

Research papers

The experiences of overseas nurses working in the NHS: results of a qualitative study

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ABSTRACT

This paper presents the outcomes of an exploratory qualitative study that examined the views and experiences of nurses who have trained overseas and travelled to work in the NHS. A constructivist methodology was employed within an interpretivist approach in which data were obtained through participant observation, focus group discussions and informal individual interviews. Eleven overseas nurses, representing six different countries of origin, agreed to participate. Analysis was based on coding, identifying patterns, generalising and formulating concepts. Six themes were identified: communication, differences in the nurse's role, the de-skilling of overseas nurses, status of overseas nurses, racial discrimination and pastoral support.

Findings showed that the nurses recruited from overseas experienced loss of status and became de-skilled. For some, this loss of status was compounded by experiences of discrimination. Recommendations centre on creating a climate of inclusion within nursing teams, and allowing overseas nurses to include the 'Scope of professional practice' course as part of their adaptation programme. There is a need for further research to identify factors that mark overseas nurses as different, and identification of the point at which their UK colleagues cease to see them in this light.

Keywords: discrimination, international recruitment, overseas nurse, status

Introduction

There is a long tradition in the UK of recruiting migrant labour into the NHS to fill nursing vacancies (Buchan, 1999). The recruitment of nurses from overseas has increased in recent years as part of a Department of Health drive to redress staff shortages. There are now more than 35 000 new overseas nurses who have registered since 2000 (Nursing and Midwifery Council, 2004). These nurses make a valuable contribution to patient care and services but their experience of working in the NHS is not always positive. Current health policy places a strong emphasis on diversity and inclusion and requires organisations to recognise that the contribution overseas nurses make to the UK goes far beyond overcoming nursing shortages (Department of Health, 2000). For instance, the Diversity Adviser for the Royal College of Nursing (RCN) stresses the importance of both individuals and the organisation seeking 'to be more inclusive, while at the same time recognising and valuing the worth of being different' (Bussue, 2002,

p.22). This means that overseas nurses should be treated 'with due regard to real differences of experience, background and perception' (Runnymede Trust, 2000).

This paper presents the findings of a study that examined the experiences of nurses recruited from overseas and draws attention to the ways in which their skills and expertise were either unrecognised or devalued.

Literature review

There is a paucity of research into the experiences of nurses who have trained overseas and travelled to work in the UK. Studies conducted in America highlight local nurses' concerns that nurses recruited from other countries might undermine standards of professional practice (Joel, 1996). There is some evidence

to support these fears. For example, a study by Yi and Jezewski (2000) found differences in the nurse's role between the USA and Korea. The Korean nurses perceived themselves as lacking the problem-solving and assertiveness skills of their American colleagues, leading the researchers to conclude that mastering the skills of assertive behaviour is a key measure of adjustment. However, differences in role do not necessarily mean that standards will be compromised. Flynn and Aiken (2002) challenge the sentiment that the practice values of overseas nurses might not be congruent with those of American nursing practice. Their survey of 799 nurses included 124 whose country of origin was outside America. Of these, 72 had received their nurse education overseas. This study found no significant differences in the value these groups of nurses placed on either autonomy or collaborative working (Flynn and Aiken, 2002). Unfortunately, the researchers did not indicate the length of time that the respondents had been nursing in America, so these findings may merely be an indicator of adjustment and adoption of American values.

In the UK, Allan and Larsen's (2003) multicentre study found that the experiences of overseas nurses were shaped by their personal, social, professional and financial expectations. This study compared the experiences of overseas nurses working in the NHS and the independent sector, finding communication, isolation, exploitation, and lack of recognition of skills and expertise to be problems in both settings. Withers and Snowball's (2003) study of the experiences of Filipino nurses also found a discrepancy between expectations and experiences. The Filipino nurses interviewed stated that their UK colleagues lacked knowledge about their nursing skills and experience. Both of these studies recommended further research into the impact of international recruitment on both UK colleagues and patients.

Gerrish and Griffith (2004) attempted to partially address this by considering the views of various stakeholders in evaluating an adaptation programme for nurses recruited from overseas. They interviewed the nurses as well as ward managers, mentors, educators and senior nurse managers. They found that the level of support and the organisational context influenced the ease with which overseas nurses became integrated into the nursing workforce. Gerrish and Griffith (2004) emphasised the importance of ensuring an organisational policy that supports diversity in the workforce. Some of the senior nurses and ward managers in their study saw overseas nurse recruitment as a means of promoting ethnic diversity in the workforce. The benefit of a two-way exchange of expertise was proposed: 'those who subsequently returned to their home countries would take with them expertise to benefit their health care system' (Gerrish and Griffith, 2004, p.584). However, this can

only be a two-way exchange if the skills and expertise of overseas nurses are recognised and valued in their UK context.

These studies, coupled with the increasing drive to recruit nurses from overseas, indicate that there is a need for further research to understand the experiences of both overseas nurses and their UK colleagues. This study provides some understanding of what it is like for trained nurses from another country to come to work in the NHS.

Aim of the study

The study aimed to explore the experiences of nurses who have trained overseas and travelled to work in the NHS.

Methods

The limited research regarding the experiences of overseas nurses and that of their UK colleagues indicated the need for a qualitative research design in order to explore the emic perspective. A constructivist methodology was selected. In this approach to inquiry, findings are created through close interaction between the researcher and participants (Guba and Lincoln, 1994). Constructivist research often takes place in the participant's own environment with the aim of understanding the human experience as it is lived.

Underpinned by an interpretive paradigm, this study was concerned with understanding the meanings given to social interactions by those involved (Ford-Gilboe *et al*, 1995). One of the potential problems of qualitative research is that data are blurred by participants' cognitions of their experience (Brenner, 1985). All of the research studies cited in the literature review above relied on either surveys or interviews as methods of data collection, and were therefore limited to the cognitions of the respondents. In an attempt to minimise the effects of these cognitions, participant observation was chosen as the primary method for this study. Participant observation consists of the 'interweaving of looking, listening and asking' (Lofland, 1971) and therefore reveals diversity in behaviour that may not be described by participants through other methods of data collection. As knowledge and experience are often embedded in behaviour (Jackson, 1989), the aim was to gain a deeper understanding of the participants' world than would be possible through verbal enquiry (Savage, 2000).

This study was conducted in Oxfordshire and was approved by the Local Research Ethics Committee.

Consent was obtained from the gatekeepers of the trusts involved before the ward managers and participants themselves were approached.

Participant observation

The initial phase of the study consisted of participant observation on a hospital ward. The researcher worked in an honorary capacity as a care assistant, working alongside overseas nurses and their UK-trained colleagues. This phase of the study was conducted over an eight-week period and consisted of 13 eight-hour shifts on one hospital ward and an additional three shifts on a second ward. The original intent had been to conduct the study in one setting. However, both the hospital manager and ward manager were very keen that this second ward be involved, and these additional shifts provided opportunities to verify the data obtained from the first setting. A total of six overseas nurses worked across these two wards. As those who consented were almost exclusively nurses, the focus of the study inevitably shifted from its previous aim of considering their role within the multiprofessional team to considering the experience of overseas nurses within the constraints of the consenting participants.

During the period of participant observation, all observations were recorded in a notebook at times when the researcher was unobserved. As the lens through which we view the world is inevitably shaped by our own prior experiences, and 'our attitudes affect what we choose to study' (Kleinman, 1991, p.185), it was important that *all* observations were recorded in as factual a manner as possible without interpretation. Indeed, as Kite (1999) stresses, it is important to focus on the 'observables' rather than the 'interpretables'. These observations were expanded in fieldnotes at the end of each shift to ensure that all data were captured.

Focus groups

Given the small numbers of overseas nurses that are currently employed in some hospital settings, it was considered very important that individuals were not identifiable in any way when the results of the study were disseminated. In view of this, a second phase was designed. The original plan was to conduct one focus group with overseas nurses working in different hospitals and another with UK-trained colleagues of overseas nurses in other hospitals. However, as no UK-trained nurses responded to the 50 letters of invitation issued, this element of the study was not conducted. The excerpts included in this paper from the UK-trained colleagues of overseas nurses are from staff on two wards only.

Of the 16 ward managers contacted, eight (50%) responded giving permission for their staff to be approached and invited to participate in the study. These ward managers were then sent letters of invitation to give to their staff, inviting them to participate and return a reply slip to the researcher in a stamped addressed envelope. Five overseas nurses responded. One additional nurse was recruited through snowball sampling.

One focus group was conducted with three overseas nurses. Two informal interviews were also conducted with overseas nurses who were unable to attend the focus group but were very keen to be involved in the study. These interviews lasted from 1 to 1.5 hours. They were tape-recorded and later transcribed verbatim. One overseas nurse who had originally expressed an interest in being involved in a focus group did not attend. No reason was given.

Adopting a multi-method approach to this study, using data from participant observation, informal interviews and focus group discussions, has helped to ensure that the anonymity of participants is protected. Validity was increased as overseas nurses working in other hospital settings validated the themes that evolved from participant observation. The findings from the three elements of data collection are, where possible, combined. Pseudonyms are used in the presentation of findings to protect the identities of participants.

Sample

A total of 11 overseas nurses participated in the study. These nurses worked in eight different wards across four Oxfordshire hospitals. The countries represented were the Philippines (5), China (2), Finland (1), New Zealand (1), Nigeria (1) and South Africa (1). Two of the overseas nurses were male and nine were female. The time spent working in the UK varied from seven months to six years. Two of the nurses were awaiting their UK nursing registration at the time of the study. For nine of these 11 nurses, English was their second or third language. Three of the overseas nurses were white.

Data analysis

Ongoing, inductive data analysis was conducted. This involved the processes of coding, identifying patterns, generalising and formulating concepts (Roper and Shapira, 2000).

Observations were 'played back' to all consenting participants (overseas and UK trained) who were asked to verify that the data was an accurate record of events. Through this process the emergent themes were verified and further clarification, expansion and

understanding were sought. The results were deemed to be valid if they reflected the reality and meanings of the participants (LeCompte and Goetz, 1982).

The following themes emerged from the combined data:

- communication
- differences in the nurse's role
- the de-skilling of overseas nurses
- the status of overseas nurses
- racial discrimination
- pastoral support.

Within these six themes, specific categories were also identified and coded to further organise the data (see Table 1). The data pertaining to each theme and category are presented here, with selected excerpts provided to clarify the findings.

Results

The data from this study only pertain to those who gave their consent to participate, and therefore present only a partial view of the participants' world. It is notable that all of the 'overseas nurses' on both wards involved in the participant observation gave their consent, indicating that, for them, 'this is an important study' (Cherry) that enables their story to be told.

Two of the overseas nurses on one of the wards used for participant observation were not classified as such by their UK colleagues. The ward manager and UK-trained staff only referred to the two non-white nurses as overseas nurses yet the nurses from New Zealand and South Africa (both white) described themselves as overseas nurses and described experiences in common with their non-white colleagues from overseas.

Table 1 Themes and categories identified

Theme	Categories
Communication	<ul style="list-style-type: none"> • Use of English • Allowances made • Changing perspective
Differences in the nurse's role	<ul style="list-style-type: none"> • Care of the older person • Spiritual care • Responsibility and decision making • Autonomy • The acquisition of new skills • Patient choice
The de-skilling of overseas nurses	<ul style="list-style-type: none"> • 'Back to zero' • Differences in perception of 'basic skills' • Loss of confidence • Effect on patient care • Restrictions in practice
The status of overseas nurses	<ul style="list-style-type: none"> • Assigned junior position • Self-imposed junior position • The need to prove oneself • Valued by colleagues • The centrality of nursing • Altered over time
Racial discrimination	<ul style="list-style-type: none"> • Patients • Colleagues • Support • Use of humour in verbalising difference
Pastoral support	<ul style="list-style-type: none"> • Informal support • Organised support • Shared affinity with others

Communication

For those overseas nurses who do not have English as their first language ($n = 9$), full integration into the ward eluded them while their capacity to communicate was restricted. As one overseas nurse explained:

‘The language is the biggest problem.’ (Cherry)

This nurse was describing not only the difficulties they experienced in communicating, but also how this set them apart from other nurses. As another nurse explained:

‘Your authority and confidence increases with English. It takes time too.’ (Kim)

In this way, overseas nurses who were not fluent in English were a distinct group that required different behaviour from others.

Many UK nurses recognised some of the difficulties faced by overseas nurses:

‘I admire them for coming all this way to live and work in another country where they have to learn another language.’ (Iris)

UK nurses took time to instruct, guide or teach the overseas nurses. However, one of the UK-trained nurses, who said she admired their courage, raised her voice each time she spoke to one of the overseas nurses. Two others tended to complete their sentences for them. This indicates, for some nurses, an implicit assumption that allowances needed to be made in the way they communicated with overseas nurses.

Further indication of the way staff organised their relations with the overseas nurses was explained by one UK-trained professional. She referred to what she termed a particular nurse’s ‘communication problems’ and said:

‘I feel I need to compensate. I probably don’t ask such detailed questions. And I ask someone else if it’s complicated.’ (Mo)

Overseas nurses from the other wards in this study also described being by-passed by healthcare professionals. In compensating for overseas nurses, some UK-trained staff made allowances and treated them differently, and in so doing assigned themselves a superior status. This resulted in some overseas nurses describing feeling ‘belittled’ (Anu). Further evidence of this is presented in discussion of the status of overseas nurses.

One overseas nurse, who had been promoted to a more senior position since first coming to the UK, said:

‘I can understand it myself now when I am in charge of the ward. Nurses in some countries are not encouraged to be vocal. When the nurse is quiet you worry. It’s ok if they ask questions.’ (Katarina)

The countries that were cited by this nurse to exemplify the point were India and China.

Differences in the nurse’s role

Some of the overseas nurses described needing to adapt to different ways of working in the UK. The most frequently cited example related to differing societal values in relation to the care of older people. In the Philippines, China and Nigeria, for example, the family were described as playing a key role in the care of older people in both hospital and community settings. This was cited in contrast to the UK where the role of the ward nurse included caring for older people who are awaiting nursing home or residential home placement.

Some overseas nurses described providing spiritual support for patients as an important aspect of their role in their home country. For example, two nurses spoke of praying with patients:

‘I can always have those words of inspiration for patients and relatives. We are very spiritual. So you have that common denominator. Here, if I mention God, I think am I saying the right thing? I miss being able to give that.’ (Theresa)

The overseas nurses also described differences in the way that nurses function in the UK in terms of responsibility, decision making and accountability, as well as assumptions regarding ‘taken-for-granted’ procedures and practices. The examples given below highlight the differences between nurses from different countries.

Different levels of autonomy in decision making in the UK

Some nurses experienced an increased level of autonomy that contributed to job satisfaction. This contrasted with nurses’ experience in the Philippines and China:

‘There, nurses just follow the doctor’s orders. We rely on the doctor all the time.’ (Kim)

‘Following doctor’s orders’ was described as ‘giving the treatments’ as well as completing blood and X-ray request forms, and arranging referrals.

One nurse described the difference between the UK and their home country:

‘If the doctor wants to send people home here [in the UK] and if you know they won’t be safe, in terms of mobility, you can say no. But in the Philippines if the doctor says ‘home’ you say ‘ok’ and just carry out doctor’s orders. Here you think more of your patient than carrying out what the doctor wants, because doctors are not always right all the time ... It makes nursing very different. You learn loads that you didn’t know before.’ (Theresa)

These examples of ‘following doctor’s orders’ contrast markedly with the experiences described by the nurses from Finland, South Africa and Nigeria:

‘You are quite dependent on doctors here. Compared to my own country where you have to make decisions for patients yourself.’ (Katarina)

In their home countries, these nurses described greater autonomy, being able to order X-rays, prescribe intravenous (IV) fluids and some medication.

Learning new skills

For many overseas nurses these included holistic care, discharge planning, and, for one nurse, managerial skills that included personnel and budget management. Discharge planning in particular was described as an aspect of the nurse’s role where much needed to be learnt. As one overseas nurse said:

‘Discharge planning was my Waterloo. In my first year I felt, why should I need to know how many steps they have at home? That’s their business. I don’t need to know. You have to know how they will cope, who will give them their medication.’ (Theresa)

Patient choice

For one nurse this marked a major difference between the country of origin and the UK:

‘Here we value the patient and what they want to do. We ask the patient.’ (Katarina)

This nurse cited as an example the involvement of families in decisions regarding resuscitation. This contrasted with this nurse’s country of origin, where doctors make these decisions.

The de-skilling of overseas nurses

One UK-trained nurse explained that when overseas nurses receive their UK nursing registration:

‘It gives them professional recognition of their qualification.’ (Meg)

However, this recognition does not automatically acknowledge their experience or clinical competence. Many of the overseas nurses described going ‘back to zero’ when they came to the UK. This state not only described their status as a ‘D’ grade, the lowest grade for qualified nurses, but also reflected their entitlement to perform certain tasks.

There appeared to be a fundamental difference in what was perceived as ‘basic nursing’ between different countries. For the UK-trained nurses, basic nursing referred to assisting patients with personal care. However, all of the overseas nurses in the study,

irrespective of country of origin, described venepuncture, IV therapy and male catheterisation as ‘basic skills’.

‘In my country these are basic skills that every nurse does every day.’ (Cherry)

One overseas nurse who was not permitted to perform venepuncture or IV therapy in the UK described her feelings:

‘You start to feel de-skilled and question yourself and your own ability. Things that were second nature you no longer know how to do. I’ve done IV therapy ever since I was a student.’ (Dee)

Another joked that:

‘The anatomy is different in England than at home.’ (Jeanie)

Her use of humour gently mocks the implicit belief that ‘if they have not been trained to do it by us, then they have not been properly trained’.

For these overseas nurses, the frustrations were not only described in terms of losing confidence and becoming de-skilled, but also in relation to the effect on patient care:

‘From a patient’s point of view, they don’t need to lie in discomfort waiting for a doctor in the middle of the night when you’ve got nurses on the ward who can do this.’ (Katarina)

‘You have patients waiting for the treatment and you have all these nurses who have the skills but are not allowed to do it. There is a long waiting list for the course. You have to wait, wait, wait.’ (Anu)

The course referred to here is the ‘Scope of professional practice’. This is a two-hour session organised by the Oxfordshire trusts, which covers the Professional Code of Conduct and issues of accountability. The overseas nurses described having to attend this course before they were able to attend additional courses on IV therapy, venepuncture or male catheterisation. They had to wait varying amounts of time before they were able to undertake this additional training. For some, six months had elapsed after they had received their Nursing and Midwifery Council (NMC) registration before they were able to attend a ‘Scope of professional practice’ course. Others had not been able to use what they regarded as their ‘basic skills’ for between four months and four years since gaining their UK registration.

Some of the overseas nurses reported having performed venepuncture or male catheterisation before having attended the relevant course:

‘... when there’s no one else who can do it’ (Dee)

or, in the case of venepuncture, when a UK-trained nurse had been unsuccessful. In the eyes of the

organisation, these nurses are not trained to perform these tasks, yet as one nurse stated:

'Patients have to wait. We are very experienced.'
(Katarina)

One nurse who had been able to administer intravenous drugs for six years in her own country said:

'When I work with an overseas nurse I am allowed to do. I can do. If I work with a British nurse I have to watch out ... I was told off.' (Kim)

This nurse had not received her NMC registration at this point and had therefore not attended the 'Scope of professional practice' course.

In addition to the 'basic skills' of venepuncture, IV administration and male catheterisation, two of the overseas nurses in the study were no longer using their extended skills in intubation, reading electrocardiograms (ECGs), and collecting arterial blood samples.

The status of overseas nurses

The notion of overseas nurses going 'back to zero' was also raised as a matter of concern by some of the UK colleagues, both trained and untrained:

'However high they have got in their own country, they have to start at our level.' (Kate, care assistant)

All but one of the nurses within this study had experienced a significant drop in occupational status since coming to Oxfordshire:

'They treated us as newly qualified. Yet we were experienced nurses. I'd been working in this country for a year and a half (in a different trust) yet when I came here I was still treated as nothing. You really have to prove yourself ... so that you are trusted.' (Katarina)

'You are a trained nurse but you are nothing.' (Anu)

Three of the overseas nurses described at times being 'treated like a child' (Jeanie).

This was evident during the period of participant observation, as there were occasions when the overseas nurses were over-ruled or where their opinions were either ignored or not sought. There were also occasions where things that they already knew were explained to them or where they were tested to make sure that they understood what had been said. This assumed ignorance denied their skills and experience and served to reinforce their junior status.

As one overseas nurse said:

'Initially they treat me like a fool.' (Kim)

This junior status was not solely imposed, however, as one overseas nurse explained:

'I put myself into a junior position.' (Kim)

The reason given for this was lack of confidence with the English language and lack of knowledge of local procedures:

'When you first start you're like a blind mouse. You can only follow.' (Kim)

In contrast, other overseas nurses felt valued by other members of the multiprofessional team and that UK colleagues did not treat them any differently:

'As a nurse, I'm the main focal point of everything. Everyone talks to you. Physios talk to you. OTs [occupational therapists] talk to you. Everyone talks to you. Especially doctors talk to you.' (Felipe)

Some overseas nurses felt this recognition of their contribution had altered during the time they had been working in Oxfordshire:

'There is a vast change now. Before I felt most English nurses don't trust us. Because they were thinking I'm from another country. English is not my first language. But now, compared to before, I think they're more confident with the Filipino nurses and think they're really good and trustworthy now.' (Felipe)

However, for those who had recently come to the UK, this lack of recognition of skills and experience was still very evident:

'You have to get them to trust you. To prove yourself.'
(Anu)

Some of the overseas nurses acknowledged that 'new English staff are also watched'. They were unsure whether this applied to all new staff, or only those who were newly qualified. For many in this study, overseas nurses seemed to fall into this latter category. They felt treated like newly qualified staff yet had many years of experience, often at a senior level, in their own country.

The experiences of the overseas nurses were not all negative:

'My mentor was a source of confidence, saying yes you can do that, you can do that. Because she would think this way, everybody tried to think this way. Because I was the first overseas nurse on that ward.' (Theresa)

In addition, some even expressed surprise at being valued by professional colleagues:

'When I became an E grade a doctor said to me, what do you reckon? I was very surprised, because in the Philippines doctors ask other doctors, not nurses.'
(Theresa)

In summary, there is considerable variation in the way the overseas nurses in this study perceived their status. Some were valued for their experience, while others felt they were treated like newly qualified nurses and felt a need to prove themselves. There was a direct correlation between the length of time they had been

working in the NHS and the degree to which they felt accepted and valued by their UK colleagues.

Racial discrimination

The discrimination described related to both patients and staff. Three of the overseas nurses described patients making comments such as:

‘I don’t want you. I want a British nurse.’ (Theresa)

The response of the UK nursing colleagues was significant in the overseas nurses’ resolution of these incidents:

‘I felt degraded [by a patient’s comments]. When my mentor spoke to the patient I felt supported. I felt welcome. Part of the team.’ (Felipe)

The discrimination experienced by some overseas nurses also came from their UK-trained colleagues. One overseas nurse, when on their adaptation programme, recalled a UK nurse calling them ‘a student’ to a patient. These words made the overseas nurse cry:

‘I’m not a student. I’m just doing my adaptation course here. I’m still a nurse. I didn’t go here just to become a student again. I’m just adapting to being here. You have to be brave.’ (Felipe)

For another nurse, the discrimination was in the form of overt racism:

‘They took advantage of me because of my English and because I am new. There was one domestic who used to call me words like ‘pratt’ under her breath. She only did it when no one else was around. It was only when I asked a trained nurse what ‘pratt’ meant and she explained that I knew what she was saying.’ (Ben)

At times, racism may be evident in the use of humour. The examples of humour identified in this study appeared to be good-natured and enjoyed by all involved. On one occasion, a UK member of staff joked:

‘We’re not having any more like her here.’ (Gabby)

This was said whilst catching the eye of an overseas nurse, who laughed loudly in response.

On another occasion, a UK nurse joked, referring to ‘your Filipino ways’ (Beryl).

At times, UK staff used humour to refer to overseas technology as inferior. However, some of the overseas nurses also used humour in this way, suggesting, on occasion, that UK technology was inferior. When discussed with the individuals involved, the humour used was not seen as harmful because it was based upon mutual respect.

These examples show how both UK and overseas nurses used humour to verbalise the differences between themselves. This is illustrated further in a joke shared by some of the overseas nurses, laughingly describing themselves as:

‘bloody foreigner’ (Maria)

and:

‘bloody, bloody foreigner.’ (Nora)

While in these examples the individuals concerned did not feel the use of humour to be inappropriate, in another context, comments such as these could be overtly discriminatory.

Pastoral support

Many UK nurses expressed concern about overseas nurses ‘being here alone’, and this resulted in UK staff providing support in a variety of ways. This support included going out of their way to drive an overseas nurse home if they had missed their bus, and taking them to local places of historical and scenic interest on their days off. The concern expressed by the UK nurses was based on their recognition of the unique situation that the overseas nurses were in. This was particularly evident when one of the overseas nurses was unwell:

‘I think it’s disgusting that there’s no one to care for them, to see to them. They [the trust] bring these nurses over here and they should provide an almoner or something. If you were ill in *** what would it be like?’ (Val)

Further support given to overseas nurses included making special arrangements such as co-ordinating the off duty to ensure access to public transport, or to coincide with a partner’s shift patterns on another ward.

All of the seven overseas nurses who had undertaken an adaptation programme within Oxfordshire spoke very highly of it:

‘It’s one of the best support that the trust has given overseas nurses.’ (Theresa)

‘I used to look forward to Thursdays when we had the study day to meet batch mates. And when the course was completed I felt “Oh no, I’m all alone now”.’ (Jeanie)

Further support was gained from a shared affinity with other overseas nurses. The common understanding of the issues faced crossed national and cultural boundaries, as some overseas nurses spoke of colleagues from countries such as Australia, Ireland and New Zealand, saying, ‘she understands’. Some went further, stating that they did not need to prove themselves to other nurses who had trained overseas.

Discussion

The findings from this study indicate that the experience of overseas nurses is varied. This in itself is unsurprising given the diversity of overseas nurses in the UK. The findings, therefore, illustrate the variety in both the experience and the backgrounds of the overseas nurses thus emphasising that the term 'overseas nurse' is not a singular unifying category of staff. The overseas nurses themselves described a group identity that crossed ethnic and cultural differences. From their point of view, they were all 'foreigners in a foreign land'. This was evident in the shared affinity between overseas nurses that was expressed through humour and negated the need to prove oneself to others who had trained overseas.

However, not all individuals who described themselves as overseas nurses were categorised as such by their UK colleagues. Their UK colleagues saw only those who were non-white, or whose first language was not English, as overseas nurses. This suggests that the significance of migrant status is varied; for these UK colleagues, ethnicity appeared to be the defining characteristic.

What remains unclear is:

- the point at which nurses who have trained overseas cease to be viewed as overseas nurses by their UK colleagues
- the elements or units of recognition that categorise an individual as an overseas nurse
- whether racial differences are a significant factor.

Richmond (1973) states that 'one of the most remarkable features of the situation in Britain is the almost universal equation of the term "immigrant" with "coloured person"'. Consequently, the term 'overseas nurse' may be a synonym for non-white nurse. It is notable that of the five nurses in this study who described racial discrimination, all were non-white and English was not their first language.

Alternatively, language and the use of English might be a unit of recognition. As indicated by one of the overseas nurses in this study, 'language is the biggest problem'. Therefore, someone may only be classed as an overseas nurse if their use of English marks them out as different. An individual who speaks perfect English, albeit accented, may be considered to be less foreign than someone whose use of vocabulary and sentence construction does not fit with notions of everyday English. While possible units of recognition have been suggested here, the limited duration and sample size of this study meant that these have not been validated, but they may indeed differ between UK-trained nurses and those who have trained overseas. Further research is required to investigate this.

The findings of this study indicate that those overseas nurses who were identified differently by their UK colleagues remained members of a distinct group who were not yet 'one of us'. While, at times, they were treated like 'visitors' or 'guests' who needed to be looked after and required special treatment, it is evident that, for some, their position in the ward family was likened to that of a child. Social identity theory suggests that individuals' self-concept is based on the desirable features of their own 'in-group' (Tajfel and Turner, 1979). 'Others', or members of the 'out-group', are construed in a negative light as a means of bolstering the self-concept of those in the 'in-group' (Taylor, 1999). Bias ensues when 'in-groups' distinguish 'out-groups' as less favourable than themselves (Tajfel and Turner, 1979). The findings of this study indicate some of the different treatments received by the 'out-group'; that is, those who were perceived as overseas nurses by their UK colleagues.

Some UK nurses were dismissive of overseas nurses' knowledge and clinical expertise, causing them to feel that they were treated like children. As 'children', overseas nurses were instructed, taught and guided, and their opinion was at times either bypassed or over-ruled. Thus they felt 'belittled' or devalued. It is particularly notable that those who were not classed as overseas nurses by their UK colleagues did not describe either the support or the dismissal experienced by the overseas nurses for whom English was not their first language. In this way, these nurses were perhaps treated no differently from UK-trained staff, but further research is needed to examine this possibility.

All the overseas nurses had become de-skilled as a consequence of coming to work in the UK. Regardless of their country of origin, all regarded venepuncture, IV administration and male catheterisation as 'basic nursing' skills that were acquired during their pre-registration education. For the UK-trained nurses, these skills are considered to be part of the extended role of an experienced, qualified nurse, and additional training is required before a nurse is able to use any of these skills. The junior status of some overseas nurses is reinforced by a system that does not recognise their clinical expertise in some nursing tasks. All the overseas nurses cited this lack of recognition as a cause of frustration that resulted in loss of confidence and de-skilling that had a direct impact on patient care. These findings are consistent with those of Allan and Larsen (2003) and Withers and Snowball (2003).

The length of time that many overseas nurses had to wait before being permitted to use these skills was, in part, reliant on how long they had to wait before taking the 'Scope of professional practice' course. In addition to this, the requirement that they undertook the same standard course as their UK colleagues who were learning new clinical skills caused further delays.

Requiring overseas nurses to undertake courses in nursing procedures in which they already have skills and experience carries resource implications. It also results in them having to go 'back to zero' which, for many who have previously held senior positions in their own countries, leads to a radical drop in status that was reinforced by the actions and attitudes of some of their UK colleagues.

Carr-Ruffino (1996) argues that managing diversity involves acknowledging that society is differentiated in a number of ways, and giving equal respect to all categories and not affording greater legitimacy to one 'majority' group or 'norm'. The lack of recognition of clinical skills, and the requirement that overseas nurses undertake the same courses as their UK-trained colleagues, does not recognise or value this diversity. Indeed, it affords greater legitimacy to the UK-trained nurses. Through this lack of recognition of clinical skills, it could be suggested that the 'in-group' maintains its superior position over the 'out-group' (Tajfel and Turner, 1979). It would appear that this occurs at an organisational level.

It is important to reiterate at this point that the experiences of overseas nurses were not all negative. Many overseas nurses described the support and recognition they had received from their UK colleagues; some UK nurses clearly made considerable effort to ease the transition for their overseas colleagues.

Conclusion and recommendations

The term 'overseas nurse' is a new one that has arisen since the mass recruitment by the NHS of nurses who have trained in other countries. The term is divisive as it sets individuals apart by nature of one particular attribute. However, the findings of this study indicate that some of the nurses who have trained overseas and travelled to work in the UK are indeed treated less favourably by some of their UK colleagues.

The main findings from this study relate to the differences in the nurse's role between the UK and the overseas nurse's country of origin. The evidence indicates that there is a lack of recognition of skills and experience, which results in the de-skilling of overseas nurses. The loss of status for many of the overseas nurses is compounded by the discrimination and racism that some of them have experienced.

It is evident that the value and worth of overseas nurses is not always recognised and fostered. For the NHS to be an inclusive organisation where individuals are treated 'with due regard to real differences of experience, background and perception' (Runnymede Trust, 2000), it is imperative that managers are aware of the danger of complacency and strive towards ensuring that overseas nurses do not experience discrimination. It is

equally important that the opinions of overseas nurses are not bypassed or over-ruled by their UK colleagues. A culture of inclusion needs to be fostered in which the skills and experience of each nurse are valued so that overseas nurses do not feel treated like newly qualified staff with the need to prove themselves.

An important first step would be for the 'Scope of professional practice' course to be included as a core element of the adaptation programme. This could suitably be provided within these trusts as the final study day during the period spent working on the wards, and would enable overseas nurses to apply for additional courses as soon as their UK nursing registration has been confirmed.

Due to the variation in the role of the nurse in different countries, consideration of each overseas nurse's skills needs to be recognised on an individual basis. Where nurses are already trained and experienced in IV administration, venepuncture and male catheterisation in their country of origin, all measures should be taken to enable them to utilise these skills in the UK, as soon as their registration is confirmed. This requires an individualised process for assessing and crediting clinical skills.

In addition, there needs to be recognition of an individual's experience and expertise if a two-way exchange of skills and expertise (Gerrish and Griffith, 2004) is to become realised. This study has highlighted areas of difference between countries that include the autonomy of the nurse, the philosophy of patient choice, the care of older people, and discharge planning. It is only through individual appraisal that objectives can be identified and appropriate support provided.

In order to obtain a fuller picture, further research is needed to consider the views and experiences of nurses and other members of the multiprofessional team who work alongside overseas nurses. If organisations are to be successful in fostering inclusiveness, consideration should be given to the extent to which UK nurses and other healthcare professionals value their overseas colleagues. Similarly, this study has highlighted the need for research that compares the experiences of nurses who have trained overseas with that of their UK colleagues. Some of the issues identified by overseas nurses in this and other studies may not be unique to them. Research is also needed to examine the units of recognition that mark someone as an overseas nurse and the point at which individuals cease to be seen as such by their UK colleagues.

Finally, consideration needs to be given to the global impact of current practice in relation to the recognition of clinical skills and experience. If overseas nurses become de-skilled while working in the UK, this will have implications for resettlement should they at some stage wish to return to their country of origin.

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CONFLICTS OF INTEREST

None.

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