

Migrant nurses in the UK: facets of integration

Summary

This article examines issues related to the motivation, integration and contribution of internationally qualified nurses (Winkelman-Gleed, 2006). The paper is based on empirical research carried out in 2002-03, combining a self-reported survey, in-depth interviews and drawing on individual experiences of workplace integration. Distinctions among different sub-groups of migrant nurses have implications for policy and practice.

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This discussion paper is based on findings from an empirical research study carried out in 2002-03 by the author (Winkelman-Gleed, 2006). It draws and discusses on the experiences of internationally qualified nurses who had migrated to Britain and were working in London (n=140 for a self-administered survey and n=22 for in-depth one-to-one interviews which included 12 refugee nurses).

With the persistent shortage of nursing staff in the NHS, healthcare employment is closely linked to migrant labourers (Winkelman-Gleed 2006, Culley and Dyson 2001). Not just in healthcare, but also in other sectors, such as construction, horticulture, food processing, retail and tourism to name just a few, migrants have become the backbone of industry (McKay and Winkelman-Gleed 2005). Thousands of nurses have been 'imported' from the Philippines, which has no historic links with Britain. Others have come from South Africa, India or Australia (ILO 2003, Buchan 2002, NMC 2005). 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 (Aiken et al 2004). Currently, as a result of international migration, a substantial number of health care workers are non-UK qualified or were not born in the UK: 31 percent of doctors and 13 per cent of nurses in the NHS are now non-UK born (Findlay 2002).

MIGRATION AND ETHNICITY

The literature on the employment of UK residents from Black and minority ethnic backgrounds does not distinguish between motives for immigration, so working immigrants, migrants and refugees are all placed in the same category of Black and minority ethnic workers (Modood et al 1997, Ramdin 1999, Panayi 1999, Parekh 2000a, 2000b). Often the terminology surrounding migration, such as 'migrants', 'immigrants', 'asylum seekers' and 'foreigners' is used very loosely, not just by the general public, but also in professional contexts and publications.

In the British context, migration has to be viewed within a wider perspective of Britain's unique historic links to other countries and her imperial past with waves of migration and immigration from Asia, Africa and the West Indies (Ramdin 1999, Panayi 1999). Moreover the debate on migration, immigration and

attitudes towards migrants and asylum seekers is closely linked to the interpretation of race and ethnicity informing relationships and identities.

Often the concepts of race, migration and ethnicity are indistinct. Writing on migrant minority ethnic groups in Britain has focused on Black people and Asians with the term 'Black' referring to those who can trace their ancestors to the Caribbean and former colonies in Africa, especially Nigeria and Ghana. The term 'Asian' refers to people from South Asia, primarily India, Pakistan and Bangladesh, but not China (Banks 1996). Migration encompasses equally complex aspects of belonging and home in relation to a particular space, history, movement and dislocation (Ahmed 2000). Thus it pays attention to visible and invisible differences, also labelled as deep- and surface-level diversity (Lau and Murnighan 1998, Harrison, Price et al 1998).

This creates perceived 'in-groups' and 'out-groups' with 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 of different Eastern European origins. Yet, they make sweeping statements about 'them'.

Based on such underlying attitudes the 'other' will always remain an unknown entity, a non-person. Moreover the 'self' will not be scrutinised in the mirror of different values. 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 other personal characteristics such as employment. Of relevance to their integration are the following distinctions between the different sub-groups of non-UK trained nurses (see box 1).

Box 1: Categories of overseas trained nurses

- Internationally trained in the EU
- Internationally trained outside EU and directly recruited from abroad
- Internationally trained outside EU and independently migrant
- Internationally trained outside EU and asylum seeker/refugee

MOTIVATION TO MIGRATE AND WORK

Even on an international scale, nursing is a female dominated career choice (Anker 2001) with women filling the 'caring' posts and men the



Overseas nurses working in the NHS need support from their British colleagues

'status' occupations (Davies 1995; Winkelmann-Gleed and Seeley 2005). Gender norms vary from culture to culture with further variations related to personal and family values. While some migrants to Britain during my empirical research stated that: 'It would be shameful for a woman to migrate by herself,' others were more open towards women migrating by themselves.

Individuals decide or are forced to migrate for a variety of reasons (see box 2). Many migrant nurses, regardless of their reasons for migrating, appreciate the opportunities to develop a professional career and earn a decent wage. The procedures related to the immigration and employment processes do not convey the depth of personal experiences that individuals undergo and the level of uncertainty related to work. A 28-year-old female nurse from Moldova made this explicit: 'For nurses from abroad, they see paper, but not the people. People have lots of difficulties to start. It is a very complicated process.'

HURDLES IN GAINING ACCESS

Unlike nurses who are directly recruited, those who have come to Britain of their own accord face a range of barriers in adapting past training and experience to UK requirements (Eversley and Watts, 2001).

A major hurdle is gaining access to a supervised practice placement. This is a requirement of by the Nursing and Midwifery Council (NMC) in order to work as a registered nurse in Britain. Despite a national nursing shortage, there is strangely also a shortage of supervision placements for migrant nurses who do not arrive in cohorts. Some groups of internationally qualified nurses pay thousands of pounds to access UK based employment and have been recruited under false pretences, working in private care homes undertaking no or very little clinical nursing.

To achieve registration with the NMC gives migrant nurses a boost which affects their personal as well as their work-related identity. This is particularly significant among refugee nurses who have limited alternatives. Some migrant nurses face exclusion when accessing employment in Britain and the following issues became apparent in my research study:

- Employers' unfamiliarity with immigration and work permit processes
- Differences in professional nursing qualifications compared to other countries
- Differences in practical day-to-day nursing duties and professional status compared to other countries
- Colleagues' prejudices or racist attitudes which were primarily based on ethnicity, not migration status
- Lack of English language ability which stressed exclusion by marking out different sub-groups of migrant nurses
- Differences in culture and gender norms complicating integration
- The experience of negative work-related feelings during early stages of the integration process, such as feelings of isolation, despair and loss of self-worth
- Relationships with their supervisors or mentors with some showing respect towards the stranger while others passed judgment on the migrants' past experience based on them being 'different'
- Entering work leads to a process of transition and re-definition of behavioural and contextual norms for the individual

LANGUAGE

The use of language is an expression of inclusion or exclusion of newcomers. Language illustrates barriers between ethnically diverse groups of people. Language illustrates divisions and coalitions among individuals who are from different ethnic or racial backgrounds. With English being the only shared language, speaking in a language that is not understood by the majority can make colleagues and patients feel isolated. It can

Box 2: Reasons for migration

Historic links migrants whose countries of origin have historic links with the UK

Family-related partners, family members or friends working in Britain

Economic reasons linked to high unemployment in the country of origin to earn more money than they could in their country of origin

International recruitment being directly recruited from another country to fill vacancies

Adventure a desire for new experiences

Language a desire to improve knowledge of English

Work experience a desire to improve career options by working in another country

Threats and persecution experience of threats or persecution in the country of origin leading individuals to flee and seek asylum

enforce feelings of insecurity and 'not-belonging'. Language as it differentiates migrants not only in relation to British-trained nurses, but also distinguishes between sub-groups of migrant nurses based on their native languages.

The ability to communicate cross-culturally influences relationships with colleagues, supervisors and patients. Lack of a migrant's ability to speak English, despite having successfully passed the required English language tests, can undermine self-confidence. A 29-year-old nurse from the Philippines noted the following when comparing the British-trained nurses' interaction with doctors to her own: 'There is a big difference. Those who were trained in Britain, are so confident with communication, talking to the doctor, colleagues, even patients. But for those internationally trained nurses there are big communication barriers.'

Not feeling understood despite trying one's best to speak another language creates barriers to integration with the existing work team. An example given by a 36-year-old nurse from Burundi highlights this: 'At first I was going to run because I will never speak English like an English-speaker. My pronunciation, my accent will not change; they didn't complain, but they took my name from the rota.' It was therefore not uncommon for colleagues to reveal their ignorance about other countries and cultures by concluding that migrant nurses are not well enough educated and come from 'primitive' or 'less developed' places. Some migrant nurses have pointed out that they are not necessarily less experienced, but have gained their experience in sometimes very different work settings.

As integration proceeds, feelings of confidence return and can be fostered by being trusted by patients and colleagues. Examples of successful integration included sharing past experience, being supportive and caring towards team members, contributing cultural and language knowledge to help patients and being engaged in organisational citizenship behaviour (Organ 1990).

Managers' attitude towards the 'newcomer' and a general willingness to explore new ways of working are key precursors to the development of capabilities that contribute to overall organisational objectives.

RELATIONSHIPS AT WORK

Relationships at work, namely interactions with colleagues of varying professional levels, mentors and supervisors form key points of contact which can enable or impede newcomers from identifying with their new work group and organisation. For migrant nurses, key relationships are with their colleagues of varying professional grades, their assigned mentor who is responsible for the supervision of the newcomer during the supervised practice period and other supervisors or managers.

Relationships can convey support, acceptance, respect and dignity. But they can also produce negative images, such as lack of cross-cultural sensitivity or prejudice.

Work-related emotions extend into the personal sphere. Positive experiences at work can enhance self-worth with associated feelings of 'happiness', of 'being accepted', 'liked' and 'trusted', all contributing to self-identity. Part of work group and organisational identity rests on 'being liked' or being part of an 'in-group'.

The way migrants are met by supervisors and colleagues either reinforces their strangeness and otherness, leading to exclusion or encourages their integration as an appreciated equal, despite being different. (See box 3)

Box 3: Integration of overseas nurses

The individual journey of migrant nurses, including refugee nurses, needs to be regarded with respect and trust, so that motivation can result from relationships as well as performing the tasks themselves, ensuring integration and personal well-being

For refugee nurses the integration into work is a fundamental step in rebuilding their lives

Relationships represent a bridge between the 'stranger' and the institution

Relationships at work and in particular the migrant nurses' relationship with the assigned mentor or another supervisor are an important factor in assisting integration either by making the newcomer feel welcomed or a burden to others

Poor relationships convey feelings of inferiority and insecurity

Positive relationships convey value and respect

The initial introduction of the newcomer to existing team members is important as positive introductions are associated with positive socialisation

A range of emotions, influenced by relationships at work, marks the journey towards professional integration. Work-related feelings can symbolise a progressive journey towards integration. Negative feelings are frequently expressed during the early stages of employment in Britain and positive ones following professional recognition. In the early stages of employment migrant nurses often reported feeling: 'bad', 'hurt', 'suffering', 'discouraged', 'met with hostility or prejudice' and 'excluded as a result of language problems'. Following registration with the NMC, these changed to more positive work-related emotions, such as feeling 'confident', 'happier', 'liked' and 'trusted'.

Negative reports about mentors included inadequate one-to-one interaction and insufficient time spent with the mentor, with some nurses not having met their mentor at all. Shift patterns and too much pressure on the mentors' time, as well as some not being prepared to work with ethnic minority nurses, complicate this relationship.

In some cases where migrants had a demoralising relationship with their mentor, other staff members took on a mentoring role, introducing the nurse to unfamiliar aspects of work.

Box 4: Requirements of good mentoring of migrant nurses

Mentors need to be selected based on their willingness and motivation to interact with migrants and not be forced on the basis of their status in the organisation

Mentors need to enjoy seeing another person succeed without feeling threatened

There needs to be sufficient time and face-to-face contacts with the migrant

The level of other responsibilities that mentors carry reflects on the seriousness that is placed on their relationship with migrants

The organisation of supervision/adaptation programmes conveys their level of importance

Mentors must be prepared so that they are aware of some of the basic, universal cross-cultural issues

Personality clashes must be addressed sensitively

On a more positive note, some migrant nurses complimented their mentors for being supportive, putting themselves into their situation and facilitating access to documents and personal development. Reports on relationships with other supervisors showed similar polarities with relationships either being encouraging, supportive and empowering or distressing and demoralising.

Migrant nurses are often very experienced professionals, as well as mature individuals, who then have to start again at the bottom of the career ladder in Britain.

This can be daunting, not only for them, but also for those working closely with them. A female nurse from Rwanda who is in her late 40s made this comment: 'Everything you know is different. I felt a bit strange, as they didn't know me. So, it's like they are not sure and it was a bit hard to integrate in the beginning.' It is therefore important for those working with migrant nurses to remember their own early career stages.

At the same time, the task of assessing a migrant nurse's abilities and competency to operate in the British healthcare system has to be taken seriously. This is where mentors have to be professional, distinguishing between personal, interpersonal and competency issues. There are very practical aspects to the relationship between mentors and migrants which can lead to successful or unsuccessful integration (see box 4).

Box 5: Requirements for supervisors of migrant nurses

Taking time to explain day-to-day routines

Being approachable and delegating responsibility to the migrant without overloading them, thereby displaying trust in the migrants' abilities

Recognising and affirming migrant's skills

Encouraging the newcomer in taking up new responsibilities while supervising them

Offering themselves as approachable resources

Ensuring that newcomers and existing members of staff are treated equally without favouritism towards the British-trained staff

Being able to learn about others' cultural background and the way things are done differently without pre-judging

Taking some time to get to know the newcomer a little and showing interest in their integration at work

Regardless of their relationship with the individual mentor who is only spending a limited amount of time with the migrant nurse, the relationship with other supervisors who are a more constant feature in their day-to-day working lives is very important. Characteristics of this relationship when functioning well are shown in box 5:

True management of diversity means that when meeting 'strangers' we also reflect and learn about ourselves. Different points of view do not necessarily mean that one view is wrong.

MANAGEMENT OF DIVERSITY

The contribution migrant nurses are making to organisations in Britain rests on the concepts of diversity management and capacity building.

The theoretical concept and practical application of diversity within the workforce is currently receiving considerable attention in the literature.

With greater acceptance of labour mobility, mergers and market expansions, corporations are becoming more and more multinational, resulting in an increasingly mixed workforce (Palma-Rivas 2000). Increased demographic diversity is also the result of increased international migration and the implementation of equal opportunities policies in the UK (Liff 1999).

However, the implications of diversity for management are not restricted to a drive towards equal opportunity quotas and the numerical representation of the local community within the workforce (Milliken and Martins 1996).

A key policy debate in the NHS concerns the challenges of balancing limited financial resources with performance targets (Maynard 2005). Capacity building as a concept is about more than resources, especially in the healthcare sector where relationships between staff and clients are the key to success (Kaplan 2000). Therefore approaches to capacity building need to take employee motivation and concepts of identity into account. This is especially crucial when the workforce is composed of individuals from diverse backgrounds (Zairi and Jarrar 2001, Gilson 2002, Grindle and Hildebrand 1995).

Demographic variables, such as organisational statistics on diversity, cannot replace the psychological processes that individuals in order to integrate (Lawrence 1997). Like many British-trained nurses, few migrant nurses would resort to the official complaints procedures or consult members of the human resource teams when they encounter difficulties. It takes time and effort to establish new identities on levels that go deeper than skin colour.

To address inequalities in the way black and minority ethnic employees are treated at work, equal opportunities policies, even though an important step in the right direction, are insufficient in themselves. Morris (2002) refers to integration as a two-way process, in which strangers are appreciated for who they are, despite being different.

Benefits of successful integration include job satisfaction for the individual and their intention to stay with the organisation, thereby addressing the retention problem in the NHS. Moreover, there is evidence to substantiate the positive effect of job satisfaction and positive work-related emotions on individuals' willingness to make a contribution to the wider organisational objectives.

While a 'sense of belonging' and 'of identification' can affect job satisfaction which is positively related to role performance, claims that 'happy workers' work harder overall seem misconceived (Bassett 1994).

A 'happy worker' can make a positive contribution to the capacity of the workgroup by contributing to the creation of a positive, productive atmosphere. Yet job satisfaction is viewed as the fit between expectations and actual experiences at work (Mullins 2002). Employees who are motivated seem more prepared to contribute to the organisation and make suggestions for improvement.

EXCLUSION OR INCLUSION

On the part of the migrant, feeling excluded limits interpersonal contact and sharing of 'self' with others.

Social exclusion at work perpetuates a 'them' and 'us' approach. This is at odds with constructive management processes aimed

at group cohesion, inclusion, equality and effectiveness. These approaches stress the role of managers in pro-actively shaping the integration process of diverse work teams.

First, attention must be paid to the socialisation period during the early stages of the journey towards integration into employment (Kanter 1977). Second, empirical knowledge of diversity in work groups enhances innovation and provides a challenge to common organisational practice. Instead of assimilating newcomers into existing practices, mutual sharing of past experiences could contribute to more effective ways of achieving objectives. Third, in relation to the concept of social exclusion, the 'other' (Ahmed 2000) takes on different meanings for different individuals and ethnic groups.

The experiences of resettlement and integration are results of personal characteristics, calling for each newcomer to be treated as an individual.

The effective management of a diverse workforce cannot be monitored through statistical feedback on age, gender, disability, health, sexual orientation, ethnicity and religion.

But managers can encourage the relational aspects of the work environment and provide an atmosphere in which individuals feel safe to offer feedback and input about their day-to-day working experiences **mcn**

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