found, it was also important to draw on Meleis et al.'s (2000) theoretical framework of transition. The concept of transition is complex and multifaceted, however, there are a number of significant elements of the transition experiences such as, ‘awareness, engagement, change and difference, time span and critical points and events’ (Meleis et al. 2000: 18). These elements are connected by complex processes and they facilitate our understanding of the experiences of overseas nurses.

According to Meleis et al. (2000), awareness is related to perception of a transition experience. Both the qualitative and quantitative phases found that overseas black and minority ethnic nurses were perceptive of their external environment and because of this awareness they were able to interpret their experiences. As illustrated in this study, some had positive experiences while others had negative. Therefore, despite these polarising differences in experiences, it would appear that awareness is an important property of transition. However, it does not elucidate why overseas nurses perceive to have had such differences in treatment and experiences.
In this study engagement is another element of this complex process. Heidegger (1962) claims that individuals engage in the world in order to understand their experiences. Indeed overseas nurses have been working and engaging in the NHS and it is this engagement that enables them to identify their differences. It is important to note that that their level of perception may have been influenced through their level of engagement and exposure to the phenomena.

Meleis et al.'s (2000) theory of change and difference is important in explicating the differences in experiences as perceived by overseas nurses in both phases. According to Meleis et al. (2000) change and difference may cause dis-equilibrium and disruptions in relationships and routines. Indeed, both phases of this study found evidence of dis-equilibrium and disruptions in the relationship between overseas black and minority ethnic nurses and that of their white British counterparts. In migrating to a different environment there is usually disruptions and dis-equilibrium. This is because both migrating and indigenous nurses have different expectations and are culturally different and, it is because of these differences disruptions and dis-equilibrium ensue.

Added to Meleis et al.'s (2000) transitory theory is the concept of time-span and it would be useful to draw on this. In both the qualitative and quantitative phases the findings revealed that overseas nurses encountered differences in adjusting to their environments and this depended on support and information available within their workplaces. Additionally, adjustment to a new environment takes time and putting a boundary on how long it will take would be counterproductive as individuals adjust at different paces.
It is important to emphasize that both phases of this study were able to offer some and indeed greater insights into the experiences of overseas black and minority ethnic nurses in the NHS in the south of England. It is because of combining these two approaches that this study was able to contribute further to the body of knowledge based on this relatively new and unexplored area.

10.3 Implications and recommendations for practice, management and policy makers

The mixed methods provide insightful information and it is anticipated that policy makers, nurses and managers would consider these implications and recommendations in the light of recruiting and retaining overseas nurses in the NHS. It is also hoped that overseas nurses, in understanding the outcome of this study, may gain some insightful information into their own difficulties and those of others and will use these experiences as learning opportunities when either temporary or permanent nurses of the NHS in the UK. This section will include implications and recommendations for practice, management and policy makers.

10.3.1 Implications and recommendations for practice

This study examined the differences in nursing practice such as the way in which care was organised in the UK. Participants felt that this did not reflect what they were accustomed to and were surprised at encountering such differences in care delivery.

Recommendation 1: It is recommended when recruiting overseas nurses to work in the NHS, it is important to inform them at the outset and through formal induction programmes of the differences in nursing practice in the UK. Such information could
contribute towards making their transition much easier. It could also help in preparing them for a different nursing culture but more importantly, such information could enable overseas nurses to provide care of the highest standard for patients.

The issue of adjustment to a new environment meant that participants felt displaced within the new environment as indicated in this study.

**Recommendation 2:** It is therefore important for British nurses to facilitate overseas nurses' adjustment to a new environment by providing and sharing information about clinical care. This is best achieved through a structured mentorship or preceptorship programme. It is anticipated that should this system be implemented then overseas nurses' displacement might be minimized as a result.

As has been identified in both the qualitative and quantitative phases that support was varied and workplace dependant. Providing support could enhance overseas nurses confidence and job satisfaction with the resultant effect on high quality individualised patient care.

**Recommendation 3:** It is recommended that support should be consistent throughout the NHS. This can be done through hospitals sharing good practice with each other.

Separateness was a sub-theme that emerged in this study. Many overseas nurses indicated that they were marginalized and treated as the 'other' and this created some difficulties for them.
Chapter Ten Discussion, Implications and Recommendations

**Recommendation 4:** It is recommended that an inclusive environment should be created as identified in the Vital Connection (DoH 2000d). This could enable overseas nurses to feel valued, less isolated and alienated from their British counterparts. Alienation and separateness could impact on teamwork and dynamics but also in recruiting and retaining of overseas nurses. There should be workshops on promoting sameness and commonalities between overseas nurses and that of their white British counterparts. It is important that all nurses attend the workshops to enable learning from each other to take place.

The NHS Plan (DoH 2000a) makes a firm commitment to developing individuals. Training and development are of increasing importance in today’s NHS. Although overseas nurses have a wealth of skills and experiences, these have not appeared to be recognised because of the differences in training and education between the UK and overseas nurses’ health care system. The Skills for Health (2006) policy document outlines the importance of training and development as these are paramount for delivering high quality nursing care.

**Recommendation 5:** It is recommended that overseas nurses should be given the opportunities to develop skills that are necessary for providing optimum patient care. This is best achieved through structured systems that allow overseas nurses to utilise their skills and attend training courses as appropriate.

The issue of unfairness in nursing practice has implications for nurses and indeed the NHS. As a result of this problem identified, the process of recruiting and retaining overseas nurses could potentially be difficult. This could create increased stress
amongst nurses due to reduced staff numbers, with the resultant effect on morale and standards of nursing care.

**Recommendation 6:** The Vital Connection (2000d) aims to put values of fair treatment and equality as central to the NHS. It is therefore recommended that managers and British nurses should at all times review the skills mix and patients allocation on a daily basis to ensure that overseas nurses do not feel burdened by excessive work or experience unfair treatment.

This study also found that overseas nurses experienced fear from both managers and their British counterparts.

**Recommendation 7:** It is important to foster a culture that encourages overseas nurses to feel at ease with their British counterparts. Training on cultural issues must be integral within the NHS for white British nurses'. Staff could attend an ‘ethnicity’ module as this could improve their skills and knowledge in order to make changes to their behaviour.

10.3.2 **Implications and recommendations for management and policy makers**

For most overseas nurses English was not their first language and this created some anxieties particularly in relation to the differences in dialects and pronunciation of words.

**Recommendation 8:** It is recommended that managers and policy makers should provide information on local dialects, as this could help overseas nurses in their
cultural adaptation to the NHS. Furthermore, it important to provide at the outset orientation courses that introduce overseas nurses to the NHS and the expectations required as overseas nurses. These could enhance overseas nurses understanding of the NHS and as such reduce their frustration, embarrassment and humiliation as a result.

Although a number of hospitals include as part of their preparation, an induction programme, it would appear that the cultural needs of overseas nurses were often neglected.

**Recommendation 9:** It is important to have inclusive programmes that cater for the different cultural needs of overseas nurses. These nurses have distinct cultural requirements, and incorporating cultural in-service training into hospitals’ induction and continuing education programme would help in addressing the different cultural needs of these nurses and it would signal to them that their needs are being catered for in the NHS.

The NHS aims to promote equality and diversity and values the benefits that individuals from black and minority backgrounds bring (DoH 2000f). It also sets standards that are expected of employers in tackling racial harassment (DoH 2001h). Despite introducing these policies in the NHS, this research found gaps in implementing and delivering equal opportunity and racial harassment policies.

**Recommendation 10:** It is recommended that the structures, systems and processes within the NHS are introduced, reviewed and monitored particularly in the light of
this study. This is because overseas nurses have perceived these processes, structures and systems to be varied. Justice and fairness are characteristics that are inherent in any democratic society and therefore these concepts should be the guiding principles of the NHS. In addition, it is important to ensure that equal opportunity and anti-bullying policies are implemented as well as strictly adhered to. Any incidents involving bullying or complaints made against managers in relation to a lack of promotion should be monitored for auditing purposes.

A number of overseas nurses felt that their British counterparts did not appreciate their efforts. Alongside this were feelings of inadequacy and the lack of trust. These were compounded by unwelcome feelings and these distinguishing attitudes were characteristics that overseas nurses encountered during their workplaces.

Performance review was another sub-theme that emerged following the analysis of the qualitative data. Some overseas nurses revealed that the process undertaken by their managers was conducted in a somewhat haphazard manner and perceived this as having no benefit. In the light of this finding, consideration must be given to the way in which performance reviews are conducted so as to reflect their purpose.

**Recommendation 11:** Managers need to identify at the outset the purpose of the review. There should also be appropriate goals set and achieved. All of this would contribute towards overseas nurses' feelings of accomplishment.
This study found significant differences between overseas nurses employed in NHS hospitals in London and those employed in NHS hospitals in non-London regions in the south of England.

**Recommendation 12:** It is recommended that NHS hospitals in London and outside of London should have similar policies, systems and processes in terms of training, development, support mechanisms to include adjusting to a new environment as these will have implications for recruiting and retaining overseas nurses.

10.4 Strengths of both qualitative and quantitative methods

This study utilised both qualitative and quantitative approaches and these can often be used to investigate similar areas by focusing on a different research question (Jones 1995). These methods collected different types of data and produced different sorts of answers (Barbour 1999). It has been suggested that qualitative methods can be useful to explore areas that have received little attention (Pope and Mays 1995). Indeed using a qualitative approach such as phenomenology enabled the researcher to explore a relatively new area. This method utilised many sources such as semi-structured and focus group interviews to obtain data from overseas nurses. The fact that this study employed such methods would indicate a major strength. The findings from this study concurred with those of Taylor (2005), Matiti and Taylor (2005) and Allan and Larsen (2003) in that overseas nurses experienced confusion and role change.

Although these studies as noted above have found similar findings to this research, none of the authors has utilised both qualitative and quantitative methods to elicit information about the experiences of overseas black and minority ethnic nurses in the
NHS in the south of England. Many of these authors utilised either one or combined methods such as face-to-face interviews, participant observations, focus group interviews or survey but none had utilised the following approaches such as face-to-face interviews, focus group interviews and a survey to explore the experiences of overseas nurses in the NHS in the south of England. The multi-method approach used in the design of this study is a particular strength.

Greene et al. (1989) suggest that qualitative research can be used as a requirement for developing quantitative methods. This involves the researcher identifying the appropriate areas that require further investigating and devising a suitable survey questionnaire. The qualitative method adopted served as a prerequisite for informing the design of the research questions. The contribution of the qualitative findings to the development of a questionnaire that included specific areas that needed further investigation such as equal opportunity, skill development and training, discrimination, support and adjustment to a new environment served to both strengthen the questionnaire and further validate the results, as a form of data triangulation.

This study used methods triangulation utilising a mixed method approach to collect data (Patton 1999). One of the drawbacks of qualitative methods is the inability to generalise to the wider population, however, this was overcome by conducting a survey. Therefore in conducting a survey the findings were made more applicable to the wider population. Indeed the qualitative and quantitative findings revealed that overseas nurses experience discrimination. Thus the findings from one methodology confirmed those of the other methodology. Moreover, the results of a combined
methodology inherent in this study enabled the researcher to draw conclusions and recommendations on how best the NHS could address the needs of overseas nurses.

### 10.5 Limitations of both qualitative and quantitative methods

Although it has been clearly shown that this thesis has successfully answered the research question, there were limitations to the methods adopted. As highlighted in the introduction, the aim of this study was to explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses in the NHS in the south of England and it was the intention to extend the knowledge and understanding in this relatively unexplored area.

This study is retrospective in nature and relied on overseas nurses’ recollection of their lived experience after the event. A study by Russell (1999) highlighting participants’ ability to recall found that their experiences differed markedly over time. Therefore, whether the accuracy of recall may have been distorted as a result of the passing of time is difficult to determine. Nonetheless, the stories that overseas nurses recalled about their experiences of working in the NHS in the south of England were insightful and informative.

The qualitative methods adopted such as twelve face-to-face and four focus group interviews to explore the experiences of overseas nurses could be considered small samples, although phenomenological approaches tend to utilise small samples to elicit lived experiences of participants. It could be argued that the utilisation of such small samples could jeopardise the validity of this study. However, the initial stage of this study was not to generalise to the wider population but to obtain rich and meaningful
data on the experiences of overseas nurses and to draw appropriate conclusions and recommendations in the light of the findings. Although this study was able to identify some challenges that overseas nurses encountered whilst working in the NHS in the south of England, it was unable to determine whether all overseas nurses stories were accurate and reflected their experiences.

A possible weakness in this study could be in the instrument used in the survey. The questionnaire included five areas that required further investigation. The aim in the construction of the questionnaire was to obtain as much information as possible about overseas nurses' experiences in the NHS and to find out the extent to which the findings from both the face-to-face and focus group interviews were applicable to the wider population of overseas nurses. Through the gathering of such information, it was hoped that this would help managers and policy makers meet the needs of overseas nurses. However, the areas covered might have reflected what the researcher perceived to be essential and needed further investigation but may not necessarily be perceived to be important by overseas nurses.

Although this study adopted both qualitative and quantitative methods to investigate the experiences of overseas black and minority ethnic nurses in the NHS in the south of England, it solely focused on the NHS in the UK. Given that the health care systems between countries are dissimilar, it is arguable whether these findings are applicable to other developed countries health care systems. However, the use of migrant nurse labour seems to be a common feature of most industrialized countries in the West.
Chapter Ten Discussion, Implications and Recommendations

The questionnaire targeted a number of overseas black and minority ethnic nurses in the NHS in the south of England in many hospitals in this geographical area. However, overseas nurses who participated in this study could have been nurses who were disgruntled with the NHS and needed to express their views. Although their views and experiences are important, those who have had good experiences are just as important. It was therefore difficult to ascertain whether the results obtained were those of one particular group of overseas nurses or a cross section of overseas nurses. As a result of this, it was therefore important to be mindful of this limitation.

10.6 Recommendations for future research

The findings from this study provided valuable information and knowledge of overseas black and minority ethnic nurses in the NHS in the south of England. The results of this study confirmed and extended those derived from previous studies. Central to this study were the insights gained and new perspectives acquired from undertaking this project.

The findings of this study serve as a basis for the following recommendations for future studies:

As this study’s purpose was to explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses in the NHS in the south of England, it might be appropriate to consider patients’ views of overseas nurses and whether the care provided was influenced in anyway possible. In addition to this, studies could consider the global impact of migration on overseas nurses.
In reviewing the literature and from undertaking this study, there seems to be limited studies that explore British nurses' views, experiences and expectations of overseas nurses. Therefore, as there is not much research in this area it would be useful to explore these aspects, as they could contribute another dimension in this area.

A longitudinal study could be conducted to explore and develop a better understanding of the working lives of overseas nurses as they develop over a period of time. During such exploration the researcher could also explore whether white British nurses treat overseas nurses whose racial features are black differently to that of overseas nurses whose racial features are white.

Another important aspect beyond the scope of this study would be an evaluation of all overseas nurses' orientation programmes to determine which of these could be used as the 'gold standard' for inducting overseas nurses into the NHS.

In this study overseas nurses perceived themselves to be different. This is because they came from a culture that is different to that of their British counterparts. It would be useful to conduct a study that would investigate the extent to which overseas nurses feel integrated within the workforce.

The findings from this research were only applicable to the NHS in the UK. Therefore it is important to carry out further studies on the experiences of overseas nurses on an international level to examine the similarities and differences in experiences across health care systems and cultures for example, the United States of America, or Australia for comparisons.
Another important area for future study would be to investigate the extent to which overseas African nurses are treated differently to that of nurses from India, Pakistan and the Philippines. This study would contribute immensely to the results found in this study.

The suggestions for future studies as indicated in the above would provide invaluable evidence to expand our understanding of and the body of knowledge on issues related to overseas nurses. The findings from these studies could provide valuable insights into improving services, policies and practice regarding the workforce of overseas nurses and their well-being in the NHS.

10.7 Summary

In summary, this chapter has provided a discussion of the findings as well as the implications and recommendations for both the qualitative and quantitative phases. It has addressed the strengths and limitations of this study and presented a number of recommendations for future research. This study cannot over emphasise how important these recommendations are and how implementing these within the NHS and other health care organisations would most likely benefit overseas black and minority ethnic nurses. Finally, although there were limitations, the knowledge and understanding derived from this study should add considerably to the body of evidence that is currently available about the experiences of overseas black and minority ethnic nurses in the NHS in the south of England.
Chapter Eleven
Contribution to Knowledge
Methodology and Theory

11.1 Introduction
This chapter provides the contribution this study has made to knowledge, understanding, methodology and theory, and will present a critical evaluation of the research process and the researcher's position within this study. In addition to these, it will include a finally thought and will conclude by summarising the main points.

11.2 The contribution to knowledge and understanding
A multi-method approach was utilised to find out about the experiences of overseas nurses and this study was able to provide greater insights into their experiences. The quantitative approach adopted confirm some of the findings of the qualitative phases and these methods provide several new dimensions that add to our knowledge and understanding but also bring to light new evidence pertaining to the overseas nurses' experiences. The qualitative phase revealed that the perception of being thrown into an unfamiliar world uncovered an aspect not previously referred to in this way in the literature. This aspect of their experience revealed that they felt displaced and out of their depth at times. This is because their new environment was different to what they had been accustomed and this was compounded further by the lack of support.

The qualitative results gave insight into overseas nurses encountering marginalisation and experiencing inequalities in the world. These were encountered in the form of
discrimination, lack of equal opportunity and separateness. These findings concur with those of Taylor (2005) and Allan *et al.* (2004). Furthermore, the sub-theme such as the invisibility syndrome provides another new dimension that no other studies have discovered. It informs us of a different type of discrimination inherent in the NHS as perceived by overseas nurses. In addition to this, the concept of bullying has not been found in any other studies and as a result a new insight is achieved.

Surviving in a new world is a relatively recent concept and within this major theme are the sub-themes such as experiencing fear and concept of self-blame. In addition to these are the concepts of living in an everyday world and making a new world and these have not been referred to in the literature in this way. These themes and sub-themes provide valuable insights into the phenomenon and increase our understanding and knowledge of the lived experiences of overseas black and minority ethnic nurses in the NHS in the south of England.

The quantitative phase revealed a number of statistical significant results such as overseas nurses, particularly African nurses, employed in non-London NHS hospitals in the south of England were more likely to perceive that they were being discriminated against in comparison to those employed in NHS hospitals in London. In addition, African nurses were generally perceived to be dissatisfied with their experiences in comparison to Filipino, Indian and Pakistani nurses particularly if they were working in NHS hospitals outside of London.

Other significant results that this study found were, overseas nurses working in NHS hospitals in London were more likely to perceive that they were being promoted,
supported and less likely to have aggressive behaviour directed at them in comparison to those in NHS hospitals in non-London regions. In addition, adjustment correlates with time and it would appear that the more time overseas are given, the less likely they are to perceive that they have been discriminated. These significant findings contribute to our understanding and knowledge, as they have not been found in any other studies in this area.

The quantitative phase of this study revealed that overseas nurses utilised two strategies, distancing self and problem solving to cope when difficulties arose in the workplace. These findings are important as they inform us of the different types of strategies that overseas nurses may adopt in aiding them to cope. No earlier studies found this and such findings contribute to the body of knowledge on overseas nurses.

This study makes another contribution such as, having satisfactory information about adjusting to a new environment would help overseas nurses to feel supported in the workplace. Moreover, the findings indicated that the more information overseas nurses receive the less stressed they became. Both support and adequate time could help in making their transition to a new environment much easier.

Furthermore, this study showed that a relationship existed between skills utilisation and sufficient time to become acquainted with a new environment. In other words, the more adjusted overseas nurses are to their new environment the more likely their skills would be used in their working environment. This finding is important because it indicates that with time overseas nurses may be able to use their skills and this adds another dimension that no other studies have found.
The contribution that the quantitative feature of this study makes is really significant in that the findings can be applicable to the wider population of overseas nurses. The quantitative phase confirmed some of the findings from the qualitative phase and this is another contribution that this study makes to knowledge and understanding in this area.

11.3 Contribution to research methodology

In nursing research, combining qualitative and quantitative methods have been used infrequently. This is because authors such as Gantley (1994) and Leininger (1994) have argued that these approaches are incompatible and yield different results. It has been claimed that whilst quantitative methods are founded on the epistemology of positivism on the other hand qualitative approaches are embedded in the anti-epistemological stances of anti-positivism (Chan 2001). Although these research approaches have different stance, it has been argued that there are merits in moving away from the customary practice of choosing either qualitative or quantitative methods (Douglas 2003).

Benzies and Allen (2001) believe that integrating both qualitative and quantitative methods emphasized their findings. Equally, Higgins et al. (1999) revealed that quantitative findings confirmed the qualitative results. In combining these approaches they serve many purposes such as confirmation where the findings of one method are checked against the results of another. Moreover, a more accurate and complete picture of the social experience of the research subject is obtained (Coyle and Williams 2000). Indeed, this study utilised both qualitative and quantitative
approaches in order to capture a more comprehensive picture of the phenomenon under investigation.

The qualitative results revealed great insight into and provided in-depth account of the experiences of overseas nurses in the NHS in the south of England. This qualitative approach allowed overseas nurses to express their views openly and freely about their experiences of the NHS. Moreover, the qualitative findings contributed to the design of a valid questionnaire that was relevant to overseas nurses and this survey specifically investigated the five areas such as equal opportunity, skill development and training, discrimination, support mechanisms and adjustment to a new environment. This survey added objectivity to this study by utilising a questionnaire and this resulted in the findings that could be applicable to the wider population of overseas nurses.

A phenomenological approach was adopted and this included three phases of which the first phase involved face-to-face interviews. The findings from this phase informed the second part of this study. The finally stage was a survey and this was informed by the second phase. By utilising these three phases embedded in a phenomenological framework have contributed a different dimension to the research methods paradigm of overseas nurses.

11.4 Contribution to theory

The purpose of phenomenology is to describe and develop a greater understanding of a phenomenon as it is lived (Streubert and Carpenter 1999). It has been suggested in the literature that two types of theory exist such as descriptive and prescriptive.
Although these do exist, it has been suggested that the strength of phenomenology lie with its description (Rose et al. 1995). According to Rose et al. (1995) descriptive theory which will be the focus of this section, describes a phenomenon, identifies its properties and identifies some of the circumstances under which it occurs. However, phenomenology does not aim to theorize but can be used to develop an understanding of the phenomenon under investigation.

The intention of this study was not to theorize, however, the concept of the journey can be seen as a powerful theoretical concept. This journey includes the following aspects, 'leaving a familiar world', followed by 'being thrown into an unfamiliar world'. Following this is, 'encountering marginalisation and experiencing inequalities in the world'. The next stage includes 'surviving in and everyday world' and following on from this is, 'living in an everyday world'. The final phase is 'making a new world'. This journey contributes to theory formation on overseas nurses in the NHS. Such a theoretical concept can be applied to the understanding of a wider group of migrant workers taking employment in the public service sectors.

11.5 Critical evaluation of the research process

It is important to review and evaluate critically the research process and to reflect on this process as a black researcher. Overall the study was successful in achieving its aims. The approach utilised was able to generate rich and detailed accounts of the experiences of overseas nurses. Throughout the thesis, the researcher has consistently demonstrated how the phenomenological approach informed by the philosophical views of Heidegger (1962) have underpinned the research process and the
interpretation. The use of this approach has enabled the researcher to illustrate the meaning overseas nurses attributed to their experiences.

Although authors such as Webb and Kevern (2001) have vehemently argued that using focus group interviews were incompatible with that of phenomenology, the researcher was able to demonstrate how the chosen methodological approach and methods utilised were congruent with the research question. The researcher was able to reveal by providing a clear decision trail of how the face-to-face interviews, focus group interviews and indeed the survey were compatible with that of phenomenology.

The study gave a clear and detailed account of the process involved, from obtaining ethical approval to interviewing and surveying overseas nurses. Throughout this process the researcher was methodical and extremely careful in reflecting how things had transpired and what helped or hindered the process. The analysis of the data was presented in such a way as to reflect overseas nurses’ experiences of the NHS.

As this study utilised both qualitative and quantitative methods, the findings from the qualitative phase were only applicable to that area where this study was undertaken. However, the use of a survey meant that the findings could be applicable to the wider population of overseas black and minority ethnic nurses particularly in the south of England. The findings from this survey were congruent with those of MORI (2002).

In evaluating this process, particularly the findings, the researcher was able to include direct quotes from overseas nurses to demonstrate that the themes derived were not the researcher’s personal interpretation but the participants’. By presenting such
textual quotes in such a manner, the researcher was able to reflect the participants’ experiences of working in the NHS.

It is important to note that despite adhering to the prescribed ethical principles and methodological rigour, there is always room for improvement in any piece of work. As researchers we learn from our mistakes and those of others, and in this way progress is made. Having made a mistake by not including an incentive with the survey, the researcher felt that this may have contributed to the low response rate. However, this is a lesson learnt from undertaking this study.

The researcher’s own background may have also posed some limitations. Coming from a minority ethnic background similar to that of overseas nurses could have its limitations. This is because the researcher may have been emotionally affected by some of the stories told and therefore elements of subjectivity could have played a part in the interpretation of the data. However, the explication of the researcher’s biographical and positional statements has helped to provide transparency. This study has attempted to be as objective as possible (Sarantokos 1998) which is one of the goals of quantitative research. So allowing the data to reflect the participants’ experiences through standardization of the process enabled the study to achieve objectivity as much as possible.

The responsibility for the interpretation of overseas nurses’ experiences of the NHS, as presented in this thesis is mine alone and cannot be thought of as providing an objective ‘truth’ about overseas nurses’ experiences. The accounts given are context-specific, having been affected by the nature of the interview and the characteristics,
educational background and social status of the researcher. Another researcher might have accessed different ‘truths’.

During this project a steep learning curve, akin at times to a mountain range, has been scaled by the researcher, from a new approach to addressing a research problem, and working within a new paradigm, all of which brought some difficulties. Overall, this study has allowed the researcher to appreciate the complexities of the research process and enabled the researcher to gain insightful information about this process and indeed overseas nurses and their experiences of working in the NHS in the south of England.

11.6 Final thought

The researcher would like to leave the reader with this thought: Overseas nurses value the experiences gained from working in the NHS, however, they feel that these experiences could further be enhanced if they are accepted for who they are and for their contributions to the NHS. Therefore the greatest gift to mankind and indeed overseas nurses is to be accepted.

Finally, one participant asked, ‘Is this study going to be for us as well as about us and how are we going to be accepted in the NHS?’ The researcher hopes that overseas nurses who freely participated in this study are able to feel that this research has been for them and that acceptance would increase.

11.7 Summary

This chapter has provided an account of the contribution this study has made to the body of knowledge based on overseas black and minority ethnic nurses in the NHS in
the south of England. Such a contribution has been in terms of knowledge, understanding, methodology and theory. This chapter has also provided a critical evaluation of the research process and concluded with a final thought. Overall, this present study has offered invaluable insights into the experiences of overseas black and minority ethnic nurses by using both qualitative and quantitative approaches and the researcher has explained the contribution that this study has made in this relatively new and unexplored area.
References


References


References


<table>
<thead>
<tr>
<th>References</th>
</tr>
</thead>
</table>


References


References


References


References


References


References


Department of Health (2001g) *Numbers of qualified nursing, midwifery and health visiting staff by ethnicity and by Strategic Health Authority*. Department of Health: London.


References


References


<table>
<thead>
<tr>
<th>References</th>
</tr>
</thead>
</table>


References


References


Kitzinger, J. (1994) The methodology of focus groups: the importance of interaction between participants. *Sociology of Health and Illness*, 16 (1): 103-121.


References


References


References


Martineau, T., Decker, K. and Bundred, P. (2002) *Briefing note on international migration of health professionals: leveling the playing field for developing country health systems*. Liverpool School of Tropical Medicine: Liverpool.


References


References


357
References


References


References


References


References


References


Royal College of Nursing (2002a) *RCN submission to spending review 2002*. February, Royal College of Nursing: London.


363
References


<table>
<thead>
<tr>
<th>References</th>
</tr>
</thead>
</table>


References


References


Appendix 1

Published Paper

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 2

Search Terms and Databases
## Appendix 2: Search Terms and Databases

<table>
<thead>
<tr>
<th></th>
<th>Care data/social care on line</th>
<th>Cinahl</th>
<th>BNI</th>
<th>Journal of Ovid full text</th>
<th>Zetoc</th>
<th>Social science citation and index to scientific and technical proceedings</th>
<th>Medline</th>
<th>Cochrane</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Overseas nurses</td>
<td>0</td>
<td>84019</td>
<td>352</td>
<td>0</td>
<td>77</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>experiences</td>
<td>3734</td>
<td>4725</td>
<td>352</td>
<td>0</td>
<td>34709</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Overseas nurses and experiences</td>
<td>1</td>
<td>260</td>
<td>352</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>International nurses</td>
<td>41</td>
<td>11626</td>
<td>3752</td>
<td>0</td>
<td>2051</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>International nurses and experiences</td>
<td>0</td>
<td>75</td>
<td>352</td>
<td>0</td>
<td>53</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>Race</td>
<td>4515</td>
<td>6536</td>
<td>2941</td>
<td>0</td>
<td>25800</td>
<td>33385</td>
<td>27482</td>
</tr>
<tr>
<td>7</td>
<td>Race and Racism</td>
<td>19</td>
<td>364</td>
<td>12</td>
<td>1704</td>
<td>557</td>
<td>875</td>
<td>300</td>
</tr>
<tr>
<td>8</td>
<td>Race, racism, experiences and overseas nurses</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>culture</td>
<td>1472</td>
<td>8725</td>
<td>1542</td>
<td>0</td>
<td>147923</td>
<td>10000</td>
<td>15639</td>
</tr>
<tr>
<td>10</td>
<td>Culture and ethnicity</td>
<td>10</td>
<td>275</td>
<td>24</td>
<td>5877</td>
<td>658</td>
<td>1304</td>
<td>542</td>
</tr>
<tr>
<td>11</td>
<td>Culture ethnicity and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>Equal opportunities</td>
<td>1206</td>
<td>81197</td>
<td>79</td>
<td>0</td>
<td>2827</td>
<td>287</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>Equal opportunities and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>Equal opportunities and race</td>
<td>5</td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>109</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>15</td>
<td>Diversity</td>
<td>803</td>
<td>2572</td>
<td>6918</td>
<td>182</td>
<td>53009</td>
<td>90972</td>
<td>27482</td>
</tr>
<tr>
<td>16</td>
<td>Diversity and ethnicity</td>
<td>0</td>
<td>125</td>
<td>4</td>
<td>3667</td>
<td>177</td>
<td>456</td>
<td>329</td>
</tr>
<tr>
<td>17</td>
<td>Diversity and discrimination</td>
<td>1</td>
<td>105</td>
<td>15</td>
<td>3663</td>
<td>119</td>
<td>972</td>
<td>409</td>
</tr>
<tr>
<td>18</td>
<td>Diversity, discrimination and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>othering</td>
<td>1</td>
<td>15187</td>
<td>4897</td>
<td>0</td>
<td>60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>Othering and racism</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21</td>
<td>marginalisation</td>
<td>64</td>
<td>19726</td>
<td>1632</td>
<td>0</td>
<td>201</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>Marginalisation and discrimination</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>68</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>23</td>
<td>Black and minority nurses</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>25</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24</td>
<td>stigma</td>
<td>877</td>
<td>11</td>
<td>929</td>
<td>0</td>
<td>1533</td>
<td>4049</td>
<td>824</td>
</tr>
<tr>
<td>25</td>
<td>Stigma and discrimination</td>
<td>25</td>
<td>160</td>
<td>28</td>
<td>154</td>
<td>57</td>
<td>273</td>
<td>182</td>
</tr>
<tr>
<td>26</td>
<td>stereotyping</td>
<td>49</td>
<td>11</td>
<td>3914</td>
<td>0</td>
<td>518</td>
<td>1154</td>
<td>2145</td>
</tr>
<tr>
<td>27</td>
<td>Stereotyping and overseas nurses</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>0</td>
<td>26</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>28</td>
<td>adjustment</td>
<td>462</td>
<td>860</td>
<td>5462</td>
<td>0</td>
<td>16761</td>
<td>59602</td>
<td>4590</td>
</tr>
<tr>
<td>29</td>
<td>Adjustment and stress</td>
<td>2</td>
<td>813</td>
<td>18</td>
<td>18015</td>
<td>387</td>
<td>5671</td>
<td>4052</td>
</tr>
<tr>
<td>30</td>
<td>Adjustment, stress and overseas nurses</td>
<td>0</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td>0</td>
</tr>
<tr>
<td>31</td>
<td>Migration or Migrating individuals</td>
<td>290</td>
<td>24817</td>
<td>23670</td>
<td>0</td>
<td>27</td>
<td>15</td>
<td>14234</td>
</tr>
<tr>
<td>32</td>
<td>Migration or Migrating individuals and overseas nurses</td>
<td>0</td>
<td>5234</td>
<td>352</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>212</td>
</tr>
<tr>
<td>33</td>
<td>Migration or Migrating individuals, overseas nurses and discrimination</td>
<td>2</td>
<td>53</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1410</td>
</tr>
<tr>
<td>34</td>
<td>Recruitment, retention, overseas nurses and discrimination</td>
<td>85</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Search terms and Databases continued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NELH</td>
<td>Psychology and behavioural sciences collection</td>
<td>PsycINFO</td>
<td>Inter nurse</td>
<td>International Bibliography of social science</td>
<td>Igenta connect</td>
<td>Dissertations Abstract</td>
<td>Sociological Abstract</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>------------------------------------------</td>
<td>----------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Overseas nurses</td>
<td>6</td>
<td>1</td>
<td>14</td>
<td>3</td>
<td>25</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>experiences</td>
<td>216</td>
<td>10866</td>
<td>80708</td>
<td>253</td>
<td>7723</td>
<td>22324</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Overseas nurses and experiences</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>International nurses</td>
<td>35</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>313</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>International nurses and experiences</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Race</td>
<td>68</td>
<td>7527</td>
<td>22581</td>
<td>158</td>
<td>24436</td>
<td>9980</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Race and Racism</td>
<td>11</td>
<td>613</td>
<td>1264</td>
<td>0</td>
<td>1959</td>
<td>378</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Race, racism, experiences and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>culture</td>
<td>157</td>
<td>18405</td>
<td>47119</td>
<td>141</td>
<td>73239</td>
<td>69056</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Culture and ethnicity</td>
<td>10</td>
<td>331</td>
<td>1450</td>
<td>3</td>
<td>1937</td>
<td>435</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Culture ethnicity and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Equal opportunities</td>
<td>24</td>
<td>182</td>
<td>192</td>
<td>2</td>
<td>1192</td>
<td>675</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Equal opportunities and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Equal opportunities and race</td>
<td>3</td>
<td>15</td>
<td>21</td>
<td>0</td>
<td>70</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Diversity</td>
<td>78</td>
<td>4410</td>
<td>12872</td>
<td>44</td>
<td>5645</td>
<td>27178</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Diversity and ethnicity</td>
<td>3</td>
<td>122</td>
<td>653</td>
<td>1</td>
<td>493</td>
<td>205</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Diversity and discrimination</td>
<td>6</td>
<td>92</td>
<td>424</td>
<td>0</td>
<td>124</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Diversity, discrimination and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>othering</td>
<td>0</td>
<td>8</td>
<td>39</td>
<td>3</td>
<td>59</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Othering and racism</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>6</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>marginalisation</td>
<td>1</td>
<td>169</td>
<td>64</td>
<td>1</td>
<td>214</td>
<td>248</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Marginalisation and discrimination</td>
<td>0</td>
<td>12</td>
<td>5</td>
<td>0</td>
<td>10</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Black and minority nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>stigma</td>
<td>26</td>
<td>771</td>
<td>3929</td>
<td>22</td>
<td>384</td>
<td>1191</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Stigma and discrimination</td>
<td>2</td>
<td>106</td>
<td>376</td>
<td>0</td>
<td>31</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>stereotyping</td>
<td>1</td>
<td>496</td>
<td>2952</td>
<td>7</td>
<td>294</td>
<td>387</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Stereotyping and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>adjustment</td>
<td>64</td>
<td>7061</td>
<td>58056</td>
<td>25</td>
<td>8559</td>
<td>14600</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Adjustment and stress</td>
<td>10</td>
<td>959</td>
<td>5813</td>
<td>0</td>
<td>102</td>
<td>770</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Adjustment, stress and overseas nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Migration or Migrating individuals</td>
<td>0</td>
<td>2</td>
<td>4243</td>
<td>0</td>
<td>23729</td>
<td>24664</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Migration or Migrating individuals and overseas nurses and discrimination</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>33</td>
<td>Migration or Migrating individuals, overseas nurses and discrimination</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>34</td>
<td>Recruitment, retention, overseas nurses and discrimination</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix 3

References perceived as relevant for the literature review
Appendix 3: References perceived as relevant for the literature review

<table>
<thead>
<tr>
<th>Databases</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caredata/Social Care on line (Jan 1986-Dec 2005)</td>
<td>4</td>
</tr>
<tr>
<td>CINAHL (Jan 1982 – Dec 2005)</td>
<td>53</td>
</tr>
<tr>
<td>BNI (Jan 1985 – Dec 2005)</td>
<td>31</td>
</tr>
<tr>
<td>Zetoc (Jan 1982 – Dec 2005)</td>
<td>11</td>
</tr>
<tr>
<td>Social Science citation and Index to scientific and technical proceedings (Jan 1981 – Dec 2005)</td>
<td>14</td>
</tr>
<tr>
<td>Medline (Jan 1966 – Dec 2005)</td>
<td>4</td>
</tr>
<tr>
<td>Cochrane (Jan 1994 – Dec 2005)</td>
<td>2</td>
</tr>
<tr>
<td>NELH (Jan 2000 – Dec 2005)</td>
<td>10</td>
</tr>
<tr>
<td>PsycINFO (Jan 1995 – Dec 2005)</td>
<td>16</td>
</tr>
<tr>
<td>Internurse (Jan 1995 – Dec 2005)</td>
<td>10</td>
</tr>
<tr>
<td>Igenta Connect (Jan 1997 – Dec 2005)</td>
<td>17</td>
</tr>
<tr>
<td>Dissertation Abstract</td>
<td>10</td>
</tr>
<tr>
<td>Sociological Abstract (Jan 1995 – Dec 2005)</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>239</strong></td>
</tr>
</tbody>
</table>
Appendix 4

Methodology [Literature used in the review]
<table>
<thead>
<tr>
<th>Author</th>
<th>Research/Literature Focus</th>
<th>Qual.</th>
<th>Quant.</th>
<th>Data collection method</th>
<th>Location</th>
<th>Sample size</th>
<th>Findings/Outcomes</th>
<th>Hierarchy of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akinsanya (1988)</td>
<td>What is the role of ethnic minority nurse, midwives and health visitors in the NHS?</td>
<td>✓</td>
<td>None</td>
<td>Literature review</td>
<td>UK</td>
<td></td>
<td>The review raised a number of issues in relation to the role of minority ethnic nurses in the NHS</td>
<td>5</td>
</tr>
<tr>
<td>Allan et al (2004)</td>
<td>Overseas experience of racism and discrimination</td>
<td>✓</td>
<td>Focus Group Interviews</td>
<td>UK</td>
<td>11 focus group interviews</td>
<td>A number of themes emerges such as racism as difference, defining racism, being white or foreign, defining discrimination, and coping with racism. Additionally the study revealed that overseas nurses experience racism and discrimination while working in the British health services.</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Allan and Larsen (2003)</td>
<td>To explore the motivations and experiences of nurses recruited from international countries</td>
<td>✓</td>
<td>Focus Group Interviews</td>
<td>UK</td>
<td>11 focus group interviews</td>
<td>There is a need to respect and value the experiences of international nurses. Furthermore support was necessary to ensure the transition went smoothly</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Alexis (2002)</td>
<td>An exploration of the importance of sensitivity to diversity and cultural differences is a key feature of</td>
<td>✓</td>
<td>None</td>
<td>Discussion paper</td>
<td>UK</td>
<td></td>
<td>Cultural differences should be seen as an asset rather than a problem. Systems are necessary to retain and recruit</td>
<td>5</td>
</tr>
<tr>
<td>Authors</td>
<td>Title</td>
<td>Methodology</td>
<td>Setting</td>
<td>Source Type</td>
<td>Summary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>---------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alexis and Chambers (2003)</td>
<td>Describes how a model of good practice can help to recruit and retain nurses of different nationalities and different minority ethnic backgrounds</td>
<td>✓ None</td>
<td>UK</td>
<td>Discussion paper</td>
<td>Valuing and being able to communicate with overseas nurses are crucial to recruit and retaining nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beishon et al (1995)</td>
<td>To explore the experiences of black and minority ethnic nurses in the NHS</td>
<td>✓ Interviews, survey</td>
<td>UK</td>
<td>14330 staff were involved in the postal survey and 150 interviews</td>
<td>Equal opportunities policies were not appropriately implemented in the NHS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buchon (2003)</td>
<td>To examine the employment policy and practice implications of the rapid growth in numbers of internationally recruited nurses working in the United Kingdom.</td>
<td>✓ Interviews</td>
<td>UK</td>
<td>10 case studies</td>
<td>It is clear that more guidance is needed on which countries were appropriate to recruit nurses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burner et al (1990)</td>
<td>To explore the cultural differences in nursing care.</td>
<td>✓ None</td>
<td>USA</td>
<td>Discussion paper</td>
<td>There are differences in nursing care in the western world</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calliste (1993)</td>
<td>To provide a discussion of Caribbean nurses migrating to Canada</td>
<td>✓ None</td>
<td>Canada</td>
<td>Discussion paper</td>
<td>Caribbean nurses have been marginalized and segregated in Canada</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canales (2000)</td>
<td>Proposes a theoretical framework for analysing how we engage with others</td>
<td>✓ None</td>
<td>USA</td>
<td>Discussion paper</td>
<td>Nurses must seek to be engaging in 'othering' efforts as it is through inclusion,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>UK</td>
<td>Data</td>
<td>Findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>----</td>
<td>------</td>
<td>----------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carter (2000)</td>
<td>To explore whether there is tension between the discourse of the new public management and equal opportunity</td>
<td>UK</td>
<td>Interviews and questionnaires</td>
<td>67% response rate and 50 interviews</td>
<td>Occupational segregation remains an integral part of the NHS. Equal opportunities policies were implemented haphazardly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chevannes (2001)</td>
<td>An examination of the recruitment of minority ethnic students to pre-registration programmes</td>
<td>UK</td>
<td>Secondary data on pre-registration nurses</td>
<td>4 case studies on pre-registration diploma students in learning disability, children, adult nursing and mental health</td>
<td>Four issues needed attention: equal opportunity, ethnic monitoring, staff training in policies and practices in relation to equal opportunity and education providers need to work towards ethnic diversity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cockburn (1989)</td>
<td>To review the potential of an equal opportunity orientation for progressive change within organisations</td>
<td>UK</td>
<td>Interviews and observations</td>
<td>55 women and men from 4 large organisations</td>
<td>Generally, equal opportunities policies are complex and difficult to achieve because equality is elusive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooke (1998)</td>
<td>To examine the views of overseas nurses visiting clinical areas in England and compared their views with the opinions of the host nurses and midwives</td>
<td>UK</td>
<td>Survey and interviews</td>
<td>7 overseas nurses [survey], 4 managers from the clinical areas and 2 managers from higher education institutions [interviews]</td>
<td>The study revealed that managers were euro-centric in their behaviour towards overseas nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cortis (2003)</td>
<td>An exploration of the concepts of culture, values and</td>
<td>UK</td>
<td>Discussion paper</td>
<td></td>
<td>There is a need to move away from the concept of culture as</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topic</td>
<td>Authors</td>
<td>Methodology</td>
<td>Participants</td>
<td>Findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>-------------</td>
<td>--------------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Racism as they relate to cancer nursing</td>
<td>Curtis and Rincomba (1996)</td>
<td>Discussion paper</td>
<td>UK</td>
<td>There needs to be a radical shift in the provision of equal opportunities in the NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An examination of multiculturalism in health care and education</td>
<td>Culley (1996)</td>
<td>Literature review</td>
<td>UK</td>
<td>Nurse educators must assist practitioners to identify ways in which they can listen to and work with minority communities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An examination of key research evidence about the work experiences of nurses from minority ethnic groups and the impact of equal opportunities policies</td>
<td>Culley (2001)</td>
<td>Evaluative paper</td>
<td>UK</td>
<td>There is a need to modernise equal opportunities policies and managers play a vital role in this agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To explore the extent of racism in Health Visiting</td>
<td>Culley and Leatham (2001)</td>
<td>Postal questionnaire and semi-structured interviews</td>
<td>UK</td>
<td>Racist attitudes and racist behaviour are common place in the NHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To explore the experiences of Caribbean nurses in the NHS</td>
<td>Culley et al (2001)</td>
<td>Interviews</td>
<td>UK</td>
<td>Racist was apparent in the NHS but was not attributable to all of their negative experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploring and describing issues surrounding young South Asian people into nursing and midwifery programmes</td>
<td>Daly et al (2003)</td>
<td>Focus groups, interviews, questionnaires</td>
<td>UK</td>
<td>Many would not encourage their children into nursing as it was considered a devalued profession in their culture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploratory</td>
<td>Daniel et al</td>
<td>Focus group interviews</td>
<td>UK</td>
<td>There are</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Study Title</td>
<td>Methods</td>
<td>Country</td>
<td>Design</td>
<td>Findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>---------</td>
<td>---------</td>
<td>--------</td>
<td>----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Study to determine the nature of the expectations and experiences of migrant nurses</td>
<td></td>
<td></td>
<td></td>
<td>Opportunities for promotion. There is a need for equality of opportunity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>The conflicting values between western and non-western countries</td>
<td>None</td>
<td>USA</td>
<td>Discussion paper</td>
<td>Differences in the values between western and non-western countries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>To describe the experiences of a group of immigrant women nurses regarding their lives and work in a culture than their own</td>
<td>Interviews</td>
<td>USA</td>
<td>10 semi-structured interviews</td>
<td>Cultural displacement, racial experiences and alienation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>To describe the current state of recruitment and retention in schools of nursing</td>
<td>None</td>
<td>USA</td>
<td>Discussion paper</td>
<td>Need for broad institutional support for all recruitment and retention of student nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>A critique of cultural education in nursing</td>
<td>None</td>
<td>USA</td>
<td>Literature review</td>
<td>Principles of transformative education as alternative to current approaches to cultural education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>To discuss racial discrimination in the British Medical Association</td>
<td>None</td>
<td>UK</td>
<td>1 participant Discussion paper</td>
<td>Indirect discrimination was apparent in the British Medical Association</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1988</td>
<td>Afro-Caribbean experiences of health, work and growing old in Britain</td>
<td>Interviews</td>
<td>UK</td>
<td>101 participants</td>
<td>Both positive and negative experiences in terms of health, work and growing old in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source</td>
<td>Methodology</td>
<td>Country</td>
<td>Sample Size</td>
<td>Findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flynn and Aiken (2002)</td>
<td>To determine if both U.S. and international nurses place high value on organisational attributes</td>
<td>USA</td>
<td>799 nurses (547 were born in the US and 252 were from 34 other countries)</td>
<td>The study showed that the absence of a positive professional practice environment may negatively affect nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gerrish and Griffith (2004)</td>
<td>To evaluate the programme an adaptation programme with reference to its objectives, outcomes and overall success from the perspective of various stakeholders</td>
<td>UK</td>
<td>17 overseas nurses were involved in the focus group interviews, 14 overseas nurses were recruited for the individual interviews. Interviews were conducted with the Assistant Chief Nurse, Recruitment Manager, Promoting Diversity Officer and three educationalists as well as two clinical support sisters.</td>
<td>Industrialised nations recruiting from the global nursing market need to invest in providing appropriate support to enable overseas nurses to adapt to working in a different health care system and social and cultural context.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greipp (1996)</td>
<td>To identify those psychosocial variables which enhance or inhibit their predicted reactions with clients</td>
<td>USA</td>
<td>268 female in a large urban hospital</td>
<td>The findings reveal that there are stereotyping and prejudices relative to client age, gender and culture in nurse-client interactions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grossman and Taylor (1995)</td>
<td>An examination of cultural diversity in nursing</td>
<td>US</td>
<td>Discussion paper</td>
<td>Cultural diversity is essential but there are differences in values of overseas nurses compared with...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference</td>
<td>Study Title</td>
<td>Methods</td>
<td>Location</td>
<td>Participants</td>
<td>Findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>---------</td>
<td>----------</td>
<td>--------------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hagey et al (2001)</td>
<td>To document and describe the experiences of immigrant nurses of colour</td>
<td>Interviews and focus group interviews</td>
<td>Canada</td>
<td>9 immigrant nurses</td>
<td>The findings revealed that immigrant nurses are marginalized and experience physical and emotional pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hall et al (1994)</td>
<td>An explication of marginalisation as a guiding concept for the development of nursing knowledge that values diversity</td>
<td>None</td>
<td>USA</td>
<td>Discussion paper</td>
<td>The relationship between marginalisation and vulnerability is clarified. The concept of valuing diversity is needed to ensure that marginalisation is minimised</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hall (1999)</td>
<td>A socio-political examination of marginalisation</td>
<td>None</td>
<td>USA</td>
<td>Discussion paper</td>
<td>Nurses have a responsibility to transform social structures in health care and they need to examine their euro-centric views, values and beliefs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hardill and Macdonald (2000)</td>
<td>To explore the experiences of overseas qualified nurses</td>
<td>Interviews</td>
<td>UK</td>
<td>16 overseas nurses were involved</td>
<td>The study illuminates the complex interweaving of economic and non-economic factors in migration decisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harris and Cummings (1996)</td>
<td>The importance of reflections on ethnocentrism and racism</td>
<td>None</td>
<td>US</td>
<td>Discussion paper</td>
<td>Advanced practice nurses could overcome ethnocentric and racist behaviour by reflection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrison (2003)</td>
<td>An examination of white staff experiences in the NHS</td>
<td>None</td>
<td>UK</td>
<td>Comments</td>
<td>Some strategic Health Authorities are failing to ensure that race equality</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

399
<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Participants</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Igiuski et al (1998/2001)</td>
<td>To investigate the establishment of positive action</td>
<td>Semi-structured interviews, survey</td>
<td>8 institutions were involved. (81 respondents were interviewed) There were discriminatory criteria applied when it came to equal opportunity</td>
</tr>
<tr>
<td>Jewson and Mason (1986)</td>
<td>An exploration of the conceptual characteristic of the practice of equal opportunities in the workplace</td>
<td>Interviews, field notes and observations</td>
<td>2 case studies (15% Black and Asian with 30% women) Inconsistent application of equal opportunities</td>
</tr>
<tr>
<td>Kagawa-Singer (1997)</td>
<td>To explore issues for early detection and screening in ethnic populations</td>
<td>None</td>
<td>USA Discussion paper Evidence showed that there is a lack of screening to detect illnesses in ethnic populations</td>
</tr>
<tr>
<td>Karlens and Nazroo (2002)</td>
<td>To understand ethnic inequalities in health</td>
<td>Survey and interviews</td>
<td>UK 5196 Caribbean and Asains and 2,867 Caucasians Ethnic identity was not related to health but showed strong relationships between health and experiences of racism</td>
</tr>
<tr>
<td>Keightley (2001)</td>
<td>Highlights Beverley Steven's experience to overcome difficult work situation</td>
<td>Interview</td>
<td>UK 1 black staff nurse Generally, Beverley was able to advance in her career and won a leadership awarded despite being of black origin</td>
</tr>
</tbody>
</table>
| Kendall and Hatton (2002) | Exploration of racism as a source of disparity | None | US Discussion paper A need for nurses and other health researchers to take the issues of race and racism more seriously if health disparities are to be
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Methodology</th>
<th>Location</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knight (2003)</td>
<td>Nurses from black and minority groups are often passed for promotion</td>
<td>UK</td>
<td></td>
<td>A need to acknowledge and promote nurses from black and minority groups</td>
</tr>
<tr>
<td>Koh (1997)</td>
<td>An examination of cultural stereotyping of black and minority people</td>
<td>UK</td>
<td></td>
<td>Black people should not be treated as a monolithic culture</td>
</tr>
<tr>
<td>Kushnick (1988)</td>
<td>Racism and stereotyping in the NHS</td>
<td>UK</td>
<td></td>
<td>Racism and stereotyping are ineffective in the NHS</td>
</tr>
<tr>
<td>Larsen et al (2005)</td>
<td>The study investigated the experiences and perspectives of overseas nurses in the UK</td>
<td>Focus Group Interviews</td>
<td>UK</td>
<td>Overseas nurses spoke of life changes and working holiday as well as the micro and macro aspects of working back home. Overseas nurses motivation to work in the UK was more than financial gain. Each Overseas nurse motivation to work in the UK is different to that of their counterparts and therefore further research is needed in this area.</td>
</tr>
<tr>
<td>Law (1997)</td>
<td>Exploration of the Opportunities for black and minority ethnic groups</td>
<td>UK</td>
<td></td>
<td>Black and minority ethnic groups need to be treated equally</td>
</tr>
<tr>
<td>Lee-Cunin (1989)</td>
<td>An exploration of black and Asian</td>
<td>Interviews</td>
<td>UK</td>
<td>Choosing nursing as a career was not</td>
</tr>
<tr>
<td>Schoolgirls views of entering the nursing profession</td>
<td>Leininger (1994)</td>
<td>An exploration of trans-cultural education</td>
<td>USA</td>
<td>Discussion paper</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----------------</td>
<td>-------------------------------------------</td>
<td>-----</td>
<td>-----------------</td>
</tr>
<tr>
<td>Macleod (2000)</td>
<td>To analyse the promotion process in higher education in the UK</td>
<td>Survey</td>
<td>UK</td>
<td>500 Academics</td>
</tr>
<tr>
<td>Magnusdottir (2005)</td>
<td>To generate an understanding of the experiences of foreign nurses</td>
<td>Unstructured interviews</td>
<td>Iceland</td>
<td>11 face-to-face interviews</td>
</tr>
<tr>
<td>Market and Opinion Research International (2002)</td>
<td>To examine the experiences of internationally recruited nurses from a range of countries</td>
<td>Survey</td>
<td>UK</td>
<td>1119 internationally recruited nurses</td>
</tr>
<tr>
<td>Martin et al (1994)</td>
<td>An exploration of conflict in multi-cultural nursing</td>
<td>None</td>
<td>UK</td>
<td>Discussion paper</td>
</tr>
<tr>
<td>Matiti and Taylor (2005)</td>
<td>To investigate the cultural experiences of internationally recruited nurses</td>
<td>Semi-structured interviews</td>
<td>UK</td>
<td>12 face to face interviews</td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Methodology</td>
<td>Setting</td>
<td>Findings</td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
<td>-------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>Mayor (1996)</td>
<td>To investigate the career experiences of leading minority ethnic nurses</td>
<td>Interviews and questionnaire</td>
<td>UK</td>
<td>88 participants (28 males &amp; 60 females)</td>
</tr>
<tr>
<td>Mellor et al (2001)</td>
<td>To determine whether situational or general knowledge of racism was evident</td>
<td>Observation and videotape</td>
<td>Aust</td>
<td>40 Asians and 40 Caucasians</td>
</tr>
<tr>
<td>Mwasasibhu (2000)</td>
<td>Discussing the challenges of mixing cultures</td>
<td>None</td>
<td>UK</td>
<td>Discussion paper</td>
</tr>
<tr>
<td>Omeri and Ahren (1999)</td>
<td>To explore and describe discoveries and discuss the importance of culturally meaningful strategies and knowledge as they relate to Aboriginal and Torres Strait Islander nurses</td>
<td>None</td>
<td>Aust</td>
<td>Literature review</td>
</tr>
<tr>
<td>Omeri and Atkins (1999)</td>
<td>To explore and describe the</td>
<td>Interviews</td>
<td>Aust</td>
<td>5 immigrant nurses</td>
</tr>
</tbody>
</table>

Many participants had negative experiences in their career development. Some Asians had identified racism where as some Caucasian did not.

There is a need to eradicate discrimination in the NHS for black and minority ethnic nurses.

Equal opportunities policies are needed, including training and development programmes for all staff.

Strategies are necessary to encourage nurse leaders who are involved in planning, coordinating and implementing curricula for nurses.

There is a need to develop trans-
<table>
<thead>
<tr>
<th>Year</th>
<th>Title</th>
<th>Methodology</th>
<th>Location</th>
<th>Study Type</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>cultural knowledge as a means to overcome cultural differences and break down mono-cultural nursing practices</td>
<td></td>
<td>UK</td>
<td>Discussion paper</td>
<td>The underrepresentation of black and minority people in health service roles</td>
</tr>
<tr>
<td>2003</td>
<td>Parish</td>
<td>The underrepresentation of black and minority people in health service roles</td>
<td>UK</td>
<td>Discussion paper</td>
<td>A need to recognise, promote and value black and minority ethnic nurses in the NHS</td>
</tr>
<tr>
<td>1999</td>
<td>Perreault and Bourhis</td>
<td>To manipulate the degree of in-group identification before the group discriminates.</td>
<td>USA</td>
<td>Experiment</td>
<td>There was a link between ethnocentrism and an autocratic style with inter-group behaviour</td>
</tr>
<tr>
<td>2003</td>
<td>Pekerti and Thomas</td>
<td>To examine the communication styles of East Asians and Anglo-European New Zealand</td>
<td>USA</td>
<td>Participant observations and interviews</td>
<td>The study revealed that task achievement required more time in the intercultural condition as compared to homogenous conditions</td>
</tr>
<tr>
<td>1989</td>
<td>Pilette</td>
<td>Description of four phases of adjustment</td>
<td>USA</td>
<td>Discussion paper</td>
<td>The complexities of adjustment and the importance of allowing overseas nurses time to adapt is crucial</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Research Question</td>
<td>Method(s)</td>
<td>Country</td>
<td>Data Sources/Details</td>
<td>Findings</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pudney and Shields (1997)</td>
<td>To analyse the promotions in process in NHS nursing</td>
<td>✓ Survey</td>
<td>UK</td>
<td>91 NHS employers in England [741 male and 8178 female]</td>
<td>There is clear evidence that whites are promoted quicker than blacks and Asians</td>
</tr>
<tr>
<td>Purcell (2002)</td>
<td>Exploration of black and minority academics in further education</td>
<td>✓ None</td>
<td>UK</td>
<td>Discussion Paper</td>
<td>Colleges and universities will have to promote race equality in their institutions</td>
</tr>
<tr>
<td>Ramadan (2000)</td>
<td>To explore cultural safety in New Zealand</td>
<td>✓ None</td>
<td>New Zealand</td>
<td>Discussion paper</td>
<td>Society needs to change and embrace cultural diversity</td>
</tr>
<tr>
<td>Ross et al (2005)</td>
<td>To predict the international migration of nurses to the UK using widely available data on country characteristics</td>
<td>✓ The NMC, World Bank and World Health Organisation</td>
<td>UK</td>
<td>165 countries during the period from 1998 to 2002 using a test regression analysis</td>
<td>Policy makers should address the impact of recruitment on source country health service delivery.</td>
</tr>
<tr>
<td>Sawley (2001)</td>
<td>To establish whether pre-registration nursing curriculum prepares students for working with minority ethnic groups</td>
<td>✓ ✓ Questionnaires and comments on each question</td>
<td>UK</td>
<td>1035 students and 303 lecturers</td>
<td>42% of students heard racist comments as opposed to 35.7% for lecturers. Both students and lecturers felt that racist attitudes mainly stemmed from ignorance and the lack of knowledge</td>
</tr>
<tr>
<td>Sheldon and Parker (1992)</td>
<td>An exploration of culture as it relates to South Asians</td>
<td>✓ None</td>
<td>UK</td>
<td>Discussion paper</td>
<td>Culture is complex and homogenising this term leads to generalisation and stereotyping</td>
</tr>
<tr>
<td>Singh (2002)</td>
<td>An exploration of the tension inherent in individual rights and</td>
<td>✓ None</td>
<td>UK</td>
<td>Discussion paper</td>
<td>Some groups rights have had adverse effects upon members of disadvantaged</td>
</tr>
</tbody>
</table>

405
<table>
<thead>
<tr>
<th>Study</th>
<th>Objective</th>
<th>Methodology</th>
<th>Sample Size</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith (2004)</td>
<td>To explore the perceptions of overseas nurses during their induction programme</td>
<td>Semi-structured taped interviews</td>
<td>20 overseas nurses from India</td>
<td>Communication issues, role definition and feelings of self-worth. The findings suggest that there is a need for greater understanding of the adjustment process and integration of overseas nurses into the workforce.</td>
</tr>
<tr>
<td>Sprangler (1992)</td>
<td>To discuss the trans-cultural care values and nursing practices in the Philippines-American nurses</td>
<td>None</td>
<td>USA</td>
<td>Discussion paper</td>
</tr>
<tr>
<td>Sutherland (2002)</td>
<td>To clarify the meaning of ethnocentrism</td>
<td>None</td>
<td>USA</td>
<td>Discussion paper</td>
</tr>
<tr>
<td>Taylor (2005)</td>
<td>To examine the views and experiences of nurses who have trained overseas and travelled to work in the NHS</td>
<td>Participant observation and focus group interviews</td>
<td>UK</td>
<td>13 eight hour shifts of participant observation were conducted and this was followed by using 11 overseas nurses who were involved in the focus group interviews</td>
</tr>
<tr>
<td>Thiederman</td>
<td>To explore</td>
<td>None</td>
<td>USA</td>
<td>Discussion paper</td>
</tr>
<tr>
<td>Year</td>
<td>Research Focus</td>
<td>Methodology</td>
<td>Country</td>
<td>Ethnicity</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>1986</td>
<td>Ethnocentrism in healthcare resulted in ineffective health care for black and minority ethnic groups.</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>An exploration of nurses migrating to Canada and experienced racism.</td>
<td>Interviews</td>
<td>Canada</td>
<td>Not Known</td>
</tr>
<tr>
<td>2002</td>
<td>To identify how differences in people's attitudes play a role in their intended behaviour towards ethnic minority.</td>
<td>Survey and interviews</td>
<td>Dutch</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>To determine the value of mentoring and networking in an organization.</td>
<td>None</td>
<td>UK</td>
<td>Discussion paper</td>
</tr>
<tr>
<td>2005</td>
<td>To examine the experiences of recently internationally qualified migrant nurses to Britain and explores their stories with the aim of understanding aspects of their work-related identities.</td>
<td>Semi-structured interviews and a survey</td>
<td>UK</td>
<td>22 semi-structured interviews and 140 respondents participated in the survey</td>
</tr>
<tr>
<td>Authors</td>
<td>Objective</td>
<td>Methodology</td>
<td>Location</td>
<td>Sample</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td>Withers and Snowball (2003)</td>
<td>To explore the experiences and expectations of Filipino nurses in the UK</td>
<td>Interviews and survey</td>
<td>UK</td>
<td>8 interviews and 45 responses for the survey Ward managers were friendly and supportive however, racial discrimination was apparent for some Filipino nurses</td>
</tr>
<tr>
<td>Yi and Jezewski (2000)</td>
<td>To understand how Korean nurses adjust to USA hospital settings</td>
<td>Semi-structured in-depth interviews</td>
<td>USA</td>
<td>12 Korean nurses The study indicated a series of obstacles Korean nurses faced, the kinds of support they needed and the strategies they used to adjust to USA hospitals</td>
</tr>
</tbody>
</table>
Appendix 5

CASP TOOL
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 6

Oxman and Guyatt’s Appraisal Tool
General questions to consider when analysing reviews

Have the reviewers presented a method for their review?
Are the review questions detailed?
Is the search for studies thorough?
Have appropriate studies been identified/selected?
Have the studies been critically appraised?
Do the reviewers detail the content of the studies?
Does the review answer the question set?
Do the conclusions link to the evidence presented?
Are the recommendations for practice made?
Who did the review?
Who funded it?

Based on Oxman and Guyatt’s (1991)
Appendix 7

University of Surrey Ethics approval letter
Dear Mr Alexis

The experiences of overseas black and minority ethnic nurses in the NHS in the South of England (ACE/2003/17/EIHMS)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed and the following conditions are met:-

1. That approval from the Local Research Ethics Committee is obtained prior to commencing this research.

2. That the letter to Dr Isaac John is amended, as it should be addressed to Dr Issac John and not Dr John Issac.

For your information, and future reference, the Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2003/17/EIHMS). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

I should be grateful if you would confirm in writing your acceptance of the conditions above, forwarding the amended documents for the Committee’s records.
Date of approval by the Advisory Committee on Ethics: 15 May 2003
Date of expiry of approval by the Advisory Committee on Ethics: 14 May 2008

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
    Dr V Vydelingum, Supervisor, EIHMS
Appendix 8

North and Mid Hampshire Local Ethics Committee letter
Dear Mr Alexis

03/B/027 – The experiences of overseas black and minority ethnic nurses in the NHS in South of England

Following the conditional approval, I am pleased to confirm full approval having responded satisfactorily to the committee’s concerns.

The following documents were re-considered:

- Letter dated 27th June 2003
- Protocol, v.2, June 2003
- Information Sheet for overseas nurses for the interview, v.2, June 2003
- Information Sheet for British based nurses for the observation episode, v.2, June 2003
- Information Sheet for overseas nurses for the focus group interview, v.2, June 2003
- Information Sheet for patients, v.2, June 2003
- Information Sheet for overseas nurses for the observation episode, v.2, June 2003
- Consent Form for British based nurses (observation), v.2, June 2003
- Interview Consent form for overseas nurses, v.2, June 2003
- Consent form for observation for overseas nurses, v.2, June 2003
- Focus Group Interview Consent Form for overseas nurses, v.2, June 2003
- Consent Form for Patients (Observation), v.2, June 2003

This approval was granted under Chair’s action and will be recorded by the committee at their meeting in July.

I must emphasise that whilst the committee look at work on ethical grounds, it is up to the Trust to finally sanction the work, taking into account financial and other implications.

To comply with good practice a list of members at the June 2003 meeting is enclosed.

The committee wish you every success with the study. The following conditions apply to all approvals:

(a) that you notify the LREC immediately of any information received or of which you become aware which would cast doubt upon, or alter, any information contained in the original

Chair Biomedical LREC: Mrs Jane Ogden-Swift
Chair Qualitative LREC: Rev’d Dr Rosemary Baker

Chairman: Peter Bingham
Chief Executive: Gareth Cruddace
application, or a later amendment application, submitted to the LREC and/or which would raise questions about the safety and/or continued conduct of the research.

(b) you need to comply with the latest Data Protection Act and Caldicott Guardian issues.

(c) you need to comply throughout the conduct of the study, with good clinical research practice standards, including obtaining informed consent.

(d) you need to refer proposed amendments to the protocol to the LREC for further review and to obtain LREC approval thereto prior to implementation (except only in cases of emergency where the welfare of the subject is paramount).

(e) you must supply an annual summary of the progress of the research project and of the conclusion and outcome of the research project and inform the LREC should the research be discontinued. Research terminated prematurely must be reported to the REC within 15 days with the reason for the termination. Final reports must be received within three months.

(g) that satisfactory indemnity arrangements agreed with the Trust are in place before the study commences.

The committee is fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) Guidelines for the Conduct of Trials involving the participation of human subjects as they relate to the responsibilities, composition, function, operations and records of an independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997.

Yours sincerely

Rev'd Dr Rosemary Baker
Chair – Qualitative and Non-invasive Committee

enc June meeting members
APPENDIX 9
MAIN INTERVIEW PROFORMA 3
MAIN INTERVIEW PROFORMA 3

Introduction
Explain the purpose of the study.
Any questions/queries/concerns the participant may have in relation to the study will be answered.
Gain permission to use the tape recorder before starting the interview.
Background information: Male/ Female, Age, Country of origin
How long have you been working for the NHS?

Motivation Process
Can you tell me about your past hospital employment experience prior to coming to the UK?
What was it like to work in your country?
Can you tell me what has led you to come to the UK to work?

Work Environment
Could you tell me what were your initial impressions of working in the UK?
How different is it when you compare working in the UK to your country?

Probe:
Can you tell me about:
- your shift pattern during a normal working day?
- how patients are allocated to you?
- how your off duty rota is done?

Can you tell me how have you been treated by your
- work colleagues?
- nurse manager?
- patients?

Infrastructure
Can you tell me about the support available in your workplace?
Probe: When you are in the work place, whom do you turn to when you are in need of help?
Can you tell me how welcome you are made to feel in your area of work?
What form does this welcome take?
How integrated do you feel as part of the health care team?
How effective equal opportunity policies are in your workplace?

**Education and Training**
Can you tell me about your training and development you have had since working in the NHS?
What training and development opportunities are available to you in your place of work?
What do you feel are your training and development needs?
What opportunities are there for you to advance in your workplace?
chosen career?
Can you tell me about your staff development appraisal you have had since working for the NHS?

**Socio-cultural**
What provision is there in your workplace to help you to adapt to a new culture?
What provision is there to help you with your language and communication needs?
What information if any, were you given on how to make contact with relevant organisations that might help support you in a new environment?
What provision is there to direct you to local facilities where you can purchase ethnic food and goods?

**General Questions**
When you think back about your experiences as an overseas black and minority ethnic nurse, can you think of an incident that stands out in your mind?

Is there anything else about your experience you feel you have not covered, which you would like to share with me?

Thank you for participating in this study.
Appendix 10

Information sheet for overseas nurses for the interview
Information sheet for overseas nurses for the interview

Date.......... No........

Title: The experiences of overseas black and minority ethnic nurses working in the NHS in the South of England

I would like to take this opportunity to kindly ask if you would volunteer to take part in this research study. Before you decide it is important for you to understand why I am conducting this research and what it will involve. Please take your time to read the following information carefully. You can discuss the research study with your partner, spouse, friends and relatives if you wish. This research is part of a Doctor of Philosophy and will be taped. Please feel free to ask me if there is anything that is not clear or if you would like further information. Please take your time to decide whether or not you wish to take part.

Thank you for taking the time to read this.

Since the inception of the National Health Service (NHS) in 1948, black and minority ethnic nurses have played a significant role in its development. From the 1960s to date, black and minority ethnic nurses have been recruited from overseas to meet the nursing shortages. There has been little research conducted in this area and most of
the information about the treatment of overseas black and minority nurses has been anecdotal. Therefore, the aim of this study is to explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses who are working in the National Health Service in England.

You have been chosen because you are currently working in either, general surgery, orthopaedic, intensive care unit or theatres. The decision to take part is entirely yours. If you do decide to participate you will be given this information sheet to keep and will be asked to sign and retain a copy of the consent form. Even if you do decide to take part in this study, you can withdraw at any time, without giving a reason.

This study will take approximately 3 years to complete. During such time you will only be involved in the interview. I will interview you at a mutually agreed location and the interview should last no longer than an hour and a half. However, if further clarification is needed, I may need to contact you again. You are not obliged to participate further in this study after the initial contact. If you feel unhappy to offer any more information about your experiences, please feel free to object.

The information I will collect from you, about your experiences during the course of the research, will be kept strictly confidential. The information will be handled in accordance with the Data Protection Act [1998]. You will remain anonymous in any report or publication.

The University of Surrey Research Ethics Committee, North West Surrey Local Research Ethics Committee and South West Research Ethics Committee have reviewed and approved the proposal for the study to be conducted.

Should you have any queries, please do not hesitate to contact me.
My contact details are:

Name: Obrey Alexis

Address: European Institute of Health and Medical Sciences
Duke of Kent Building
University of Surrey
Guildford
GU2 7XH

Telephone Nos: 01483 684545
07751774752 (Mobile)

Email address o.alexis@surrey.ac.uk

My supervisor’s details are:

Name: Dr. Vasso Vydelingum

Address: European Institute of Health and Medical Sciences
Duke of Kent Building
University of Surrey
Guildford
GU2 7XH

Telephone No. 01483 686707

Email address v.vydelingum@surrey.ac.uk

Many thanks for taking part in this study.
Appendix 11

INTERVIEW CONSENT FORM FOR OVERSEAS NURSES
INTERVIEW CONSENT FORM FOR OVERSEAS NURSES

THE STUDY: The experiences of overseas black and minority ethnic nurses working in the NHS in the South of England.

Please initial here

I, the undersigned, voluntarily agree to take part in the above study.

I have read and understood the overseas nurses’ interview information sheet provided and dated........(version......) for the above study and have had the opportunity to ask questions.

I have been given a full explanation by the researcher of the nature, purpose, location and the likely duration of the study and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to comply with any instruction given to me during the interview and to cooperate fully with the researcher.

I understand that all personal data relating to me is held and processed in the strictest confidence, and in accordance with the Data Protection Act [1998]. I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I realize that I am free to withdraw from the study at any time without the need to justify my decision and without prejudice.
I understand that I may experience some inconvenience due to the time involved in
the study. On the other hand, I realize that I may find it beneficial and satisfying to
talk about my experiences. I also appreciate that I will have the opportunity to discuss
this topic with the researcher. I understand that this study may provide some useful
information about the way in which the NHS caters for the needs overseas nurses.

I understand that the University of Surrey holds insurance, which covers claims for
injury or deterioration in health which arise directly from participation in clinical
trials but that it applies only in those situations where the University can be shown to
be legally liable.

I confirm that I have read and understood the above and freely consent to participate
in this study. I have been given adequate time to consider my participation and agree
to comply with the instructions and restrictions of the study.

Name of participant (BLOCK CAPITALS): ....................................................
Signature:............................................................................................................................
Date: ..............................................................................................................................

Name of witness (BLOCK CAPITALS): ....................................................
Signature:............................................................................................................................
Date: ..............................................................................................................................

Name of Researcher (BLOCK CAPITALS): ....................................................
Signature:............................................................................................................................
Date: ..............................................................................................................................
Appendix 12

Main Focus Group Interview Proforma
Focus Group Interview Proforma

Aim: To discuss issues based on your experience as overseas black and minority ethnic nurses in the NHS.

Venue: Convenient location with some degree of privacy
Duration: 1-2 hours
No. of participants: 6-10 overseas black and minority ethnic nurses
Facilitator: Obrey Alexis and Observer: A qualified professional

Guidelines for undertaking focus group interviews.

1. Introduction and welcome by the facilitator.
2. Brief overview of the project and a copy of the information sheet
3. Consent from participants.
4. Ground rules for the interview:
   - Confidentiality will be adhered to at all times.
   - Allowing others to have their say.
   - Views of participants will be respected and valued.
   - You are under no obligation to divulge any information you are not happy with.
   - In the event that someone breaks down emotionally, the interview will be discontinued. Counselling will be offered or the individual will be directed where help is available.
5. Permission to use the tape recorder will be sought.
6. Focus group discussions: discussion will be based on the themes identified within this project.
7. Summing up and thanking the participants for taking part
Activity

A game: Participants will be given a sheet, which is big enough for all of them to stand on. Whilst standing on the sheet they will be kindly asked to turn the sheet onto the other side without stepping off it.

Theme 1: Unfamiliar World and the NHS

Discussion: How important migrating to the UK is for you?
How important to you is preparation for a new culture and why?
What do you think of the NHS having to employ overseas nurses?
In your everyday work in the NHS, are there issues that might affect your ability to function as a staff nurse?

Theme 2: Marginalisation and inequalities

Discussion: What do you understand by the terms black and minority ethnic?
What does discrimination mean to you?
Have you ever been discriminated prior to coming to the United Kingdom?
If yes, what effect did it have on you as an individual?
How did you cope with it at the time?
Have you ever been discriminated since arriving to work in the NHS in the United Kingdom?
If yes, what effect did it have on you as an individual?
How do you cope with it now?
Why do you think unequal treatment exists?
Have you an instance or instances where you felt as an overseas' nurse?
Have you had experiences of being treated as an ‘outcast’?

Theme 3: Surviving in the NHS

Discussion: Can you tell me how important professional development is to you?
What would you say is necessary to survive in the NHS?
How important are these qualities to you?
What do you value most about your everyday experience of working in the NHS?

Thanking the participants for taking part

NB: Within each theme, participants will be given the opportunity to discuss each question at length before moving onto the next one.
Appendix 13

FOCUS GROUP INTERVIEW CONSENT FORM
FOR OVERSEAS NURSES
FOCUS GROUP INTERVIEW CONSENT FORM
FOR OVERSEAS NURSES

THE STUDY: The experiences of overseas black and minority ethnic nurses working in the NHS in the South of England.

I, the undersigned, voluntarily agree to take part in the above study.

I have read and understood the focus group interview information sheet provided and dated............... (version....... ) for the above study and have had the opportunity to ask questions.

I have been given a full explanation by the researcher of the nature, purpose, location and the likely duration of the study and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to comply with any instruction given to me during the focus group interview and to co-operate fully with the researcher.

I understand that all personal data relating to me is held and processed in the strictest confidence, and in accordance with the Data Protection Act [1998]. I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I realize that I am free to withdraw from the study at any time without the need to justify my decision and without prejudice.
I understand that I may experience some inconvenience due to the time involved in the study. On the other hand, I realize that I may find it beneficial and satisfying to talk about my experiences. I also appreciate that I will have the opportunity to discuss this topic with the researcher. I understand that this study may provide some useful information about the way in which the NHS caters for the needs overseas nurses.

I understand that the University of Surrey holds insurance which covers claims for injury or deterioration in health which arise directly from participation in clinical trials but that it applies only in those situations where the University can be shown to be legally liable.

I confirm that I have read and understood the above and freely consent to participate in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of participant (BLOCK CAPITALS):

Signature:

Date:

Name of Researcher (BLOCK CAPITALS):

Signature:

Date:
Appendix 14

North and Mid Hampshire Local Research Ethics Committee Approval Letter

for the focus group interviews
Dear Mr Alexis

03/B/027 – The experiences of overseas black and minority ethnic nurses in the NHS in the South of England

Multisite Approval for the survey in the South of England

In connection with the paperwork received on 20th January 2005 requesting approval for the survey – the final stage of your study, I can confirm that the committee is happy for you to proceed with the survey within multisite domain in the South of England.

Yours sincerely

JANE OGDEN-SWIFT
Chair
North and Mid Hampshire Local Research Ethics Committee
Appendix 15

Information sheet for overseas nurses for the focus group interview
Information sheet for overseas nurses for the focus group interview

Date........... No........

Title: The experiences of overseas black and minority ethnic nurses working in the NHS in the South of England

I would like to take this opportunity to kindly ask if you would volunteer to take part in this research study. Before you decide it is important for you to understand why the research is being conducted and what it will involve. Please take your time to read the following information carefully. You can discuss the research study with your partner, spouse, friends and relatives if you wish. This research is part of a Doctor of Philosophy and will be taped. Please feel free to ask me if there is anything that is not clear or if you would like further information. Please take your time to decide whether or not you wish to take part.

Thank you for taking the time to read this.

Since the inception of the National Health Service (NHS) in 1948, black and minority ethnic nurses have played a significant role in its development. From the 1960s to date, black and minority ethnic nurses have been recruited from overseas to meet the nursing shortages. There has been little research conducted in this area and most of
the information about the treatment of overseas black and minority nurses has been anecdotal. Therefore, the aim of this study is to explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses who are working in the National Health Service in England.

You have been chosen because you are currently working in either, general surgery, orthopaedic, intensive care unit or theatres. The decision to take part is entirely yours. If you do decide to participate you will be given this information sheet to keep and will be asked to sign and retain a copy of the consent form. Even if you do decide to take part in this study, you can withdraw at any time, without giving a reason.

This study will take approximately 3 years to complete. During such time you will only be involved for the length of time the focus group takes. I will interview you at a mutually agreed location and the interview should last no longer than two hours and will be held at an appropriate venue suitable for you. However, if further clarification is needed, I may need to contact you again. You are not obliged to participate further in this study after the initial contact. If you feel unhappy to offer any more information about your experiences, please feel free to object.

The information I will collect from you, about your experiences during the course of the research, will be kept strictly confidential. The information will be handled in accordance with the Data Protection Act [1998]. You will remain anonymous in any report or publication.

The University of Surrey Research Ethics Committee, North West Surrey Local Research Ethics Committee and South West Research Ethics Committee have reviewed and approved the proposal for the study to be conducted.

Should you have any queries, please do not hesitate to contact me.
My contact details are:

Name: Obrey Alexis

Address: European Institute of Health and Medical Sciences
Duke of Kent Building
University of Surrey
Guildford
GU2 7XH

Telephone Nos: 01483 684545
07751774752 (Mobile)

Email address o.alexis@surrey.ac.uk

My supervisor's details are:

Name: Dr. Vasso Vydelingum

Address: European Institute of Health and Medical Sciences
Duke of Kent Building
University of Surrey
Guildford
GU2 7XH

Telephone No. 01483 686707

Email address v.vydelingum@surrey.ac.uk

Many thanks for taking part in this study.
Appendix 16

FACE TO FACE INTERVIEW WITH PERSON J
INTERVIEW WITH PERSON J
Interview held on 13th January 2004 at 20.00 pm at Person J’s home

Background information:
Country of origin: Philippines
Sex: Female
Age: 30 years
Qualifications: Bachelor of Nursing Science (Philippines) and Registered General Nurse (Philippines and UK)

Experience in home country: 5 years working on a surgical ward
Experience in the UK: 3 years
Grade in the NHS: Grade D

OA: Can you tell me about your past hospital experience prior to coming to the United Kingdom?

P I worked for close on five years in the district hospital in the Philippines and a 400 bed capacity hospital. However – I mean the surgeons and the people that I worked with [...] and the mortality rate and the survival rate for patients but despite that the economy basically didn’t really provide the fulfilment that I was looking for in terms of growth and development of my career. At the same time again the economy wouldn’t give us the support we need to help out with the family basically, sending the siblings to school, and all sorts of things. So the opportunity came for nurses to work overseas [...] here in England or some states but primarily here in England because they were mass hiring them and the paper work necessarily was that massive compared to if you were to leave for the States. So I eventually landed up here in England for further growth and development at the same time, economic.

OA: So when you came to work in the United Kingdom in this particular hospital that you are working in at the moment could you tell me what were your initial impressions of the National Health Service?

P I really didn’t have a clear cut picture of how different British kind of nursing is. Because as you probably know where I came from it is pretty much part of the States where we have nursing assistants and we basically carry out orders – doctors orders and I think that is the most important part of the job. However when I came over here the impression that I had was this hospital was big and enormous and quite – it was intimidating really because I had to go through the process of getting used to the accent and way they did the nursing – the culture – the culture of the nursing profession over here. So in a way it was very intimidating to begin with. And on top of that we were very few I would think and the people that I worked with had expectations from me which I really didn’t know if I exceeded their expectations or I was way below what they expected me to be so – it was never clear cut. I mean we were there basically to fill in numbers
or specific needs or areas of learning, and weaknesses or strengths were never really stressed. They would give a good pat on the back but really for what purpose because the shift went well period. So ... the individualised learning goals like or learning needs of a new comer to the hospital that was totally missed out.

OA: So you talk about the culture being different, in what way is the culture different then?

P I think the nurses here are a bit more independent of the doctors orders. Equal footing I would say. Somehow the good part of it is they see themselves as equal footing to the doctors. However in terms of them being very assertive and stuff like that however I wonder if I am now trying to recall my very first few days over in England where I worked. I was just trying to recall whether the assertiveness was there to protect the patient in terms of it is the management of the patient correct. Is it heading for the right direction. Or is it more like the clerical job that the doctors – that these nurses were after – like filling in fluid sheets or may be this patient wanting to go home and stuff like that. I am not so sure whether the assertiveness of the nurses were directed on the – it was patient centred or was more for themselves really. They want to get the top guns or...

OA: What I am going to ask you now tell me about your story. What is like to actually work for the National Health Service?

P Well it was in this country where I – I really took interest in taking further studies like specialising in an area and stuff like that so I think that is a good thing. Back home it is very rarely – the nurses are very rarely given an opportunity – especially for a newcomer. You have to be may be back home you have to be assertive and they will give you grants. However over here they have like you know they do open up areas where you can improve yourself like cannulation and stuff. However, there is – we are pressured to somehow behave in a certain way like we are some how it would raise their eyebrows if we were to be assertive or refuse – we are finding it difficult to refuse requests from them, like shifts, things like those. They sometimes would see it differently if we were to question things that they want us to do. That is I how I feel personally.

OA: Why is that?

P I don’t know. I am not so sure really. I mean if it were somebody else of different origin may be they would think okay she is just being assertive but if it were somebody coming from my country I sometimes feel a sense that they would black as whiners or moaners or people who just were rebellious by nature. So I don’t know. I just feel like that. We are really expected to just follow orders I suppose. In the way of harmony I don’t know. That’s the attitude that we have I am not so sure. If we were like to challenge them in a way they would probably find it very very difficult taking a challenge from us that is how I feel.
You mention the opportunity to go on courses in your story. I just want to explore that aspect further. What sort of courses have you been on since working for the National Health Service?

I have been to two already. One was Care of the Critically Ill patient. The second one that I am on now is principles of cancer care. So in the three years that is how far my extra readings have got to. The second course that I was it took me a while to get into the course. I don't know – I had to read for a year for approval and this was an up hill battle.

Was that a problem in terms of having to wait for a year?

I think so. Because the first person I spoke with left his job. And I don't know who he handed that over to. It just got lost in the system and I had my second appraisal for the year 2003 and it was the only time that application was re-opened and my assessor pushed for it. So... I don't know that was very suspicious how it came to be missed really. There were other people whom I knew went ahead with the course. I should have really been with them. But I did not get the opportunity to do so.

What other training needs or development do you feel that you need in order to perform your job properly then?

I think my first course would mostly cover the basic things that I need to know and I suppose the hands on experience of your day to day exposure to the unit where you work is good enough for me. I mean we also have like – not lecture days – study days – one day a study day on glucometer – using glucometers and stuff like that which is sponsored by the hospital themselves. They are abundant. So I think that would cover the basic things that I need so far. Management training – I don't see myself really undergoing any management training for now. I am way below that. The echelon of management if you like.

Why do you think that is?

I don't know. There are more senior nurses than I am to begin with. Far more experienced than I am in this area that I work in. So... what annoys me – may be I see more senior nurses that I am being by passed for newcomers.

What sort of newcomers?

Newcomers like – being promoted – taking the E. grades when they some of my D grade colleagues have been there since year one and their arrival and may be are most qualified to assume the role. They are really well experienced but I don't know if anyone is pushing them to apply for the E grade post or it is just them saying – refusing the offer or... I don't know.
OA: And who might these newcomers be then?

P: Well they are – specific examples – English nurses. I haven’t seen any E grade staff of coloured origin that has by-passed the current staff. I just don’t know with the new batch of nurses coming in.

OA: So what opportunities are there for you to advance in your work place then?

P: Pretty much the same stuff, courses, lectures. They are the only in-service courses they do offer to develop yourself.

OA: The reason I ask this question is because I am sensing that you know people who have been by passed for promotion. So my question is, how effective are equal opportunity policies in your place of work?

P: I have no idea. How equal would that be. Well – I really couldn’t say because I obviously do not know what the qualifications are. I mean these E grades who have come in these newcomers what their qualifications are like. And what the qualifications are – I cannot see from some experience of the people that I work with can be promoted to an E grade because the management that they give their patients is equally good as any F grade – as any well experience F grade. Here is a newcomer who really wouldn’t know a thing – that is I don’t know – I think that becomes their edge because they can speak better, they can express themselves better, being English their national language and stuff so. I guess it is in their culture not to be so I don’t know – it would be I think not really rude but it would be so forward for somebody coming to the Philippines to like aspire for a higher post when it is not being offered to them. It wouldn’t like – they probably have their own audience but they wouldn’t put it into action not unless they know they have a lot of support behind them. Being really pushed and stuff. So…. it is very sad because you can really see the difference between new E grade – newcomer E grades and long time D grade staff. You can see the output of the job in things like those. So I am not so sure how longer they are going to proceed with that procedure. I mean how their treatment is like and how long they will continue treating these D grades as the scum of the earth.

OA: Can you tell me why have they been by-passed for promotion?

P: I am not so sure. It could be that the opportunity has cropped up and may be they are just too embarrassed or shy to go for the job – for the post. I am not so sure. Or it was never offered to them in the first place and then there is lack of information, dissemination on the part of management to like have resources within the acute ward itself. Like oh this person has been here let’s review his capabilities. I think he has what it takes to be an E grade let’s offer the post to him. In the same way that I would be offering the E grade post to outside applicants. I am not so sure whether that has actually been the case and it was on
the part of this D grade who has been refusing the offer or but it is unlikely I think it has never been offered to them.

OA: Have you noticed whether it has been offered to someone else?

P It might have ... I can speak for the F grade post.

OA: That is fine.

P I think it has been offered to some other people internally. One actually another Filipino. And well he didn't get the post so... I think it has been offered for that F grade post, but for the E grade post I don't think that it has ever been the case that it has been offered to the D grades, several of the D grades that I know of who were very much capable of being E — assuming the E grade post. I don't think it has ever been offered to them.

OA: Okay then, can you tell me how have been treated by your work colleagues?

P I think it goes through a stage of you know you being observed and ignored until you have proven yourself over a period of time. Or a comment about how well you have performed in your job. It goes through a stage. Initially it was all eyes are on you when you come in. I don't know if they are waiting for you to make mistakes and they can blow it out of proportion or what, but yes at first you feel like you are being watched all the time. And whether it is a good thing or a bad thing I am not so sure. Then the next process to go through is probably you being able to actually — I mean be really comfortable in asking for their help without feeling stupid really for asking those questions and stuff — that sense of may be trust develops and then finally you just get treated as one of the guys and most often they still hope and they still expect you to be the most flexible person in the world. Like I don't know may be going on first break and stuff all the time. Or you know doing whatever they say without questioning their orders may be they still expect you to be that kind of person. I don't know if it is just particular for my people but somehow I feel — I mean I personally do feel it — I mean favours that they ask of you. You would always be like that person who would be expected to say yes maam.

OA: For example what sort of favours?

P Going to work in a different environment. They are really pleased for me to work there. However, regardless of whether you are Filipino or you are an English people or whatever your race is everyone should take their turn. Most of the people that they ask to work in this particular area would either be me or somebody who has always been there before and then they know that we have had enough of working in this acute area. You are always asked to go for a break first of all even if you are not ready, even if you still don't want to, you are still asked to, or may be to be flexible in terms of your shift. If they need a person for this
time and just like now I got a phone call from this area asking me to work tonight instead of Sunday night so things like those. I mean I am sure – I hope they don’t take it personally if you say no to these requests but some how you feel that they resent you for saying no to what they have asked you. Things like those.

OA: You also mentioned that you feel sometimes as though you are being watched all the time. How does that make you feel?

P I mean it is good if you are being watched in a supportive way. They sometimes do it in a way that makes you suspicious you know like they are really waiting for you to make a mistake and then it is the end of your nursing career. They are just waiting for you to like fall. So I mean the supervision isn’t in a very supportive way. That is the problem. There are areas of that kind of watching over you sort of thing. Or the other extreme is that they totally ignore you. And do your stuff and there is nobody to validate if you are heading for the right direction or not. So in terms of you managing the patients. Yes. I think those are the horrible funny experiences that I do go through on a day-to-day basis when I am working in the hospital.

OA: So you mention that the support is not there, tell me more about this?

P There was a time when this new nurse came in and she usually works in another area and she was going to work on this acute area for a day or something and the sister was – the sister was there explaining to her all the things that she needed to know and I was – I found myself in the same position before. It wasn’t like that at all. Nobody came to say that this is what you need to know, and this is what you need to do. I had to learn things on my own. I don’t know why that could have happened, but there is always the discrepancy of how much support they give the people who are not of the same racial origin that I am.

OA: So you think there is a difference do you?

P Yes, I think so yes. As to whether they trust us more, that they think we can cope better and the English nurses don’t I am not so sure. But it does exist. It does exist.

OA: And how does that make you feel?

P Fascinated actually because I am not so sure what their motives are. I always have the attitude – the blame culture attitude I think and we are always – [...] and stuff like that. It makes you wonder, it makes you wonder, where how much loyalty are you supposed to give to your job. If they don’t look after the staff well enough to – what is the point in staying in the job for as long as you ever live. There are good people on the job but when you see those differences in the way you are treated, that is the trouble, that is when you just want to leave the place and look for another place to work in.
OA: Is that the way you feel?

P Well right now, because I don't know, I still do not see myself staying here for a very long time. I would like to move on to another hospital and see what the culture is like — the work ethics and how management is like. The trouble — you wouldn't mind sticking it out here but you think it is the Health Service everywhere in the country run by the Health Service so there is a chance that the management issues that I am faced with would still be the same management issues that you would be facing when you go to London but when you hear your friends or success stories of people being promoted to F grades or E grades right the way in in bigger hospitals, then the temptation to leave the hospital is really great. The hope that your role will develop as you came looking for in the first place might — I mean the process might just be hastened if you were to leave your present workplace. So ... right now I am surviving mainly with the help of me being settled here and in terms of me having my own friends and all that but I mean if I were to be asked if it is the hospital or management that is keeping me here I think none. If it weren't for my Filipino friends that I have gotten used I would have left the hospital a long time ago. I believe that people — there are hospitals that treat their staff better. The area I work in itself probably is not the problem — may be it isn't their intention but somehow they need to do better and this research study I think they should focus a bit more — studies such as this to get to the real bottom — I mean to the bottom of the satisfaction that the overseas workers — nurses get in terms of the way they are treated in England. So it comes down to the basics I suppose.

OA: So how are you treated by your nurse manager?

P How — well on the overall she can be very impersonal sometimes. I can only base what I am saying regarding the belief and stuff based on what I have seen — observed from some of my colleagues. I mean you do hear stories like being granted compassionate leave because their cat died, the cat was dying and then hearing some other colleague of mine was wanting some carers leave because her daughter was ill and she wasn't granted any. So ... She wasn't granted any compassionate leave or carers leave and yet some people whose pet dies gets some, some compassionate or carers leave or compassionate leave I suppose. Some people can stretch their compassion leave for two weeks, some people says — our manager says the maximum they can give you is just a day. So — where does that come from. It is not looking after the welfare of the employers is it. There are some discrepancies which again is pretty much obvious of how the manager treats us. I don't know. If she ... there are times when she seems to be very unapproachable like...

OA: Unapproachable.
Unapproachable yes. She is not the kind of person who gets down to the coffee room to share lunch or something may be. I don’t know may be that is just not her. May be I am expecting more from her. Yes. Although having said that once you get to speak to her and then you know you are blurtting our your problems and all this she does listen to you. Still I think she is a very – she is a kind of manager who is a stickler for rules. I don’t know how flexible she is but she is a stickler for rules. There is no way like you can sway her like when she has made her decisions.

OA: If she is a stickler for rule why is it there is rule for one person and there isn’t for another.

P I am not so sure, I am not so sure, I am not so sure. I mean she will always say that management, the rules are as to whether those rules change from person to person I am not so sure.

OA: So moving on from there what about how you are treated by your patients?

P It is difficult. I come from a culture that is ... I don’t have what you call the stiff upbringing back home. Back here some – you see a world of extremes, like somebody would be highly emotional patients or relatives or a group that really would be saying everything is fine with them and wouldn’t really ask you for any help at all. So I have encountered some patients from different groups like one extreme from the stiff upper lip, and the other one is the highly emotional ones.

OA: By highly emotional what do you mean?

P Well I think they are the kind who would be more demanding in terms of needing the attention or asking you for it and every discomfort that they can ever think of. I think what gets me they can – they feel more comfortable opening up to people from their own – I mean with their own – the English people basically. I don’t think they would ever be really comfortable opening up to somebody like me. Not unless I don’t know... I take the initiative and really encouraging them to do so. The effort between me and an English nurse, the effort that we would put in in encouraging these people to open up it would take me twice the effort of what the English nurse will do.

OA: Why.

P I don’t know. They somehow. They are a bit hesitent may be, because they probably are embarrassed that I won’t be able to understand how they are feeling. Or things like those. They just don’t want to show how vulnerable they are, I suppose. So there will always be ... you are always out there to prove yourself that you know we are here to help out, in the same way an English nurse would be there to help out.
OA: So is that the way you feel you are always there?

P Yes I guess so. I guess so. I think that is on my part because they are never really confident may be probably because of the differences in culture, in practice. Things like those.

OA: If we move on a bit, can you tell me about your shift pattern during a normal working day?

P Normal working day – well probably it would be bedside nursing care. It is a one of assessment, observations, see how the patients are, monitor changes in the patients and report any significant changes. But mostly bedside nursing care.

OA: Moving on from there, how are patients allocated to you then?

P Sometimes there are people who ask the charge nurse or sometimes he asks us which patient we would like to be assigned to, sometimes they assign the patients depending on your what they think is your qualification basically. If I were a D grade they wouldn’t expect me to look after patients who were very unstable. Sometimes they do but... it is like that, they try to balance it with your experience I think. The more experienced nurse is the more they are expected to handle difficult cases.

OA: And how is your off duty rota done then?

P Initially they ask us to request the days that we would want to be off. Things like those so they try to accommodate as much as they can. Mostly they do, but it all depends on how the staffing levels are like.

OA: And how useful is that?

P Well so far I couldn’t really complain with how the shift patterns work I think because they as desperate for staff so, I mean what ever it is that you request because they are so few of us now you get it really. So far so good but there are times when it really could be a bit different. It can go pear shaped. I think that they do their best to accommodate you anyway.

OA: I am just going to explore socio cultural issues. When you first came to work for the National Health Service, what provision is there in your work place to help you to adapt to a new culture?

P What was happening the most, I know I am a very flexible kind of person. I get along well with anybody and all that. There were people who I considered, who were very friendly who I came with and they have been very supportive. They brought me to their homes and they really considered me as an equal rather than somebody who would be working for the National Health Service to make the
numbers right. So people have been very welcoming. People of my kind have helped me to understand the new culture, acculturating myself and adjusting to the new environment I find myself in. Also the study days that I got in they have been very helpful in a way. I have never been very – I mean even the simple tasks like cannulating and things I have never done that before I mean back home. But we were given those training days, so they were very helpful. People who believed in us. We are here and we are useful, we are significant members of the team. Those have really helped me.

OA: Just to pick up on something you mention, you mentioned about the training days and being able to cannulate which is more or less like a skill. So if you compare what you were doing in the Philippines to what you are doing now, can you tell me whether you feel you have been acquired more or less skills?

P I think I would have probably acquired the same skills that I know now back home but it would have taken me a greater number of years to do that. Because you have to consider the expenses that go with it. I mean all the training I do want to go through whilst over here it comes in, you acquire them faster I guess, because there are opportunities, I mean the opportunity is there all the time. I mean they run classes like twice in a year or so and for somebody like me who grabs any opportunity to ... I feel like I have only worked in the hospital for the last five years but I mean roughly I worked five years in the real hospital setting and even that hospital wasn't so ideal. So coming over to England, working in a district hospital that had all these facilities. I think you really would feel the need to learn more and catch up with the things that you have missed. Having been unemployed for a long time or underemployed for a long back home. How would I compare it. Perhaps the ... I would have probably progressed back home at a very slow pace, but over here the opportunities here and sometimes it just depends on you and how I don't know, but initiative you have got to have it within you, it is best to pester your manager or the people that you need support from. It comes to that. They get annoyed but in the end they listen as long as you have to be really forceful with what you say. Be assertive and that is the same thing goes too with every institution. It is like plan if you want to develop yourself, I think the most ideal would be an effort from the management, and some of the effort being by the applicant. I think it has to be the applicant doing the pestering and the pleading for the management. Which is most unfortunate I think.

OA: So when you first came what provision was there to help you with your language and communication needs?

P Not much really. We just learned as we went along working. There was a time when I was so scared of taking phone calls, answering the phone even because the language was so different and it was funny that people always questioned the way we spoke like we were Americans, everybody just kept saying. But in terms of people just spoke the way they did and they took extra time to explain the meaning of such and such. So there wasn't any formal sit down class to help us
improve the way we spoke although having said that there was a night class that the hospital sponsored before and that has been attended by two persons that I know of. But everybody wasn't forced to join that. It was a voluntary thing for nurses to attend or anybody who needed to enhance their speaking of English. But no formal sit down class.

OA: So what information were you given then on how to make contact with relevant organisations that might help support you in a new environment?

P The only thing they stressed was joining the union. Things like the Filipino Community and things like those there wasn't any ... or the gym, the local gym and stuff. It wasn't stressed that much. It was just more of the union. You joining the union.

OA: What about information about facilities where you can purchase ethnic food and goods?

P None at all. They showed us the local supermarket and that was it - bang. Places where you could shop for some clothes. Nothing like what you have mentioned.

OA: When you think about your experience as an overseas nurse can you think of an incident that stands out in your mind?

P Okay. I think it would probably - it would be too extremes. One would be a good one and the other not. Does it have to be a personal experience or anything relating to work?

OA: Related to work, yes.

P Well the lack of support that I got hence affecting my confidence in how I was to deal with patients. It was when I was assigned in a unit that was very new to me which was also - like an experimental unit for the whole hospital. There was no clear cut policies of how this unit was run. Or if there were it wasn't doing its job in making the unit as harmonious and peaceful as it should be, organised as it should be. People were just asked to run the wards and it didn't matter whether you had what it takes to run the ward or not. I mean that is something that ... that I something that I always remember. I was always asked to run this ward and I didn't know a thing of how this ward ran. All I knew was to be really patient centred in my care. I didn't know anything about management, organisation or asserting myself in you know this ... trying to delegate parts to people. They never sent me somebody who could do delegation and stuff. But still I was expected to run the ward, especially at weekends. So it was very very bad for me being a new comer.

OA: And how did that make you feel then?
P It is almost like it put some doubt in my mind that I can’t do things as well as they can. Because of that horrible experience. I mean may be I had the job done but at the expense of like me not having proper breaks or the ward being in such a terrible mess. It wasn’t any balance at all between... it was properly done basically. I mean the job was done but it wasn’t properly done at all. And then having all these bad experiences, this bad output after shift, I tended to think that I was such an awful nurse. How could I have finished the shift, yes, the patients have all been looked after but something is still missing. And it all comes back to your confidence being undermined basically and you start thinking well this is may be as far as I can get. So therefore the initiative to stick it out with this area and dream dreams for this area was just lost in space. I decided to leave this area.

OA: Could you tell me whether you had any experience of being treated as though you knew nothing?

P Yes. There was a time when the fluid balance of the patient was being checked and despite me having referred the discrepancies there – the doctors really didn’t give any orders for how to correct it or to do something about it and the manager came – one of our senior nurses came in and she just gave out a comment this is poor fluid management and she actually – I think she was directing the comment to me basically because I was the person that was looking after the patient for the whole shift. So hang on I was thinking – I called the attention of the doctors several times and they haven’t said anything.

OA: And how did that make you feel?

P Shrugged it away. Probably – I am very very upset now thinking about it. I am now upset but you just tend to get used to it and besides I knew what I had done at that time – I kept referring to the doctor pointing it out so I knew there was a problem with the fluid management but I couldn’t do anything. So ... and she shouldn’t have said that in the first place because I think it was really rude for her to be saying that in front of ... but I said something else like can you do something about it and the next time you can do this rather than bluntly saying this is poor fluid management.

OA: My penultimate question is that what will make you stay in the United Kingdom if given the chance?

P I think better pay, better opportunity to enhance myself, to develop myself. I think that would be the factor for me to considering staying her for a long time. Better access to self improvement, self development basically in terms of my education, my training, my financial standing. I need to pay the rent all the time and then the feeling that we are needed here and that we are appreciated for our good deed we do for the patients rather than thinking we are just here to complete the numbers.
OA: My final question is this – is there anything else about your experience you feel you haven’t covered which you would like to share with me?

P: I think it is this. Often patients or doctors or anybody from the different disciplines like from the nurses would treat us differently would somehow show that they lack confidence in us and it is very sad to say that our managers themselves and senior nurses themselves cannot stand by our side during that time. I mean I would expect charge nurses or senior nurses to like speak to these professionals and tell them that you know you don’t have to remind me of this because this Filipino nurse or this South African nurse is here and she is capable of carrying out whatever it is that you are saying she is capable of and coming up with good decisions. or if there are any problems with she is capable of speaking to me. I mean there are times when doctors come in and give up orders or ask how the patient has been doing and they would rather speak to somebody else other than the nurse looking after the patient and in that situation I mean the charge nurses themselves like speak out for us instead of allowing the doctors to get away with this sort of behaviour. It is not acceptable. We are capable to giving appropriate information about our patients because we know what is happening with our patients. So the doctors or people from another discipline lack confidence in us because our senior nurses themselves perhaps lack confidence in us as well. And I want that changed. I hope that they would tell these doctors no, speak to the nurse who is looking after the patients. This Filipino nurse is capable of understanding and making decisions based on appropriate instructions. Therefore don’t talk to me, talk to her, ask her. I think this is so important.

OA: Okay then well thanks very much for participating in this study.
Appendix 17

FOCUS GROUP INTERVIEW ONE
Focus Group One
Interview held on 2nd July 2004 at 18.30pm

Background Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Country of origin</th>
<th>Sex</th>
<th>Age</th>
<th>Qualifications</th>
<th>Grade in the NHS</th>
<th>Experience in the UK</th>
<th>Experience in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>Philippines</td>
<td>F</td>
<td>40</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>E</td>
<td>3 years</td>
<td>5 years</td>
</tr>
<tr>
<td>IB</td>
<td>Philippines</td>
<td>F</td>
<td>36</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>3.5 years</td>
<td>4 years</td>
</tr>
<tr>
<td>IC</td>
<td>Philippines</td>
<td>F</td>
<td>45</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>E</td>
<td>3.5 years</td>
<td>6 years</td>
</tr>
<tr>
<td>ID</td>
<td>Philippines</td>
<td>F</td>
<td>34</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>4 years</td>
<td>6 years</td>
</tr>
<tr>
<td>IE</td>
<td>West Indian</td>
<td>M</td>
<td>48</td>
<td>Registered Nurse (UK and Trinidad)</td>
<td>D</td>
<td>2.5 years</td>
<td>10 years</td>
</tr>
<tr>
<td>IF</td>
<td>Philippines</td>
<td>F</td>
<td>30</td>
<td>BN (Philippines) Registered Nurse (UK and Philippines)</td>
<td>D</td>
<td>2.5 years</td>
<td>2.5 years</td>
</tr>
</tbody>
</table>

Interviewer: How important is migrating to the UK for you all generally?

Candidate 1D: For me it's generally for the family. I wouldn’t be here if not for my husband. I wouldn’t be here if I did not value my family and they are important to me.

Candidate 1F: Same thing with me.

Candidate 1B: Career wise and family wise it is important.

Candidate 1A: Mine is family wise I am doing this for my family.

Interviewer: So you are doing it for your family, any one else?

Candidate 1C: Opportunity and experience

Candidate 1A: It depends on whether you are single or married. We have different views but I wouldn’t want to stay here if it wasn’t for my family

Interviewer: So you don’t want to stay here at all if it was not for your family?
Candidate 1A: Because they way they treat me. I am not sure I would want to stay here.

Interviewer: What do you mean? Could you elaborate?

Candidate 1A: I wasn’t given equal opportunity.

Interviewer: What do you mean by equal opportunity? Could you elaborate on this?

Candidate 1A: I think when we came we were treated, well I was treated as a senior nursing student and my mentor did not know what to do with me as she was not prepared for a nurse like me. I came with a lot of skills and I was not given the opportunity to use these skills. This was frustrating but in the end I survive all of this. I also want to say that other staff with less experience were given the opportunity to use their skills but I suppose because I was from overseas they would not allow me to use my skills. The other thing was, I had to start from scratch as the system is different from mine and that put me into a second-class category in this country.

Candidate 1D: Because of the language barrier, we are not fluent in English we are bypassed for promotion.

Candidate 1E: I think the worst thing that I had experienced was that my confidence had reduced. We were babied but not in a good way. They also thought that we were there to agree with their views all the time and the minute that we sort of disagree with their views and they think we’ve got other ideas even if it could work they wouldn’t support it because they must have been so used to their own ways and something new coming from people from a different culture is just unacceptable for them.

Candidate 1B: Yeah, we are always in a supportive role in here we are never given a chance to prove our leadership abilities. We are never given a chance to prove our abilities. Other white staff nurses would be given the opportunity to run the ward but I would because I think they don’t trust me or they think I am not good enough but I have lots of experience and I would wish they would give me a chance.

Candidate 1E: Sometimes when you come up with ideas they do give you a bit of leeway in making decisions for the ward, however my greatest fear me personally is that should something happen they would just leave you, they wouldn’t back you up and this could affect your confidence.

Candidate 1C: No one will back you up, it’s always your mistakes that they really notice and they will blow it out of proportion and this can sometimes affect your confidence. They never appreciate your efforts.

Candidate 1C: Every good thing was not appreciated

Candidate 1E: It’s something that is expected of you that’s what they are going to say.
Candidate 1D: The worst thing about this is whenever you do something which
doesn’t conform to their own you know their standard you won’t hear it from them
directly. We should be told personally by whoever, by the mentor or the superior but
we aren’t. Everyone in the department knows everything about you but not you
personally, so that’s very unfair you know.

Candidate 1C: You’d be the talk of the town about your mistake.

Candidate 1A: Before you know what you have done everybody already knows. One
thing I would also like to see is we should be treated professionally like for example if
something was wrong with me or with others I should be taken to a room and spoken
to quietly. It should be done properly. We are professionals you know we should be
dealt with professionally, isn’t it?

Candidate 1D: Talk to properly not for every one to hear.

Candidate 1F: Maybe because the way we speak English is not as good as them so
that’s their basis for they way in which we are treated. They often say that we don’t
know anything. I have heard this one comment, “you don’t know anything” I just
kept quite and did not respond as they don’t know me.

Interviewer: So who made that comment to you?

Candidate 1F: A white staff

Candidate 1F: I wished I knew what’s his basis for his accusation but I didn’t. I
consider him as an equal. He is not a staff nurse he is only a health care assistant. I
don’t think that this person realises how hard I work because if he did such comments
would not be made. It is really sad to say this but we are not given the respect we
deserve. I am only doing my best. I have survived all this as I am able to tell this to
you.

Candidate 1D: Nobody appreciates you everyone is just using us.

Candidate 1F: I didn’t know what to say but just looked at him and stayed quiet.
When I am upset I tend to say nasty thing so I just kept quiet.

Candidate 1A: I think because of our culture we are so respectful isn’t it. We just say
that’s okay and we would just ignore this one because he or she is older than me you
know

Candidate 1E: I think we are very accepting and maybe there is always the fear of not
being able to talk back to them like they do to us.

Candidate 1A: I can express myself but I have to think of the correct grammar before
I could answer them. I could respond back in my own language but because I am a
respectful person I just would not. Also they are very good at changing their stories
and I am afraid that they would say something that I had not said.

Candidate 1E: Maybe they can gang up on you
Candidate IF: Who would believe you?

Candidate 1C: They are good at changing their stories and they can sometimes be very abusive to you, can they?

Candidate 1B: There is still this fear that they could send us back home

Candidate 1A: Because number one we are just temporarily here. They are here no matter what happen to them they won’t lose anything. But for us we would be thrown out with our families and we would have to start all over again. So we have to consider this at times.

Candidate IF: So that’s one of the reasons why we don’t really speak up to them because if you do and they don’t like it, you could be in big trouble.

Candidate 1D: What would be the consequence?

Candidate 1A: Yeah we don’t know the consequence, legalities.

Candidate IF: We’re just careful

Candidate 1D: We are just careful you know what I mean. They are permanent here and no matter what happens they can stay here but we are temporary nurses here and if we say something that they don’t like we would be thrown out of the country.

Candidate IF: I’ve heard a lot of stories about London hospitals. There are a lot of foreign nurses who have been promoted. They are handling the responsibilities given but here there is only one. This particular hospital will give you a lot of reasons why they are not going to promote you and I think this is unfair. Other staff will be recruited from outside and they will be promoted very quickly.

Candidate IF: It’s sad to say but there’s this new staff nurse who just came and was promoted.

Candidate 1A: The thing is within a month she was promoted

Candidate 1E: Those unequal opportunities such as in terms of promotion you see people who are more qualified than the people that they sort of promote and that’s very discouraging I mean people who do not deserve to be in a higher post than you. People who couldn’t even support or have the skills to do the job are promoted.

Candidate IF: Because they are friendly, and the colour of their skin is similar to the manager, that’s why they get the job. Being the wrong colour is a disadvantage.

Candidate 1D: You know there is a saying if you are close to them in colour you will be promoted.

Candidate 1C: It’s because our skin colour is different and I suppose our hair as well and there is nothing I can do about this.
Candidate 1F: Is that it? I am the wrong colour.

Candidate 1A: It's a shame that you have to be white to get promoted to a higher grade. Being the colour that I am cannot be changed but it is sad that my colour is affecting me from promotion. I wish they would understand this.

Candidate 1B: I wish to be honest that I would if I could but I was born like this.

Interviewer: Can you tell me a bit more about your environment?

Candidate 1A: I can say that I was bullied in this environment. I was expected to do things that I was not happy to do and one or two colleagues were bullied as well. I could not speak to my manager because she was the one who was bullying me. I did not speak to my husband about it. The bullying soon stopped because I said that if it continued I would go to my union or her manager about this.

Candidate 1C: We are expected to work hard which we don't mind. We are given responsibilities way beyond our job description and we are not happy about this. I think that I am doing an F grade job but I am paid as an E-grade. What I could not understand was, the F-grade position came up and I was told that I was not good enough for the job even though I had been doing the job for such a long time. This was discouraging. The surgeons were happy with my work and my colleagues so I could not understand why the position was not offered to me.

Candidate 1E: And the person who gets the senior job is somebody who you would be mentoring.

Candidate 1A: Yeah and you would have to teach them. The sister would say you would need to support your F grade but who is supporting me the poor E grade.

Candidate 1C: It is not that we don't like teaching others but it's I feel that the F grade should be teaching the D and E grades not the other way round.

Candidate 1A: If I think that I don't have the skills and experience of an F grade, I don't think I would go for the job because I think it is unfair on the D and E grades if they have to teach me.

Candidate 1C: They don't care, they believe that the grade is more important than the skills so they will apply for the job and they will get it but they don't have the expertise to undertake the role.

Candidate 1F: And because of this F grade inability to perform it had a great effect on staff morale.

Candidate 1E: The ability to be a good clinician and at the same time a good manager they cannot combine these. I think our race can combine being a good manager and as well as a good clinician but why aren't we being recognised for these skills.
Candidate 1B: You know what the problem is the goal post is moving if they want somebody to be promoted they will change the post I mean they will create a post a new job description just to suit the person they want for the job.

Candidate 1A: I heard about a job in this department and I was hoping to apply for it to be told that there were no vacancies. The following month a new staff nurses was appointed to fill the post that never existed. This made me very angry.

Candidate 1E: Something similar happened in my department but I just got used to the way my manager would appoint staff. I just don’t bother to apply for jobs now.

Candidate 1A: I have lots of experience in this department and junior members of staff were given acting positions but I was not because I’m not a good actress.

All candidates laughed at the sense of humour portrayed by candidate 1A.

Candidate 1B: No it’s because you need to change the colour of your skin.

Candidate 1A: There’s no acting post for me but all of them are acting

Candidate 1E: They were made to assume a grade higher than there actual post except it sort of stop in her case. Everyone just got promoted one step ahead except for her when she was already doing the job anyway and when she applied for the post they gave reasons that she was not qualified.

Candidate 1A: She was not even given the chance to be interviewed that’s the worst thing.

Candidate 1D: Where I work it is a different. For example, little things like carers leave and things like that I remember when I came here my son was still very little and every time he was sick I had to go off sick as well because they won’t give me carers leave. I have a white work colleague who’s got a twelve years old girl and because nobody will be looking after her she was given two days carers leave. My son had measles and I wasn’t given any so where’s the justice. What I would also like to say is when the ward is quiet they will send home their white colleagues and I would have to stay back because I was not allowed to go home. Do you think this is fair? I don’t think it is

Candidate 1F: Before, I refuse to believe that such things existed but the longer I stay here I am of the belief that overseas nurses are treated terribly.

Candidate 1B: When I came here I was so quiet because I was adjusting to the new environment.

Candidate 1D & 1C: So naïve.

Candidate 1D: We were very used to our system like everybody’s frank that whatever you say you are true to it but in this place it’s a different thing, some are nice to you in your face but when you turn your back they are nasty.
Candidate 1B: But when I became confident and skilled and worked for a while I realised the issue with this hospital was the politics.

Candidate 1F: Yeah politics that’s it that’s the word. I don’t know if it’s true for other NHS trust but this hospital is very political.

Candidate 1C: The political part of this hospital is that white nurses are given “F” grades with little experience

Candidate 1F: Really? And I haven’t seen one of my kind holding a high post?

Candidate 1C: There’s one now. You know you have to be a sucker before you get the post.
Candidate 1E: I mean you have to be, you have to be a willing servant for them and sometimes your willingness to do things goes beyond your job description.

Candidate 1D: And you cannot be yourself because we Filipinos are always ourselves we don’t tend to be sickly nice or pretending to be nice we are what we are. We always show our best and we don’t go beyond that.

Candidate 1C: They want us to be extremely sweet to them.

All: Your wish is my command that’s how we feel.

Candidate 1C: They want us to do that.

Candidate 1F: I think that’s true with my other colleagues too.

Candidate 1B: What I have noticed is, the manager has already spoken to one of her white colleagues and offered the job to her. The interview is only a matter of formality. I think this should not happen but this is a regular occurrence in this department. Staff are offered position provisionally.

Candidate 1E: They are very selective of the person they put in post. They often put their white colleagues.

Candidate 1C: The question is that it has been told to us that there would be a post for this “F” grade and then we’ve been waiting for it to be advertised but it never did. Only to be told that the new “E” grade that came only one month ago was offered the job.

Candidate 1D: Where I am working it’s a different setting. Some consultants wouldn’t do any ward rounds if there isn’t a white person around. If it’s only me they would not do the ward rounds.

Candidate 1E: This also happens where I work. I also think the lack of support by managers do worry me. I sometimes feel that when orders are given, these should be given to nurses and not through the ward manager or a white nurse. I feel that the manager’s role should be to confront the doctor and tell him that this nurse is qualified
to carry out orders. They are as capable as we are to do the things that you want done for the patient. I mean to care for the patients so don’t talk to me you should speak to the nurse who is looking after the patient. Most times the manager and the consultants would discuss the patient and I will be ignored even though the patient is cared for by me.

Candidate 1D: In the end you are the one who have to carrying out the orders and care for the patient so the orders should be directed at us.

Candidate 1E: This is the same where I work. Doctors would pass on information about patient in my care through the manager or my white colleagues.

Candidate 1F: You are supposed to be the one who should speak to the doctor or the consultant because you are the one caring for the patient.

Candidate 1D: But that had never been addressed, never.

Interviewer: Have you had any experience of open discrimination?

All: We have had subtle discrimination.

Candidate 1A: A manager once called a nurse in this environment I work in daft. She said, “you’re daft”. I don’t know why she was said this but this was not acceptable.

Candidate 1F: Is that a very negative word “daft”?

Interviewer: It means stupid or you don’t know anything.

Candidate 1E: She was so upset she went home.

Candidate 1A: And she was pregnant

Candidate 1E: How dare that manager?

Candidate 1A: I once asked my manager if it was okay for me to join an agency. My manager said yes but also said that agency work could sometimes be dangerous. I did not bother with what she said. I was happy that my manager had given me permission to work for this agency. The next thing she said to me, have you got much experience. I just could not believe what she was saying. I have lots of experience. How rude of her. I don’t see her treating her white colleagues like this. She is often good to them and treats them with respect and does not discriminate.

Candidate 1E: It’s not supposed to be her problem anyway, why is she concerned about your experience?

Candidate 1A: I just do not understand my ward manager. I have lots of experience and I have taken care of so many patients in her absence. If I knew nothing I would ask for help but so far the need never arose.

Interviewer: What about your experience person D?
Candidate ID: Where I work it is very different. All the dirty jobs you would end up doing. They will go have their cup of tea and they will leave me to clean up after them. They certainly don’t ask me to join them. I feel that discrimination is rife where I work. My reason for saying this is, I do not see any of my white colleagues doing the dirty jobs. It is always the foreign nurses.

Candidate 1C: Or even a fag. We don’t go for fag breaks, do we?

Candidate ID: Even when it is busy they will need to have their cup of tea. They cannot live without this.

Candidate 1A: With us we are used to that work first before anything else.

Candidate ID: The culture I am from we have to finish our jobs first and then after that we can do whatever we like but for them they always have to stop for a cup of tea or coffee. If I’m in charge of this particular bay and a white person is in charge of another bay every time the bell rings nobody would come out from their bay nobody as in health care or a qualified nurse because they know that we are there. Even if you call them to help you they will just ignore you.

Candidate 1A: I mean it’s good to have a coffee break but as you know it’s our attitude to put our patients first before ourselves.

Candidate ID: Every time I discharge a patient I am the one to clean the bed but for the white nurses if they discharge their patients the health care assistants will be the ones to clean after the patients have been discharged. But for me and other overseas nurses, it’s from top to bottom we have to do everything and if we have to ask for some help that’s a different question.

Interviewer: What do you mean?

Candidate ID: You don’t get it. Sometimes they would even talk nasty things about you.

Interviewer: What do you mean?

Candidate ID: If I ask they will say, ‘you can do it? The white nurses would say, ‘why can’t you do that.’ But if other white nurses need help, these health care assistants would get on their feet and would do whatever was required. But for us it’s like begging all the time for some help. So my experience on the ward wasn’t really very nice.

Candidate 1C: At the end of the day they are the hard worker.

Candidate 1E: They get all the credits and for us overseas nurses we get nothing.

Candidate 1A: White nurses and health care will get all the credit from the manager but I get my credit from the patients. There was this patient who kissed me and said thank you for the help I gave. I was so happy that this patient appreciated all the help I
gave. She also said that if it was not for people like me, the NHS would not be able to function. I really felt proud to be part of the NHS. To be honest I do not need my manager to give me credit because I know it would come but at least my patients are appreciative.

Candidate 1D: Whenever I have my appraisal my manager will get the feedback from my work colleagues which is very sad because if your work colleagues do not like you then you can have an unfair appraisal. From my last appraisal, I don’t think I have achieved the goals set. My manager is good at setting goals but when it is time for me to achieve these goals, there are no opportunities. Sometimes I wonder what is the point of the appraisal.

Candidate 1A: I wish if patients would appraise me because definitely I would get a good appraisal. We are working for the patients so they too should have a say in our development.

Candidate 1D: That’s right

Candidate 1A: That’s why we just go with the flow and would not say anything. We would keep quiet.

Candidate 1D: They are making our lives difficult on the ward but I have to survive this because I need to provide for my family.

Interviewer: What do you mean? Do you want to elaborate? Do you want to or not you don’t have to if you don’t want to divulge that information?

Candidate 1D: They give me a hard time with my appraisal, there are no opportunities to develop and if there are, the white nurses will be the ones to get first preference and they make you feel unwelcome but as I have said, I need to survive this and to prove to them that I am tough. They also want you to assert yourself but when you do you are in trouble.

Candidate 1A: Pack your thing and go home.

Candidate 1E: You are marked

Candidate 1F: You are marked.

Candidate 1D: Your days are numbered.

Candidate 1E: They make your life a living hell. You can’t speak out how you feel and if you do, you are called in the office and be told off. So you can’t win, can you?

Candidate 1A: If ever my manager needs to take me to the office, I will always ask for a witness because I don’t trust her. She changes her story and because of this I need a witness.

Candidate 1D: But you cannot get your colleague I mean the same colour as a witness because it’s definitely bias. They will say it’s bias.
Candidate 1A: For me I don’t care about if it’s white or what as long as I’ve got witness you know.

Candidate 1E: With all this discrimination and the lack of support, my loyalty for this hospital has gone. I don’t see myself staying here in the next five years or so.

Candidate 1D: The same here. Because I am not appreciated and recognised for what I do I can’t see myself staying in this country.

Candidate 1C: You work hard you put your heart in it and you get nothing in return. I will certainly move on.

Candidate 1E: Still nothing

All: Nothing, Nothing

Candidate 1D: No consolation

Candidate 1E: I mean the earliest chance that I get to leave I will take the opportunity pack my bags and say good bye.

Candidate 1D: That’s right the only thing that we are grateful is for the experience because you cannot buy the experience, can you? But you have to go through the whole of the experience to learn and I did learn a lot.

Candidate 1A: We are not happy with our work.

Candidate 1D: We just functioning as nurses.

Interviewer: In terms of professional development what opportunities are there, if any at all?

Candidate 1D: I have been on this ward, and told that I would not be able to go on the intravenous therapy course. All of a sudden there’s a new graduate who was hired and she was there only for a month and was given the course. This is very demoralising isn’t it? It’s like what am I doing here. This new graduate was given the support by the manager but because I am of a different colour the course was not offered and there was no support.

Candidate 1C: I am not use to writing essays and when I am told that I will need to write a 5000 word essay, this causes me some concerns. I would prefer to have practical rather than theory but this is the British way of learning. It is so different from my education.

Candidate 1A: Because nursing has different scopes, research, training isn’t it? Some people are just good at research. Some people like you are good at research. I’m good at practical things you know isn’t it?

Candidate 1A: Some people could write research very good but not me I’m not that person.
Candidate 1D: I think the reason why I am not good at writing essay is because I am not used to this type of educational system here in England.

Candidate 1F: We can write but the grammar is not that perfect really.

Candidate 1C: And not 3,000 words as I am not used to this.

Candidate 1A: In my country the less words you use the more marks you get.

Candidate 1F: The content.

Candidate 1A: In my exam I can remember my clinical instructor saying to me if you can use less words to answer the question as long as it makes sense then marks will not be deducted. This is what I am used to not 3000 words.

Candidate 1D: Don’t beat around the bush.

Candidate 1C: Briefly.

Candidate 1A: That’s the word briefly. And they would comment if you had beaten around the bush. They hate it isn’t it?

Candidate 1F: That’s the system they are used to here. We have to write essay explaining every experience you encountered. There is nothing we can do with that then so we have to follow that one.

Candidate 1C: Comply with it.

Candidate 1F: That’s one of the requirements.

Candidate 1D: That’s one of the things that’s putting some foreign nurses off going for courses.

Candidate 1B: In my area where I work, in terms of education opportunity they usually offer it to the white nurses before overseas nurses can have a course.

Candidate 1E: It’s just now that they are offering these courses to us because we have complained.

Candidate 1D: Because the courses are all finished and therefore they can say that there are no courses. It’s sad to say this but it’s true.

Candidate 1E: All of them have already been promoted.

Candidate 1A: Maybe with us within this environment they have no choice because we are the majority. Honestly, you go to this area where I am working you will see lots of foreign nurses and not many white nurses.
Candidate 1A: “D” grades in this environment are handling the complicated patients. Just an ordinary “D” grade and they still do not trust us to run the ward.

Interviewer: In terms of surviving what would you say is necessary to survive in the NHS, if anything at all?

Candidate 1D: Willpower, physical strength

Candidate 1E: We need to be tough, we need to be strong and we are.

Candidate 1A: We need to have our permanent residency to fight them back and they won’t throw us out.

Candidate 1B: But for management, they should treat us equally I mean equal opportunity. They should recognise our effort and treat us as equals not as second class citizens. We are doing a job just as our white colleagues and we deserve to be treated the same.

Candidate 1F: Yes, treat us equally.

Interviewer: Finally what do you value most about your everyday experience of working in the NHS if any at all?

Candidate 1F: For me it’s the patient, when they give you positive comments by saying you are doing a good job, keep it up.

Candidate 1F: Comments such as, ‘I’m satisfied with the care you gave me.’

Candidate 1D: For me it’s the experience itself because you know you cannot pay for the experience you learn something from it.

Candidate 1F: It’s the only thing they can’t take from you, it’s inside your head.

Interviewer: Okay.

Candidate 1B: Sometime I do receive some cards personally with my name on it saying thank you for your effort. So I appreciate gestures such as these.

Candidate 1F: One patient she gave me a tin of chocolate, although she wrote the wrong name I knew she’s referring to me.

All: Are you sure?

Candidate 1F: The patient asked for my name and thought I was caring. I am the only male in this department so it could be any one else but me.

Candidate 1B: I got the feeling that they thought we only value the money How naïve of them to think like this. We value the experience.

Candidate 1F: Because we do a lot of overtime.
Candidate 1B: Don’t be hypocrite they need money too you can’t buy anything if you don’t have the money. You even need money to be able to go on holidays etc. But it’s not only the money that you want, you need the recognition you need the respect you need their equal treatment and their support.

Candidate 1A: Any way everybody who works at the hospital needs money isn’t it?

Interviewer: Can you tell me who supports you in the NHS?
All: Other overseas nurses

Candidate 1A: For me I got good support from my black “G” grade the one I work with but not from my manager.

Candidate 1A: Have you noticed that most of the managers the ones who are discriminating us I don’t know why. Maybe because they don’t work with us they don’t know who we are or how we work because they are just sitting in their offices.

Candidate 1D: Sometimes I think the health care assistants are insecure of us I mean I don’t want to use the term but it’s the way I perceive it you know because who are we to come to their country and take their jobs and be in a position of power.

Candidate 1F: I feel that too especially the auxiliary nurses, they think I’m just here to run after them or to do the dirty jobs but I am here to make patients better. Care for patients.

Candidate 1C: They are knowledgeable to us because they have been working in the area for a long time for sixteen to twenty years of course they are very familiar with the area where things are or how things are done so you have to ask them also.

Interviewer 1F: That’s true.

Candidate 1D: But when it comes to legalities and responsibilities it would be your responsibility.

Candidate 1F: It’s your neck on the line.

Interviewer 1B: Sure.

Candidate 1F: But sometimes I feel that they are not comfortable with us being here.

Interviewer: Have you got anything else that you would like to add?

Candidate 1D: On the wards, if one of the wards is short staffed definitely it would be a foreign nurse who would be moved around. This happened to me at least three times in one week. This was so unfair. I don’t see the white nurses having to move from one ward to the next.
Candidate 1B: The same with us in this area it is always the foreign nurses who will be moved, they don’t move white staff and it happens all the time. But I need to survive in this area so I just do as I am told.

Interviewer: Thank you ever so much for this interview.
Appendix 18

Published Article

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 19

Published Article

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix 20

Questionnaire information sheet for overseas nurses for the survey
Information sheet for overseas nurses for the survey

Date........... No........

Study Title: The experiences of overseas black and minority ethnic nurses working in the NHS in the South of England

Invitation Paragraph
I would like to take this opportunity to kindly ask if you would volunteer to take part in this research study. Before you decide it is important for you to understand why I am conducting this research and what it will involve. Please take your time to read the following information carefully. You can discuss the research study with your partner, spouse, friends and relatives if you wish. This research is part of a Doctor of Philosophy and involves filling out a questionnaire. Please feel free to ask Obrey Alexis if there is anything that is not clear or if you would like further information. Please take your time to decide whether or not you wish to take part.

Thank you for taking the time to read this.

What is the purpose of the study?
Since the inception of the National Health Service (NHS) in 1948, black and minority ethnic nurses have played a significant role in its development. From the 1960s to
date, black and minority ethnic nurses have been recruited from overseas to meet the nursing shortages. There has been little research conducted in this area and most of the information about the treatment of overseas black and minority nurses has been anecdotal. Therefore, the aim of this study is to explore, describe and develop a greater understanding of the experiences of overseas black and minority ethnic nurses who are working in the National Health Service in England.

Why have I been chosen?
You have been chosen because you are currently working in an acute NHS hospital in the South of England. The decision to take part is entirely yours. If you do decide to participate you will be given this information sheet to keep and will be asked to sign and retain a copy of the consent form. Even if you do decide to take part in this study, you can withdraw at any time, without giving a reason.

Duration of the study and what do I have to do?
This study will take approximately 4 years to complete. During such time you will only be involved in the survey. You will either receive a questionnaire through your human resources department or through the post from an independent organisation. All you would need to do is to fill out the questionnaire, which will take approximately 15 minutes to complete and return it in the freepost self-addressed envelope provided.

What are the possible benefits of taking part?
The benefit to you will be the opportunity to contribute to a broader understanding of the experiences of overseas black and minority ethnic nurses and to a wider debate in the National Health Service over preparing overseas nurses for work in the NHS. The findings may benefit policy makers and other independent organisations of how best to address the needs of overseas nurses.

What are the possible drawbacks of taking part?
There are no foreseen drawbacks or risks involved to participating.
Confidentiality
The information I will collect from you, about your experiences during the course of the research, will be kept strictly confidential. The information will be handled in accordance with the Data Protection Act [1998]. You will remain anonymous in any report or publication.

Ethics Committees
The University of Surrey Research Ethics Committee, North and Mid Hampshire Local Research Ethics Committee and NHS Research Ethics Committee [multi sites] have reviewed and approved the proposal for the study to be conducted.

Should you have any queries, please do not hesitate to contact me.

My contact details are:

Name: Obrey Alexis

Address: European Institute of Health and Medical Sciences
Duke of Kent Building
University of Surrey
Guildford
GU2 7XH

Telephone Nos: 01483 686765
07751774752 (Mobile)

Email address o.alexis@surrey.ac.uk
My supervisor’s details are:

Name: Dr. Vasso Vydelingum

Address: European Institute of Health and Medical Sciences
Duke of Kent Building
University of Surrey
Guildford
GU2 7XH

Telephone No. 01483 686707
Email address v.vydelingum@surrey.ac.uk

Many thanks for taking part in this study.
Appendix 21

Invitation letter to participants
INVITATION TO TAKE PART IN THE STUDY BASED ON THE EXPERIENCES OF OVERSEAS BLACK AND MINORITY ETHNIC NURSES IN THE NHS IN THE SOUTH OF ENGLAND

Dear Participant,

May I introduce myself as Obrey Alexis and I am a post-graduate student at the University of Surrey. I am currently undertaking a PhD at the European Institute of Health and Medical Sciences and I am interested to hear from you about your experiences of working in the NHS as an overseas black and minority ethnic nurse.

The research will be conducted in the form of a survey and participation is entirely voluntary. If you choose to participate, the information gained would provide me with a better understanding of your experiences and may help policy makers and other organisations that employ overseas nurses of how best to meet the needs of such nurses.

The information I will obtain from you will remain strictly confidential. The questionnaire should take no longer than 15 minutes to complete. Please fill out the questionnaire and return it in the freepost self-addressed envelope provided along with one of the signed consent forms.

If you do have any questions or queries, please do not hesitate to contact me.

With regards,

Obrey Alexis

Version 02: Jan 05

504
Appendix 22

SURVEY CONSENT FORM FOR OVERSEAS NURSES
SURVEY CONSENT FORM FOR OVERSEAS NURSES

THE STUDY: The experiences of overseas black and minority ethnic nurses working in the NHS in the South of England.

Please initial here.

I, the undersigned, voluntarily agree to take part in the above study.

I have read and understood the overseas nurses’ information sheet provided and dated........(version........) for the above study and have the opportunity to ask questions should I need to.

I understand that all personal data relating to me is held and processed in the strictest confidence, and in accordance with the Data Protection Act [1998]. I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I realize that I am free to withdraw from the study at any time without the need to justify my decision and without prejudice.
I understand that I may experience some inconvenience due to the time involved in filling out the questionnaire.

I understand that the University of Surrey holds insurance, which covers claims for injury or deterioration in health which arise directly from participation in clinical trials but that it applies only in those situations where the University can be shown to be legally liable.

I confirm that I have read and understood the above and freely consent to participate in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of participant (BLOCK CAPITALS):
Signature:
Date:

Name of Researcher (BLOCK CAPITALS):
Signature:
Date:
Appendix 23

North and Mid Hampshire Local Research Ethics Committee
Dear Mr Alexis

03/B/027 – The experiences of overseas black and minority ethnic nurses in the NHS in the South of England

Multisite Approval for the survey in the South of England

In connection with the paperwork received on 20th January 2005 requesting approval for the survey – the final stage of your study, I can confirm that the committee is happy for you to proceed with the survey within multisite domain in the South of England.

Yours sincerely

JANE OGDEN-SWIFT
Chair
North and Mid Hampshire Local Research Ethics Committee
Appendix 24

Final Questionnaire
EXPERIENCES OF OVERSEAS NURSES IN THE NHS

QUESTIONNAIRE

CONTACT DETAILS:

Obrey Alexis

Tel. No.: 01483 686765

Email: o.alexis@surrey.ac.uk
Introduction

This questionnaire is part of a broader study that seeks to explore the experiences of overseas black and minority ethnic nurses in the NHS. As an overseas nurse you not only make a significant contribution to the NHS but you are also an important person within this organisation. As your experience of the NHS is valuable to me, I wonder if you would be kind enough to fill out this questionnaire if you have been working for the NHS for a minimum of six months, and return it in the envelope provided.

It is anticipated that the findings from this study may help contribute towards improvements in the experiences of overseas nurses in the NHS.

Throughout the questionnaire you will be asked various questions based on your experience as well as what it means to be an overseas nurse. I would like to inform you that a code number will be used on each questionnaire and this ensures that your anonymity is guaranteed within this study. Enclose with this questionnaire will be an information sheet that outlines the purpose of the study. It is important that you read the information sheet provided as it tells you what the study involves.

Instructions

The questionnaire is divided into six sections and you will need to reply to all sections. Please put a tick in the appropriate boxes as indicated: ☐☐☐

If you make a mistake and tick the wrong box, please block out your answer and then tick the correct box.

I would like to take the opportunity to thank you for your participation in this survey.

THANK YOU
Section 1: Biographical Profile

Please tick the box that closely represents your age

1. Age: (1) 21-25 □ (2) 26-30 □ (3) 31-35 □ (4) 36-40 □ (5) 40 and over □

2. Sex: (1) Male □ (2) Female □

3. Current Grade
   D □ 1
   E □ 2
   F □ 3
   G □ 4
   H □ 5
   I □ 6

4. How long have you worked in the NHS in your professional capacity?
   ................................................................................................................

5. For how many years did you work in your home country after qualifying?
   ................................................................................................................

6. What is your country of origin?
   ................................................................................................................
7a Before coming to the UK, did you work in any other country other than your own?

Yes [ ] No [ ] (Go to question 8)

7b If yes, please specify which one(s).


8. What is your ethnic origin?

(1) Black Caribbean [ ] (4) Black African [ ]
(2) Indian [ ] (5) Pakistani [ ]
(3) Asian other [ ] (6) Black other [ ]

9. What nursing qualifications do you hold? (Please tick all that apply)

1. Registered General Nurse [ ]
2. Diploma in Nursing [ ]
3. Degree in Nursing [ ]
4. Masters in Nursing [ ]
5. Doctor in Philosophy [ ]
6. Other (please specify and tick box) [ ]

10. How long was your nurse training?


514
11. Have you had any in-service training in your country of origin?

Yes □  No □  (Go to question 12)

If yes, please specify

........................................................................................................

Section 2: Equal Opportunity

Please tick one of the boxes against each question:

12. I believe that applicants from overseas black and minority ethnic countries are refused nursing jobs in the UK based on their colour or race.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

13. Have you ever applied for promotion?

Yes □  (Go to question 14)  No □  (Go to question 17)

14. Did you get the job?

Yes □  (Go to question 17)  No □  (Go to question 15)
15. I believe I have been refused promotion in the NHS for reasons based on my colour or race?

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

16. I believe I have been by-passed for promotion for reason based on my colour or race.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

17. Are you aware of your hospital Trust’s equal opportunity policy?

Yes □ (Go to question 18) No □ (Go to question 19)

18. How effective do you think it is in your workplace?

1. Very effective □
2. Fairly effective □
3. Not very effective □
4. Not effective at all □
19. I perceive that equal opportunity in the workplace is only given to my white British nursing colleagues.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

Section 3: Skill Development and Training

Please tick one of the boxes against each question

20. How satisfied are you when you compare the number of training courses you have attended with the number of training courses your white British counterparts have had while working for the NHS?

1  Satisfied □
2  Neither satisfied nor dissatisfied □
3  Dissatisfied □
4  Very dissatisfied □

21. In your workplace, to what extent have you been denied the opportunity to go on training courses for reasons based on your colour or race or ethnicity?

1. Never □ (Go to question 23)
2. Rarely □ (Go to question 22)
3. Sometimes □ (Go to question 22)
4. Often □ (Go to question 22)

517
22. What do you perceive is the basis for refusal? (please identify)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

23. How easy or difficult is it for you to get information on courses in your workplace?

1. Very easy □
2. Fairly easy □
3. Neither easy nor difficult □
4. Fairly difficult □
5. Very difficult □

24. To what extent are you encouraged by your manager to go on training courses?

1. Never □
2. Rarely □
3. Sometimes □
4. Often □
25. How often have the nursing skills you acquired from overseas been utilised in your workplace?

1. Never □
2. Rarely □
3. Sometimes □
4. Often □

26. I believe I have more qualifications than my white British nursing colleagues.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

26b. If agree or strongly agree, please specify

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

27a. When you compare your work experience to that of your white British nursing colleagues, how would you describe it?

1. Better □
2. About the same □
3. Worse □
27b. If better, please specify.

........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#

28a. Are there any specific skills that you have not used since working for the NHS?

Yes ☐ No ☐

28b. If yes, what are they? (Please specify as many as you can)

........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#
........................................................................................................................#

Section 4: Discrimination

Please tick one of the boxes against each question:

29a. To what extent have you felt discriminated against or experienced discrimination in the workplace?

1. Never ☐
2. Rarely ☐
3. Sometimes ☐
4. Often ☐
29b If you tick any of these boxes, 2, 3 or 4 please list the way(s) in which you felt discriminated?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

30. I believe because of my colour or race patients or their families behave in a difficult, aggressive or hostile way towards me.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

31. I believe that white British nurses behave in a difficult, aggressive or hostile way towards me for reasons based on my colour or race.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □
32. To what extent, were you treated differently to that of your white British nursing colleagues by your manager because of your colour or race?

1. Never □
2. Rarely □
3. Sometimes □
4. Often □

33. To what extent, were you treated differently to that of your white British nursing colleagues by white doctors because of your colour or race?

1. Never □
2. Rarely □
3. Sometimes □
4. Often □

34. I believe patient information has deliberately by-passed me and been given to my white British colleagues whilst I have been on duty.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □
Section 5: Support Mechanisms

Please tick one of the boxes against each question:

35. I feel supported in my workplace.
   1. Strongly disagree □
   2. Disagree □
   3. Neither agree or disagree □
   4. Agree □
   5. Strongly agree □

36a. Have you ever had a work related problem?
   Yes □  No □  (Go to question 37 then 40)

36b. What do you perceive is the reason? (please specify)
   ..............................................................................................................
   ..............................................................................................................
   ..............................................................................................................
   ..............................................................................................................

37. If you had a work related problem whom would you most likely turn to
   for help? (Please select one from the following list)
   1. Ward Manager □
   2. Work Colleagues (White) □
   3. Work Colleagues (Overseas Nurses) □
   4. Family/Friends □
   5. Other (please specify) □
38. I find coping with work related problems in the workplace to be stressful.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

39. Which strategy or strategies have you used to cope when problems arise in the workplace? (Please tick those that apply)

- Distancing self □
- Escape avoidance □
- Confrontation □
- Accepting responsibility □
- Self control □
- Seek support from colleagues □
- Problem solving □
- Re-appraisal □

40. The systems and processes to support my work are inadequate.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □
41. The quality of support and guidance are excellent.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

Section 6. Adjustment to a new environment.

*Please tick one of the boxes against each question:*

42. I have been given satisfactory information on how to adjust to a new environment.

1. Strongly disagree □
2. Disagree □
3. Neither agree or disagree □
4. Agree □
5. Strongly agree □

43. My white British nursing colleagues have helped me to adjust to a new nursing environment.

1. Never □
2. Rarely □
3. Sometimes □
4. Often □
44. I have been given sufficient time to become acquainted with procedures and methods of working in the National Health Service.

1. Strongly disagree
2. Disagree
3. Neither agree or disagree
4. Agree
5. Strongly agree

45. I have been expected to adjust to a new environment and nursing culture too quickly.

1. Strongly disagree
2. Disagree
3. Neither agree or disagree
4. Agree
5. Strongly agree
Please feel free to add any more information in the spaces provided, that you think would help to further explain your experience.
Thank you for taking the time to fill in this questionnaire.

Please return the questionnaire to the University of Surrey in the stamped address envelope.

If you have any questions, please do not hesitate to contact Obrey Alexis, European Institute of Health and Medical Sciences, University of Surrey, Guildford, Surrey, GU2 7TE. Telephone number: 01483 686765 or 07751 774752 (Mobile) Email: o.alexis@surrey.ac.uk or obrey2001@yahoo.co.uk

It is anticipated that this study should not cause any distress to you but should you experience any uncomfortable feelings whilst filling out this questionnaire then here are the details of two support groups that might be of help to you: SupportYou.org and upsq01@aol.com.
Appendix 25

Questionnaire Evaluation Sheet
Questionnaire Evaluation Sheet

Please will you be kind enough to comment on the following aspects:

The clarity of the questions:

The presentation/layout of the questionnaire:

The information provided about the study:

The time it took to complete the questionnaire:
The clarity of instructions given on filling out the questionnaire:
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Any other comments:
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................