# CHAPTER 6

## Integrating

### Aspects of meeting the 'other'

The notion of 'otherness' is being constructed not by reflecting upon oneself, but by presuming characteristics of others. In addition to the relationships with colleagues, mentors and other supervisors or managers, there are further facets that signify the journey towards integration. When meeting 'strangers' we learn about ourselves and about the 'other' and different points of view or ways in which things are accomplished. This chapter therefore looks at language, culture and gender as expressions of the 'other' and examines migrant nurses' integration within this context.

*'In Africa there is no stress working in hospitals, but you get to know more clinical procedures, you are forced to practice more. Here nurses work under stress, they work in fear of making mistakes and being held accountable, back home nurses are very respected.'*

Migrant nurses from regions such as the Middle East may have worked in relatively successful health care systems while others from countries such as Ghana may even have worked in a health care system that was originally modelled on the British one. Thus some international approaches to nursing resemble the British nursing ethic more than others because of their shared colonial history.

Attitudes of prejudice among people are most commonly based on external characteristics, such as skin colour, texture of hair or accents and even

though ‘ethnic labelling’ has its shortcomings by stereotyping individuals and grouping them together, ethnic categories are part of ethnic monitoring in many organisations. While ethnic monitoring questions group individuals into categories such as ‘White’, ‘Mixed’, ‘Asian’, ‘Black’ or ‘Chinese’ with several sub-categories to each, this terminology is often not used when people describe themselves to others. For example, a migrant nurse may describe their own identity by stating that they are a *‘refugee’*, a *‘Palestinian’*, a *‘woman’* and *‘mother’*. Other self-definitions can include labels like: *‘student’*, being *‘African’*, *‘Burundian’*, an *‘Arab’* or *‘Rwandan’* or they point to religious beliefs stating that as a *‘Christian’* they had suffered persecution in a Muslim country or as a *’Muslim’* they feel awkward wearing a nurses’ uniform in Britain and working with patients of a different gender to themselves. Therefore such self-definitions can differ greatly from how others, who only notice obvious appearances, perceive ‘the stranger’ within the work context.

One male migrant nurse encountered the following remarks from firstly a patient and secondly a colleague:

*‘I don’t want to be treated by a terrorist.’* (remark made by a patient) and: *‘All Arabs treat women like slaves.’* (remark made by a colleague to the same nurse)

It seems difficult to discern if any such clichés made to describe ‘the stranger’ are the result of ignorance and thoughtlessness or of prejudices. Moreover, universal statements about ‘others’ are made by British-trained nurses, as

well as some internationally qualified nurses about other sub-groups of migrants.

Perceptions about the 'other' vary greatly and the following two examples indicate the extreme views expressed by two migrant nurses about the way they perceived their British-trained colleagues:

*'I think that British nurses are more organised than Pakistani nurses.'*

*'The average British nurse is not ready to work, so they always need support and if the support is not coming, they get hysterical.'*

Both statements are generalisations based on individual perceptions of working for a relatively brief period of less than a year with a finite number of British-trained nurses. Yet, we all find ourselves thinking or expressing universal observations about other people around us even though we neither know them properly nor do we fully understand if they are representative.

Consequently labels, such as 'British', 'Pakistani', 'Jew' or 'Arab' are commonly used in order to describe people's behaviours, not just their geographical origins. For this they do not appear very useful categories as individual encounters with 'others' vary and interpersonal encounters reveal commonalities as well as differences. The following comment provides an illustration of such commonalities among differently labelled groups of nurses.

A 95-year-old Jewish refugee doctor who had migrated from Germany to Britain during the 1930s mentioned the preference that British nurses who held Seventh-Day-Adventists' beliefs had for working at the London Jewish Hospital. Working in a Jewish organisation enabled them to regularly celebrate the Sabbath which would have been more difficult in other British hospitals:

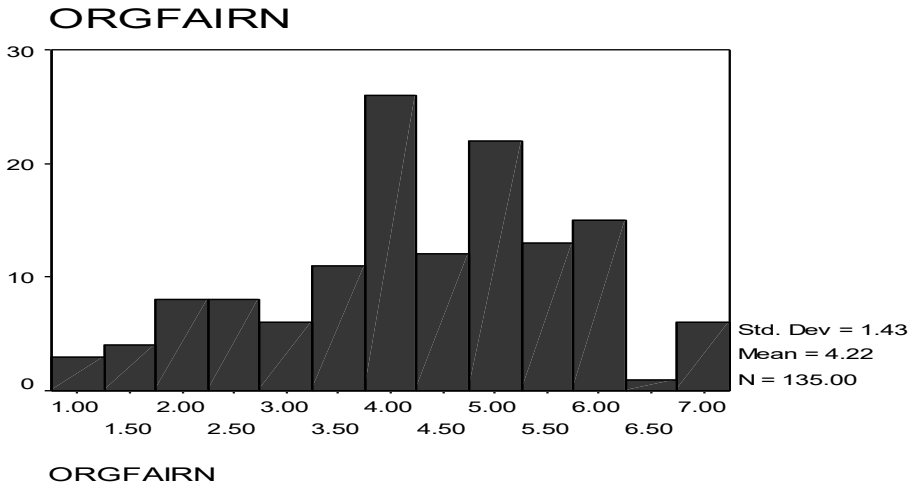
> *'About half of the nurses* (at the London Jewish Hospital in the1930s and 40s) *were German Jewish, a third of them were Irish and very few were English. Most of these English ones were Seventh Day Adventists. Saturday was a holy day for them, they didn't need to do anything that was not urgent - there were no routine operations.'*

Differences in skin colour are a further, often more explicit example of diversity than held religious beliefs and conclusions are readily drawn on the basis of someone 'looking' similar or different. As was made clear in the quote about skin colour and classroom behaviour above, conclusions and assumptions made on the basis of such surface-level diversity can lead to behaviour of inclusion or exclusion towards others.

True equality relates to procedural or interactive justice which is concerned with the fairness of the employment process reflected in the day-to-day behaviour of supervisors and colleagues. The survey conducted in the empirical study showed that most respondents perceived organisational procedures and equal opportunities policies as fairly implemented (mean of 4.22). However, this should not serve to neglect the few who have

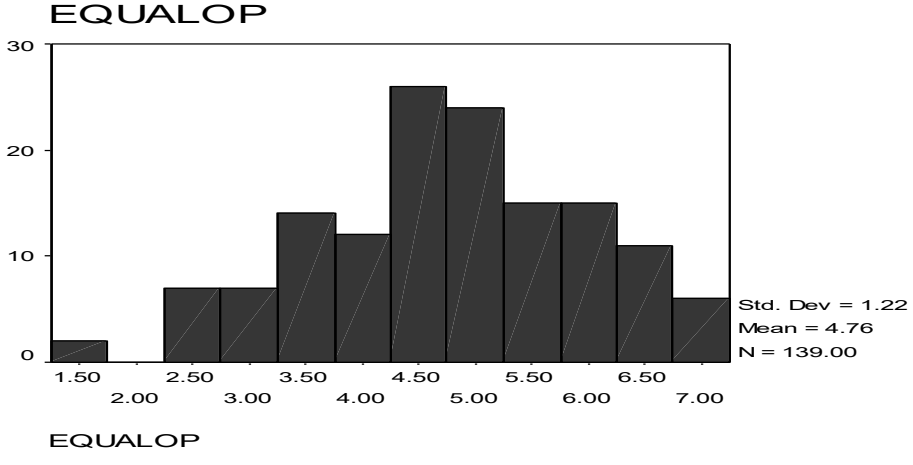
experienced serious discrimination as demonstrated in the distribution of survey respondents' perceptions of procedural fairness on a scale of 1 to 7 with a score of 7 being 'very fair', shown in figure 6.1:

Figure 6.1 Procedural fairness – perceptions given by survey respondents




The next figure, figure 6.2 illustrates the distribution of responses related to perceptions of the implementation of equal opportunities policies, reflecting that most rated this as medium to high with a score of 7 being the highest (mean of 4.76):

Figure 6.2 Equal opportunities – responses



Equality and procedural fairness reflects in the following work-related behaviours:

- Implementing of open communication procedures among all members of staff
- Showing respect for migrant nurses and those who appear ‘different’ regardless of the nature of these differences (age, gender, ethnicity, disability)
- Avoiding any form of discrimination
- Truly adhering to the spirit of Equal Opportunities policies
- Becoming credible and accountable in the way existing policies are implemented
- Stopping incidences of bullying and harassing
- Providing support to staff who feel discriminated against and helping them to utilise procedures to make themselves heard
- Implementing flexible working hours to allow individuals to space for personal commitments

The following examines issues, such as language, racist attitudes and gender norms as symptoms of procedural inequality when engaging with the ‘other’.

## Meeting others – language

The use of language is a further expression of inclusion as well as exclusion. Language illustrates barriers between ethnically diverse groups of people as it illustrates the creation of divisions and coalitions among individuals who are from different ethnic or racial backgrounds.

The following is an account between a migrant nurse from Burundi and her colleague from the Caribbean. On hearing that the Burundian nurse was fully qualified, but had trained in a different language presented a personal encounter which contributed to a deeper understanding between 'strangers':

*'There are nurses from Jamaica and they are from English speaking countries. 'How long did you do your training?' one of these nurses asked me and I replied, 'well, I did my training for four years' – and she looked at me in a very astonished way, saying: 'is it true?' I said, 'yes, but I didn't do my training in English, I did it in French.' - 'Oh really?'*

The same nurse then went on to talk about her own experiences of feeling excluded while some sub-groups of internationally qualified nurses share a common language, providing them with a collective identity:

*'Sometimes, I feel lonely, like I am on my own. No one is covering me because when other groups of nurses from the Caribbean or Nigeria are together, it's like they are covering each other. If one of them does something, no one will make a big deal. But if you are on your own, no one is there for you and it is a bit difficult. It can't be very easy for them as well, but there is the language and they have so much in common.'*

Another phenomenon of shared language is that some migrant nurses may use their mother tongue when speaking to colleagues form the same ethnic background which can equally be the case among colleagues from Europe, and the Philippines as well as other countries. With English being the shared language within the UK employment context, speaking in a language that is

not understood by the majority can make colleagues and clients feel isolated, as this female nurse from the Philippines expressed:

*'Some of the African nurses speak their own language. They also do this when they gather together in front of the patient. So, if you don't know the language you may think they are speaking about you.'*

Being excluded on the basis of language not only makes people feel isolated, but for newcomers it can enforce feelings of insecurity and 'not-belonging' in a place. The recognition of employees supporting each other on the basis of shared ethnic identity can exacerbate isolation of the minorities and hinder integration for those who are not part of that group. Thus the use of language creates boundaries as it differentiates British-trained nurses, but also creates sub-groups of migrant nurses based on their native language. Language therefore defines parameters for social inclusion or exclusion and leads to individuals feeling accepted or isolated.

## Meeting others – facets of racist attitudes

The Parekh Report[1] quotes perceptions by individuals belonging to minorities of their career advancement in the NHS in these words:

*'Black employees should feel lucky if they reach the status of ward or service managers as not many make it beyond that. While White managers feel that their rights to manage are well earned, Black managers are made to feel privileged when reaching that position. For many, the only way to grow into the job is through undying loyalty to those who pull the strings. Of course, that means distancing*

*themselves from any blackness and to be seen to be tough on people of the same racial background so as to show that racial affinity is not going to get in their way. Frankly, it scares the hell out of me to see how divided we are among ourselves.'*

Even though individuals who appear outwardly different can find commonalities in other aspects of their lives. However, attitudes of prejudice, linked to superficial characteristics can stop individuals from establishing meaningful relationships with someone who appears different at first sight. Such experiences of racism can be found among all ethnic categories, thereby confirming its relation to external appearance rather than immigration status. Experiences of racism further complicate the integration of migrants because it contributes to their exclusion.

There is some evidence that those nurses who migrated to Britain in the 1950s and 60s have found it difficult to move into more senior positions; many remain in lower paid grades and job roles and the literature presents evidence of discriminatory practice hindering their progression[2].

Even though most discriminatory attitudes may stem from the attitudes of a White majority towards a minority of ethnically diverse individuals, this is not always the case and there are also irregular aspects of racist attitudes. While prejudices that focus on race or ethnicity may primarily come from White colleagues, they can also be present among other Black and minority ethnic

colleagues, reflecting that racism has more faces than just skin colour as noted by Parekh.

The following statement illustrates what is commonly seen as a 'typical' observation of racial discrimination:

> *'When we go in placement and they put you on duty with a White trainee nurse, the staff give that one* (the White nurse) *more attention than you, because they think you are Black and the ward sister is White.'*

In some cases a deeper change in underlying attitude among some 'White' senior staff is required for nurses from minority ethnic backgrounds to experience true equality and this cannot be accomplished through written policies.

Prejudices or 'prejudgements' are mostly not drawn on the basis of observed behaviour, but on the conclusions that individuals draw from what they see. For example, a British-trained nurse might observe an African nurse working at a different pace to him or herself, drawing the conclusion that they are *'lazy'*. While some nurses from African countries may be happy to admit that they work differently, they would resent such a foregone conclusion. In fact they might express that they work in a more *'relaxed mode'* which is not only more enjoyable but also creates less work-related stress.

It is difficult to assess to what extent claims that attitudes of discrimination towards non-British nurses directly and exclusively hinder their career

progression. There are often a number of complex reasons why individuals do not progress, are unable to do so or do not wish to progress in their careers. However, the fact that there is an unrepresentative high number of White, male managers in the NHS compared to a largely female and often non-White general workforce raises some questions about the fairness of the promotion processes in place.

Some managers express concern about some minority ethnic nurses using the 'racism argument' for their own lack of ambition. While some nurses who came to work in Britain twenty years ago have not progressed into senior nursing posts and they themselves blame racist attitudes towards them. To unravel all the complexities of racism goes beyond the scope of this book, but it certainly forms an important aspect along the journey towards integration.

The following migrant nurse had applied for a post in an Intensive Care Unit (ITU), a speciality with many unfilled vacancies, resulting in this particular unit having to keep a number of beds unused. After being refused for the post, the nurse felt puzzled and distressed and had this to say:

*'I didn't get the post and I was very upset and I didn't find any valid reason why I was refused. For several nights I didn't sleep. There is nothing in my career profile that could be refused. About my head nurse, I am very sure that she has given a very good reference and I have worked here five years and in the past year I have not taken any sick leave. I can't think that I have been refused for professional reasons. Which means that if the government here is*

*trying to treat all the people the same way, there are still people here that don't treat all the people the same way.'*

While some migrant nurses experience such seemingly explicit discrimination, others observe that their colleagues are reluctant to change and develop their skills. Thereby their lack of openness to embrace difference hinders the introduction of new and more inclusive procedures at the workplace.

At the same time, as figures 6.1 and 6.2 above have indicated, many migrant nurses feel treated fairly and equally. A 45-year-old female nurse from Ghana who is a single parent with three children only had praise about how she was treated:

*'My mentor is White, they are all English. I don't find any difference at all. I haven't experienced anything bad. There is no discrimination in my workplace.'*

Prejudices and the creation of perceived 'in-groups' and 'out-groups' create layers of social exclusion. Many individuals do not distinguish between different countries of origin of migrant workers and would not even be able to distinguish between people from African and Caribbean countries or different Eastern European origins. Yet, they make sweeping statements about 'them' and 'all' being lazy or slow. Often such strong statements are the results of personal or collective feelings of anger and resentment leading to a strong 'us' and 'them' thinking, typical of prejudice. Based on such underlying attitudes the 'other' will always remain an unknown entity, a non-person and

moreover the ‘self’ will not be scrutinised within the mirror of values that differ. Any such attitudes stifle organisational development even if policy statements embrace diversity, equal opportunities and fairness.

Even though racism deals specifically with prejudices related to skin colour and ethnicity, similar attitudes also translate to gender in relation to employment.

## Meeting others – gender norms

Even on an international scale, nursing is a female dominated career choice[3] and with gender norms being culturally constructed, they vary from culture to culture. For example, the notion of ‘otherness’ commonly seems to include the expectation that women and particularly Muslim women act submissively. Consequently it may come as a surprise to some White British-trained nurses that some women from a Muslim background can be outspoken, while others do indeed behave in a very reserved way[4].

Stereotypical notions of masculinity seem to pressure men into some of the best-paying and most prestigious nursing specialities or management roles, therefore allowing male nurses to progress more easily. This seems to be confirmed when looking at male nurses’ career progression. MacDougall[5] explains this by stating that while men often enter nursing for the same reasons as women, namely a desire to care for others, perceived job security and the power that accrues to a professional position, the pressure (from

themselves or others) to conform to stereotypes of the 'dominant male' causes many to move away from caring roles into managerial positions.

Gender norms differ from country to country with further variations related to personal and family values. While some migrants to Britain state that: *'it would be shameful for a woman to migrate by herself'* others do not share such extreme views. Yet others feel misunderstood or even appalled, but unable to address gender-related behaviours in their British work places, as this female nurse from Somalia has encountered: *'this male nurse, when he is talking to you, he likes to put his arm around you.'* While such behaviour may not reflect professional norms in British hospitals, the migrant nurse may nevertheless feel unable to address a male supervisors' sleazy behaviour.

When comparing responses given by male and female migrant nurses in the empirical questionnaire, there is no evidence of any correlation between gender and any current or previous clinical speciality, career progression or shift pattern. Yet, the sample shows other gender-related differences:

- The majority of men (80% of all male respondents) were of Asian/Filipino origin, which nearly always meant that their employers had recruited them directly.
- The percentage of men who were financially supporting relatives outside the UK was slightly lower at 84% compared to 92% for women.
- Only five men (20% of all male respondents) had dependents living with them, compared to forty-four of the women.

- The female respondents had worked longer in their profession and nearly twice as long in their current post, the organisation and the NHS than the male respondents.
- When using t-tests to compare male and female nurses' responses, results showed that female respondents reported a higher perception of their organisation's implementation of equal opportunities policies and higher levels of support from both, their supervisors and colleagues than the male respondents.

The fact that gender norms differ and how this can reflect in patient care becomes clear in the following statement made by a migrant nurse who had spent some years working in Kuwait:

*'Actually, in Kuwait there would be no male and female patients on the same ward and you have male nurses for male patients. Here even though they are in different sides of the ward, it is more mixed and patients visit each other and sit on each others' beds. In Kuwait, if there is a male nurse we as female nurses should not be asked to look after the male patients but here they don't care. I just try to be patient and get used to it'*

Varying gender norms illustrate some of the adjustments migrants have to undergo when integrating into a very different employment context.

Migrant's perceptions of the implementation of equal opportunities policies, fairness and their own ability to be involved in their organisation are all indicators of their successful integration. Once migrants believe that they are

treated equally and fairly, they can concentrate on their career and develop professionally without added worry about being treated less advantageously than their British-trained counterparts.

**References**

[1] Parekh, B. (2000) *The Future of Multi-ethnic Britain, The Parekh Report*. London: The Runnymede Trust.

[2] Beishon, S., Virdee, S. and Hagell, A. (1995) *Nursing in a Multi-Ethnic NHS*. London: Policy Studies Institute.

[3] Anker, R. (2001) *Gender and Jobs, Sex Segregation of Occupations in the World*. Geneva: International Labour Office.

[4] Summerfield, H. (1996) Patterns of adaptation: Somali and Bangladeshi women in Britain. In: Buijs, G. (Ed.), *Migrant Women, Crossing Boundaries and Changing Identities*. Oxford: Berg.

[5] MacDougall, G. (1997) 'Caring – a Masculine Perspective' *Journal of Advanced Nursing* 25: 809-813.