Strangers in a British world? Integration of international nurses

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Abstract

This article, based on research carried out in 2002–2003, examines 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. The migrant nurses' encounters at work may highlight their difference to the majority, namely the British qualified nurses. Despite attempts on behalf of some healthcare employers of embracing diversity, the process of achieving acceptance and respect as a migrant worker can be a taxing one. Findings indicate that the nurses' identity as a 'migrant', rather than as a 'man' or 'woman', drew most comment in their day-to-day work. While the nurses encountered some prejudice because of their foreign origin, they also experienced fair and respectful interactions. The study highlights the complexity of work-related identities among international migrants, a group of employees which, despite nursing shortages in the NHS, has attracted little research interest and poses a challenge to management.

Key words: Overseas nurses ■ Migration ■ Gender ■ Identity ■ Integration

In 2002, there were 10 000 vacancies for nurses, midwives and health visitors, out of which 2750 were in London. More recent figures for 2004 show 2719 registered nurse vacancies of 3 months or more in London (Department of Health (DoH), 2001, 2002; Laurance, 2002, 2003; Hutt and Buchan, 2005). This high number of nursing vacancies has led to a range of initiatives: promoting the profession to increase the numbers of young and male nurses (Whittock and Leonard 2003; Hutt and Buchan, 2005); attracting nurses who decided to take a career break back into nursing; and well-publicised efforts to increase overseas recruitment. These internationally recruited nurses form a minority among the NHS workforce and even though there is some increase in the number of male nurses, nursing continues to attract more women than men.

The BBC (1999), reported that 'hospital managers have had to recruit nurses from South Africa in a bid to stave off a staffing crisis', while Brindle (2000) said that 'the NHS is turning to China in a desperate attempt to recruit nurses for Britain's short-staffed hospitals'. In response, international recruitment drives led the NHS to publish a code of practice prohibiting direct recruitment from African countries (DoH, 1999). Nevertheless, African nurses continue to be recruited by the independent sector or they emigrate to the UK in search for a better life and eventually many still end up working for the NHS (Buchan, 2002). This exodus of nursing staff from their home countries in search of opportunities in the UK has not gone without comment, not least because

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Cover picture.

of the stress caused to the local health services when qualified staff leave their home country. However, the quest for qualified nursing staff shows no sign of abating (Mensah et al, 2005).

Overseas registration statistics show a steady increase in the number of nurses and midwives being recruited from outside the UK and the European Community, with the largest numbers in 2000/01, 2001/02 and 2002/03 coming from the Philippines, India and South Africa (Nursing and Midwifery Council (NMC), 2004). As a result of international recruitment, one in three registered nurses in London is from overseas compared with the national average of one in ten (Buchan, 2000). A small number of these nurses are refugees, forming a sub-group of migrant nurses. It is interesting to note, given the low numbers of male nurses registered in Britain, that out of the 220 nurses on a database for refugee nurses held by the Royal College of Nursing, 29.4% are male (RCN, 2004). It is often argued that some countries, like the Philippines train a surplus of nurses in the assumption that many will work elsewhere and send remittances. Yet, the number of nurses in the Philippines per 100 000 people is only half that of Britain; 418 compared with 847 (Aiken et al, 2004). Estella (2005) reports on the nursing situation in the Philippines and says that even though the number of male nurses is rising, migrant healthcare workers are predominantly female and when they leave, many families loose their traditional caregivers. While it may be easier to migrate as a man in some circumstances — research findings vary — there are more male migrant doctors than female, yet numbers of migrant workers in the East of England show an almost even gender distribution (McKay and Winkelmann-Gleed, 2005).

The sentiments of some British citizens towards migrants, reported in the press, would seem to suggest that the public's view of NHS policy to fill the gaps in the nursing profession with migrant workers raises issues about their reception: 'Today, we are being swamped by people arriving illegally from a multitude of countries and cultures, who care nothing for Britain, our traditions or our way of life' Littlejohn (2003, p11). Hardly a week goes by without some comment in the press on migrants, reflecting a dynamic debate surrounding international migration and integration and highlighting a desire to control the people-flow into Britain by distinguishing between the 'wanted' and 'unwanted'. Yet, for nurses, being among the 'wanted' does not necessarily guarantee a warm reception (Kyriakides and Virdee, 2003).

Barriers to entry into nursing because of masculinity

Women constitute three-quarters of the NHS workforce in Britain and just under 90% of nurses are female (NMC, 2004). At the same time the number of registered male nurses has been gradually increasing: 9.89% in 2001, 10.21% in 2002, 10.48% in 2003 and 10.7% in 2004 (NMC, 2004, 2005). Many of the male nurses choose specialties like psychiatric nursing, casualty or intensive care while women are concentrated in lower paid jobs, such as cleaning, catering, nursing (e.g. geriatric nursing or nursing on general medical wards), paramedical, ancillary and clerical positions (Porter, 1992; Davies, 1995). Despite attempts to challenge this, looking after sick people continues to be seen as an extension of tasks viewed as 'feminine' (Mackintosh, 1981; Leonard, 2003) and the presence of male nurses confronts common perceptions of masculinity (MacDougall, 1997; Charles, 2002).

It remains a global struggle to attract men into nursing and it is, therefore, unremarkable that the growing number of publications on migrant nurses assumes them to be women, confirming that nursing generally is viewed as a woman's occupation (Davies, 1995; Ekstrom, 1999; Evans, 2002; Whittock et al, 2002; Davies, 2003; Fealy, 2004). When a nurse is a man, a qualifier is often used: he is a 'male nurse' (Muldoon and Reilly, 2003). De Lange suggests that the usual categorization is that 'nurses are single whereas doctors have wives' (2004, p1) because they are male.

Evans (2004) describes how prevailing definitions of masculinity act as a barrier to men's entry to nursing in Canada, Britain and the United States. This view is supported by a Swedish study from Öhlén and Segesten (1998) who report that members of the public voiced their uncertainty over interacting with a male rather than with a female nurse. However, not only the public may resent the presence of a male nurse, and in a British study on the gendered interaction between doctors and nurses, a male nurse commented that he felt threatened and disempowered by the gender discourse and his female colleagues' perception of a 'real' nurse (Leonard, 2003). It is ironic that stereotypical notions of masculinity seem to pressure men into some of the best-paying and most prestigious nursing specialities (Williams, 1995). MacDougall (1997) explains that while men often enter nursing for the same reasons as women: 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.

The impact of gender on the experience of nursing

Even migrant nurses who have come to Britain through agencies may find themselves in difficult situations with the job and working conditions not turning out to be what had been promised. Yet, for those who have come to Britain independently of recruitment agencies, including those who have come as refugees or for non-work-related reasons, the barriers to gain access to employment are formidable and current studies describe the obstacles (Refugee Council 1999; Hardill and MacDonald, 2000; Coker, 2001; Culley, 2001; RCN, 2001; Harrison, 2003). While many migrant nurses may encounter English language problems, refugee-specific barriers can consist of the lack of access to professional documents to prove qualifications and work experience and access to work references. This, combined with a lack of guidance and encouragement from employers and regulatory bodies as to how past qualifications can be recognised in Britain (Eversley, 1999; Eversley and Watts,

Table 1. Description of the survey scales

Scale name	No. of items	Coefficient alpha	Scale description
Job attitudes			
Equal opportunities	7	0.80	The extent to which employees agree
Social factors			
Support from supervisor	4	0.92	The extent to which employees receive
Support from colleagues	4	0.90	The extent to which employees receive

2001), can make integration a truly cumbersome process for them.

In the early years of internationally qualified nurses migrating to Britain it appeared obvious that they were only filling vacancies and their integration into the workforce and right to be treated equally and fairly was not asserted by them or their employers (Ramdin, 1999). As Modood et al (1997) point out, discrimination against manual and public sector workers was integral to industrial relations during the post-World War II years. Since then the Race Relations Act 1976 has led to the establishment of the Commission for Racial Equality (CRE) whose duties are to eliminate racial discrimination (Suter, 1997). Managers can now be held responsible for racial equality in their organizations (Phoenix, 2002). Higher than average levels of unemployment among minority ethnic groups in Britain and their under-representation in management roles indicate that the reality differs from what the law sets out to achieve (Mwasandube, 2001). Recently some policy makers have acknowledged underlying prejudices in the British healthcare sector (Beishon et al, 1995; Coker, 2001) and the studies signify that people of minority ethnic identity are still socially constructed as the 'other', rather than as 'normal' (Ahmed, 2000; Phoenix, 2002) with an 'exclusionary culture' persisting in the healthcare system (Blackford, 2003; Kyriakides and Virdee, 2003).

The study

Study setting

With over 1 million employed staff, the NHS is now the largest employer in the UK, and in England it employs 782 100 staff members in total, and out of these 338 600 are nurses, midwives and health visitors (NHS Confederation, 2002). In London, the NHS employs 55 000 nurses and midwives and requires an increase of 30% over the next 5 years to meet staffing requirements as a result of turnover and recruitment problems (Easmon, 2003).

Methodology, data collection tools and sample

This paper is based on research with internationally qualified, foreign-born nurses in London. A complementary research strategy applied quantitative (a survey, $n=140$) and qualitative methods (semi-structured interviews, $n=22$). For the self-administered survey five London-based hospitals were selected through self-selection and contacts. Ethical approval was sought and obtained from each hospital and individual participating in the study, and all data collection tools were piloted.

Interviews: In-depth interviews were conducted throughout 2002 ($n=22$: 20 female and 2 male) with follow-up interviews ($n=7$: 5 female and 2 male) in 2003 to examine progression towards integration in more detail. Access to the interview sample was provided through a refugee organisation based in East London which supports migrant nurses in accessing employment in the NHS, regardless of their motive for coming to Britain. These same nurses also completed the survey. This data was complemented by key informant interviews ($n=26$), which among, others included NHS managers.

Table 2. Demographic background to survey respondents

Measure		Total	Female Respondents	Male Respondents
Number of respondents		$n=140$	$n=115$ 82.14% of sample	$n=25$ 17.86% of sample
Demographic mean age		34.19 years	34.7 years	31.7 years
Ethnicity			Asian, including Filipino: 66 White: 15 Black or Black British: 28 Other: 2	Asian, including Filipino: 21 White: 3 Black or Black British: 1
Hours worked	Full-time	137	112	25
Number of respondents		97.86%		100% of male respondents
	Part-time	3 2.14%	3	0
Financial support to relatives outside UK		75.71 %	92% financially support relatives outside the UK	84% financially support relatives outside the UK
		24.29%	8% don't financially support relatives outside the UK	16% don't financially support relatives outside the UK
Marital status	Married	65 46.4%	54 47% of female respondents	11 44% of male respondents
	Single	56 40%	40 35% of female respondents	14 56% of male respondents
Dependents living with them in the UK		49 32.1%	44 38.3% of female respondents	5 20% of male respondents
Length of time in nursing in months		121.4	128.3	92.7
Length of time worked in current post in months		20.9	23.3	10.4
Length of time in current organization in months		19.4	21.3	11
Length of time in NHS in months		21.6	23.9	12.5

The survey: The survey consisted of previously tested measures (Price, 1997) using a seven-point Likert scale and the following ones measures feature in this paper:

- Measures for 'equal opportunities' were taken from Institute of Employment Studies scales, tested and applied in a national NHS survey (IES, 2000)
- Measures for 'supervisory and colleague support' were adapted from Caplan et al (1980).

In addition to demographic and employment-related information, the survey investigated work-related factors, such as support received and work attitudes and employees' intention to stay with the organization.

Reliability and discussion of the data collection tools

Table 1 summarises the survey scales in terms of the number of items and coefficient alphas (confirming the reliability of the scales used). Likert scales ranging from 1 (strongly disagree) to 7 (strongly agree) have been applied consistently to all questions and all the scales measured the individual nurse's perception of either themselves or their employer.

Reliability coefficients were in the commonly accepted range between 0.80 and 0.93 (Nunnally, 1978). The number of items ranged from four (for 'supervisor' and 'colleague support') to seven (for 'equal opportunities'). A response rate of 38% led to 140 useable responses: 115 women (82.14%), and 25 men (17.86%), further demographic details are given below in *Table 2* and this complements the interview data.

Even though the survey and interviews covered the same themes, using quantitative measures to investigate individual experiences and attitudes have been criticised (Macnaughton, 1996), but applying well-tested measures, using a self-report methodology to ensure anonymity and by aiming for a large enough sample, problems of reliability were minimized.

Findings

Description of the survey sample based on gender

As *Table 2* below shows, four out of five survey respondents were female, confirming the view of a number of commentators that nursing is a 'female-orientated career' (Anker, 2001).

The majority of all migrant nurses who responded to the survey were of Asian/Filipino origin (62.1%), which nearly always meant that their employers recruited them directly or through an agency. This information was determined through key informant interviews with recruitment managers in the hospitals participating in the research. The details of the ethnicity of the male nurses showed that 21 of the 25 male respondents were of Asian/Filipino origin, three were White and one was Black or Black-British. The data also showed that out of the total 140, 137 (98%) worked full-time. All male nurses worked full-time. Among the nurses who worked full-time, 66 (47% of the total sample) worked a mixture of early, late and night-shifts; 30 (21% of the total sample) worked a mixture of early and late shifts and out of the remainder, 32 (23% of the total sample) worked long 12-hour shifts. Besides working long shifts, more women (38%) than men (20%) had dependents living with them and would rely on support from relatives and friends or child-care institutions. There was not much difference between the proportion of married male and female respondents (44% of men and 47% of women). However, a higher proportion of men were single (56% of men compared to 35% of women) and none reported being separated, divorced or widowed. The percentage of men who were financially supporting relatives outside the UK was slightly lower at 84% compared to 92% for women. Only 5 men (20% of all male respondents) had dependents living with them, compared with 44 of the women (38.3% of all female respondents).

There was no evidence from the survey data of any correlation between gender and any current or previous clinical speciality, career progression or shift pattern. However, the female respondents had worked longer in their profession and nearly twice as long in their current post, than the male respondents. Yet, more than half of the key informants, including NHS managers were White and male with only three originating from minority ethnic backgrounds.

Results from *t*-tests used to compare male and female nurses' responses (*Table 3*) show 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 mean responses and distributions of responses to the implementation of equal opportunities policies placed the interview data into a wider context by showing that most migrant nurses perceived their implementation as relatively high. However, as the stories below highlight, there were examples of potential inequalities. Demographic variables, such as organisational statistics on diversity, cannot adequately reflect the psychological processes that individual migrant nurses have to go through in order to integrate (Lawrence, 1997).

Table 3. Gender related to perceptions of the employing organization

Variables	Male (n = 25) Mean/(sd)	Female (n = 114) Mean/(sd)	df	t-value	Significance
Equal Opportunities	4.25 (1.17)	4.87 (1.20)	137	-2.36	0.02
Support from Supervisors	3.98 (1.49)	4.75 (1.64)	137	-2.15	0.03
Support from Colleagues	4.09 (1.30)	4.90 (1.42)	137	-2.61	0.01

df = Degrees of freedom, sd = Standard deviation

Experiences of nursing in Britain

The examples presented in this section were typical of the interview sample and they illustrate firstly, the perception of migrants by British-trained nurses and patients; secondly, migrant nurses' integration; and thirdly their carer progression.

Perceptions of migrants and migration

Ahmad felt the hardship of being separated from family and experienced the relationship with his mentor as supportive, so he was taken aback when a patient said to him:

'I don't want to be treated by a terrorist.'

and a colleague stated:

'All Arabs treat women like slaves.'

Ahmad did not speculate on whether these statements had been made as a result of ignorance and thoughtlessness or of prejudice, but he made the following plea for 'respect' from British people during his interviews:

'I just want them to respect me, I have respect of British people.'

Hadija, compares her experience with that of other migrant nurses who had come from the former British colonies and felt, at times, alienated:

'…sometimes it is hard to work, because staff they don't understand, they don't understand.'

For Ahmad, gender norms clearly define if an individual is able to travel across international borders:

'It would be shameful for a woman to migrate by herself.'

When asked what his advice to British-trained nurses who wanted to work in a different country would be, he said:

'It is different for them when you are in a culture that is different for girls. It so difficult for me but for girls I think they should think a lot about it. For girls, I think especially for the women in the Middle East the approach and attitude is different.'

The fact that acceptable norms for female migrants vary in different regions and also influence subsequent adaptation to life in Britain was confirmed by the research data with some, particularly those from the Middle East, viewing females migrating independently as unacceptable, thereby endorsing Ahmad's view, quoted above. For female nurses from Ghana, migration to Britain has long been a common occurrence owing to the colonial links and similarities in nurse training. In Britain they often found themselves as part of a wider community of Ghanaians. Yet, individual family background does affect experience and personal circumstances can overrule a technical freedom to travel, thus Melinda, a nurse from Ghana, was prohibited from leaving her country and only felt free to travel after the death of her father:

'I have a lot of friends here and nieces. Most of them came down when the UKCC regarded you as a fully qualified nurse. I didn't come because my father didn't allow me to travel. I was the only girl and he didn't want me to go. It was not until he died that I started travelling.'

As the personal identities are formed through family, environment and culture, regardless of skin colour and gender they also form perceptions of migration and migrants.

Migrant nurses' integration

Ahmad's encounters with colleagues, supervisors and patients reflect mixed experiences. While his supervisors and mentor were acting in a very supportive, professional manner, his quotes show that other work-related contacts were less encouraging.

Hadija explains that migrant nurses come to Britain with years of professional experience:

'Remember we are not student nurses. I am not a student nurse, I qualified, I have 25 years' experience of being a nurse, I have not started here; I am adapting my knowledge.'

Regardless of gender, relationships between the migrant nurses and their colleagues generated more negative remarks about auxiliary and agency nurses than about fully qualified colleagues who were generally reported as being supportive and professional. Hadija confirmed that senior staff were supportive, but had encountered prejudices from other colleagues as a result of English not being her first language:

'The sister supports myself but otherwise they are holding me back and they are also prejudiced they thought because we are not English speaking so we don't know nothing.'

Language issues are a double-edged sword, on one hand for the migrant nurses to speak English as a second or third language caused cross-cultural communication problems between them and some colleagues. On the other hand it was also acknowledged that such language skills were an asset when communicating with minority ethnic patients, particularly in multi-cultural parts of London. For example, Iqbal, a 31-year-old male who was an asylum seeker from Pakistan, mentioned in the interviews that he was pleased that his multiple language skills were frequently drawn upon by colleagues and doctors. This gave him a feeling of making a valuable contribution to the hospital in addition to his professional nursing skills:

'My contribution is that I speak Urdu language, so I can translate. There is a lot of patients, I can translate easily from Hindi, Punjabi and Urdu. I can speak a little bit Pashtu.'

In addition, the interview findings showed that differences in gender norms can lead to conflicts either within the family or within the employment environment. Manager Brown, during a key informant interview, illustrated how cross-cultural misunderstandings had led to a complaint at his organization:

'A young man, in his 20s came in for relatively minor surgery. The nurse on night shift was Nigerian and noticed that he wasn't sleeping and said to him "What's the matter with you?" and he said, "Well, actually", and he had been psyching himself up to say this all day, "I am really scared about tomorrow." And what she said to him was, "Don't be such a big baby, go to sleep now." He was devastated and at the time I think he felt very small indeed. After the surgery he was quite angry about it and it became a formal complaint.'

The nurse had behaved in the way that had upset this British patient immensely, while she probably felt it was appropriate for this man to conform to a gender stereotype of a 'strong' man.

In trying to establish his identity in exile, Iqbal appreciated the direct support offered to him in the form of the provision of literature and help with written work, as well as the personal introduction by his mentor to the existing work team:

'When I started in theatre she introduced me very well to the other staff and she also taught me, gives me help with written work and gives me nursing articles. She is very complimentary. Yes, I am happy with her.'

He emphasized that the success of cross-cultural relationships are down to personalities as much as wider social and demographic characteristics:

'Personally, I think it depends on the candidates, how they handle people, my situation, I am happy here.'

Yet, not every migrant nurse feels like that and Farah, a young, experienced midwife

from Iran, expressed her frustration during the supervision period when her mentor criticized her for giving a women who had come to the clinic complaining of vaginal discharge some advice on hygiene. Yet the mentor told Farah: 'I want you to know women here change their underwear every day, we are not in your country.' This left Farah who had acted very professionally feeling distraught:

'My mentor, her behaviour and her attitude — honestly at that point I just cried, I just started to cry.'

A young, single female nurse from Somalia who had also worked in Kuwait, Samah, confirmed that she needed time to get used to the reflection of gender norms in British hospitals:

'It is different, in Kuwait there would be no male and female patients on the same ward and you have male nurses for male patients. Here it is more mixed and patients visit each other and sit in each others' beds. If there is a male nurse we 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'

For her there was nothing strange about 'male' nurses, indeed in her experience they had a vital role to play in the work environment which she was used to: a segregated society in an Arabic country. Nevertheless, the fact that she now worked with male colleagues who behaved differently to the gender norms she was used to, as well as working on mixed wards, posed problems for her. She had experienced quite unprofessional behaviour from her male colleague, which she found hard to address while she was still adjusting her skills to British standards. She said:

'This male nurse, when he is talking to you he likes to put his arm around you…so, when I get my PIN number I am not staying quiet.'

Her experience highlights what is typical for most migrant nurses — that they feel vulnerable and insecure while they undergo the 3–6 month-long adaptation process before becoming a British-registered nurse.

Migrant nurses' career progression

Ahmad works full-time in addition to pursuing further studies and was keen to progress in his profession. While there was no concrete evidence that career progression among the migrant nurses was directly and exclusively hindered by individuals' attitudes towards them, his experience may raise some questions regarding fairness and suggests that prejudices and discrimination may affect migrant nurses' professional progress. Ahmad had applied for a post in an intensive therapy unit (ITU), a specialty with unfilled vacancies and empty beds. After being refused for the post, he felt puzzled about the reasons for this and said:

'I was very upset and didn't find any valid reason why I was refused and for several nights I didn't sleep. I don't think that I have been refused for professional reasons, which means that there are still people here that don't treat all people the same way.'

Six months later Ahmad said that during the recruitment he had been asked what his response would be to a patient who thought he was a terrorist. This is not a question that is commonly asked in nursing interviews and it is questionable if it would have been asked if the nurse in question had been White. Within the limits of the interview sample it is difficult to ascertain how common such incidences were.

Ahmad, not having been deterred by some of the disheartening encounters, mentioned that he had embarked on a part-time Masters degree in healthcare management, as well as continuing to work full-time as a nurse for his NHS Trust.

'In a few months my manager will promote me from D grade to E grade. That will be better not only financially, but also psychologically.'

Despite his encounters with racist sentiments from a few patients and colleagues, he was satisfied with the hospital.

Iqbal expressed that, in addition to having been offered a safe place to live, he wanted to make use of the professional opportunities:

'When I came here (as a refugee) I tried to better my job as well.'

He was positive about the opportunities he was offered by his employer and confirmed the availability of study days, pointing to the cost incured in running them:

'They have to pay for someone to go to the ward and also they pay for the class. So, it's a very good thing.'

He managed to get a job in theatre care in the same hospital that supported his adaptation, showing appreciation of the investment that was made in him. He had settled into the British approach to nursing and continued to learn about the different types of surgery, enhancing his skills.

Hadija had also been promoted, but many of the migrant nurses who started with her at the same hospital had left due to pressures they felt themselves under in the day-to-day ward management. Farah was encouraging other migrant nurses and midwives and considering her options for career development.

Discussion

The sample allows us to outline some broad conclusions on the multiple identities experienced by migrant nurses and the ways in which gender identity may affect the work experience of both female and male migrants working in the British health service.

People classify themselves and others into social categories based on observable and hidden commonalities, defining multiple identities, differentiating 'me' from 'you' as an individual and 'us' from 'them' as a group (Tajfel and Turner, 1979; Brewer and Gardner, 1996). These notions of self-perceived identities become apparent in the interviews and the encounters with colleagues, supervisors and patients. How Ahmad viewed himself as a 'Muslim' and as an 'Arab' influenced his identity as a 'male' and as a 'migrant'. Among all the migrant nurses different facets of personal identity surfaced and were dominant in different encounters with others. Yet, in each encounter the migrants' self-perceptions as males or females and nurses diverged from the picture others had painted in their own minds about 'Muslims', 'Arabs', 'male nurses' and 'migrants'. In the interviews the identity as a migrant was central, rather than as a man or woman.

Ahmed (2000) argues that employment can enhance the feeling of belonging within a foreign place. Hogg and Terry (2000) echo this by stating that self-identification is closely linked to identification with a social group as individuals seek a positive social identity by belonging to an in-group, which enhances self-worth. Individuals who are prevented from socially identifying at their workplace might remain or become 'a stranger', someone who feels isolated and excluded. By going out to work like most other people, points of identity with them can arise. The 'stranger' becomes a familiar

feature for 'natives' and differences can be overlaid through the discovery of similarities. Thus the stranger does not have to assimilate, but, at best, the focus can turn from facets of distinction to acceptance and an integration of diversity and the interaction with others, colleagues and supervisors in particular, gives work further meaning. At worst, the recognition of difference can lead to exclusion and expressions of unfairness and intolerance by the majority as the stranger may be perceived as a threat and accused of taking 'our' jobs.

The migrant nurses generally expressed satisfaction with their work environment and the way they felt treated. They were proud to contribute language skills and Iqbal's translation eased communication between doctors and patients. This not only gave him credibility as a professional, but also enhanced his sense of belonging and of identification with the work environment. On the other hand critique from mentors and overt or hidden discrimination fostered migrants' exclusion by making them feel 'different', 'rejected' and 'second-class citizens'.

For both men and women, interpersonal relationships formed a bridge between the 'stranger' and the institution, thus either hindering or fostering multiple personal and work-related identities as part of the integration process. Relationships were also marked by problems in cross-cultural communication and perceptions of individuals' cultural background, leading to assumptions projected from one person to another. As Morris (1968) and Tajfel (1978) point out, members of minority groups can feel some commonality in race, nationality, culture and history and in addition may share experiences of discrimination and social disadvantage in their host community. However, experiences of racism were found among all categories of migrant nurses, which confirmed racisms relationship to external appearance, such as skin colour independent of immigration status. Prejudice, however, was not one-sided and the creation of perceived 'in-groups' and 'out-groups' reflected that migrant nurses themselves held prejudices against other sub-groups of migrant nurses, thereby creating different layers of social exclusion. This was demonstrated when nurses from Eastern Europe, who perceived their registration in Britain as more complicated than that of nurses from Africa, commented about the 'laziness' and difficult 'accents' of their African colleagues.

Thus racist attitudes did not just exist among a majority towards a minority group of people, they also existed among minority groups and were focused on obvious as well as subtle differences among individuals. Such racism may be the result of perceptions of skin colour or country or religion. Ahmad, being a Muslim, for example, faced a particular type of racism associated with the widespread fear of Islamic terrorists. For Ahmad, a turning point had been the 11th September 2001. Talking of his colleagues' behaviour during that September he observed that his colleagues did not speak to him about the event, but rather ignored him and displayed signs of being suspicious, which he hoped would not reflect a general idea about Muslims. As noted above, he was referred to as 'a terrorist', a term that is popularly equated with men rather than women, so his male identity as well as perceptions about his socio-cultural background probably played a part in this labelling.

The findings show that perceptions of 'self' differ from those of others related to the multiple personal and work-related identities that emerged in the research. Male migrant nurses' integration into the British healthcare system highlighted the complexity of what constitutes the 'stranger' and different facets of identities emerged in different work situations, creating boundaries and commonalities.

While a gender comparison of the demographic survey data revealed few variations in terms of age, ethnicity and employment status, women had in general been in nursing longer than the men and had also been with their current organization, in their current post and with the NHS for longer. This finding does raise questions about career progression and the type of work that men and women undertake. Halford and Leonard (2003) in their study of the ways in which hospital spaces impact on the working lives of nurses, observed that professional differences in access to space are intermingled with gendered differences. Across both hospitals [in their study], all but one of the ward nurses were women and they stated that male nurses rarely work in mainstream wards, being concentrated in specialties like intensive care, theatres and A&E.' (Halford and Leonard, 2003: 204). They go on to explain this difference in terms these spaces being 'generally smaller and more bounded spaces where male nurses are often in charge, at least of routine matters' (ibid). In a survey of nurses employed in the NHS in England and Wales, Finlayson and Nazroo (1998) found that men were twice as likely than women to be serving in the highest nursing grades, a finding also supported by other studies (Beishon et al (1995); Davies, 1995; MacDougall, 1997; Whittock et al, 2002); Brown and Jones, 2004).

From the in-depth interviews it was learned that many of the migrants had formerly worked in senior positions and were experienced practitioners. Yet their promotion experiences in Britain revealed a mixed picture with some nurses being rejected while others were supported through to promotion. The differences found in our survey data in the length of time in the present position, as well as the expectations expressed regarding careers may support the finding that men's career paths in nursing differ from women's. Yet, this will have to be looked at in further detail once the research participants have had a chance to fully establish themselves in their careers in Britain.

Conclusion

The authors set out to explore if gender played a role in migrant nurses working in the British healthcare system. Given the size of their sample the authors tentatively assert that the identity as a foreign born internationally qualified nurse is a more important label then gender identity. Male migrant nurses may get labelled disapprovingly more easily than their female colleagues as they are not only not the norm in the nursing profession, but moreover, as migrants in a white, female dominated profession they stand out even more. On the other hand, the fact that male nurses tend to progress more easily into more prestigious nursing specialties or into management roles, appears to be reflected in the career progression experienced by the authors' informants. Yet, in order to access this space for their future job security they may have to contend with losing parts of their personal identities as they group themselves with the majority, which is often 'male' and 'White'.

Gender and cultural identities strongly influenced work-related ones, however, professional identity and a commitment to career progression was an overriding motivational factor. Developing their career was more important to the migrant nurses than being committed to the workgroup or organization.

The findings do indicate that the 'other' (Ahmed, 2000) takes on different meanings for different individuals and ethnic groups.

The experiences of resettlement and integration are the results of personal characteristics, calling for each newcomer to be treated as an individual. This should warn managers not to group all their 'minority ethnic' employees together as one seemingly homogenous group and to recognize that each male and female migrant nurse brings different talents and skills which they offer to the health service and to their profession. BJN

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KEY POINTS

- Efforts to meet demands created by nursing vacancies drew a substantial number of migrant nurses to Britain and their integration is key for the success of care delivery and team relationships.
- Male as well as migrant nurses form minorities and their perception as 'strangers' present a challenge to management.
- Male migrant nurses identify foremost with being migrants, not men.
- Gender and cultural identities strongly influence work-related ones, however, professional identity and a commitment to career progression is an overriding motivational factor.

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