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The social reproduction of institutional racism: internationally recruited nurses' experiences of the British health services

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ABSTRACT

In an increasingly competitive global labour market, more countries with nursing shortages are recruiting from abroad. The UK is no exception. However, little research has been conducted into the experiences of racism and discrimination among internationally recruited nurses in the UK. The empirical data in this paper contribute to understanding how immigrant workers from Black and other minority ethnic backgrounds experience working in British health services and provide empirically grounded accounts of individual and institutional racism.

A total of 67 internationally recruited nurses (IRNs) participated in 11 focus group interviews which were held at three sites in the UK: Leeds, Cardiff and London. These focus groups were audio-taped and analysed using NVivo, version 1.3. In focus groups, IRNs described discrimination and racism as central to their experiences as IRNs working in the UK. This study demonstrates the ways in which racism and institutional racism work in healthcare practice from the perspective of IRNs and how they cope with these negative experiences. The data suggest that racism and institutional racism are understood in more complex ways than previously reported and that institutional racism may be reproduced through negative stereotypes of foreigners and professional hierarchies which are forms of structured social relations. These structured social relations are reproduced in complex professional relationships and hierarchies, in the meaning of ethnicity and stereotypes for individuals and the relationship between racist attitudes and racist behaviours.

Based on these findings, we argue that racism and institutional racism are reproduced through personal and interpersonal as well as structured social relationships, and provide working examples of the concept of institutional racism in practice. We discuss the implications of the findings for equal opportunities policies in the health services.

Keywords:

Introduction

The purpose of this paper is to explore the experiences of discrimination and racism among internationally recruited nurses (IRNs) who are recruited to work in the UK, and to develop an understanding of institutional racism that reflects the complexities of these nurses' experiences of racism and discrimination. The empirical data in this paper contribute to an understanding of how immigrant workers from minority ethnic backgrounds experience working in the British health services. We present the findings from a larger study (Royal College of Nursing, 2003b), which had the broader aims of describing the work experiences of IRNs in the UK, exploring why IRNs come to work in the UK and their motivations for staying in the UK. The full findings are discussed in detail in the published report (Royal College of Nursing, 2003b).

Background to the study

Miles and Brown (2003) and others (Anthias, 1999; Yuval-Davies, 1999; Gilroy, 2000; Bhopal, 2004) argue that racism is an ideology rather than a scientific theory. Racism therefore represents human beings and their social relationships in a distorted manner (Miles and Brown, 2003). Racism works through the signification of historically and socially contingent characteristics to identify a population. These characteristics are negatively evaluated or induce negative consequences for people bearing these characteristics (Miles, 1989, p. 71). Racism against individuals in employment was made illegal in the Race Relations Act 1976. Research findings from studies in the UK health services suggest that racism exists in pervasive forms to intimidate Black and minority ethnic staff[1] and prevent career progression (Shields and Wheatley Price, 2002; Randle, 2003) despite the presence of equal opportunities legislation (Culley, 2001). Black and minority ethnic British nurses experience racism from patients as well as staff. There is evidence that it pervades healthcare, causing victims to feel isolated, exploited, frustrated and angry (Cortis, 1996; Culley, 1996; Gerrish, 1999; Hagey *et al*, 2001; Hawthorne, 2001; Puzan, 2003). It is known that there may be demographic and gender differences in experiences of racism among both British Black and minority ethnic healthcare staff as well as among overseas nurses (Shields and Wheatley Price, 2002).

Institutional racism has been widely debated and discussed in British literature (Anthias, 1999; McLaughlin and Murji, 1999; Yuval-Davies, 1999; Culley, 2001; Shields and Wheatley Price, 2002; Miles and Brown, 2003; Bhopal, 2004) following the report of the inquiry into the death of Stephen Lawrence. The report defined institutional racism as:

> the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people. (Home Office, 1999, para. 6.34)

Anthias (1999) points out that this definition is not useful in determining whether it is the institution and its policies that are racist or the individuals within those institutions who are racist. Neither does it help define whether it is racist ideology or other forms of discrimination such as culture, gender and social class, which lead to exclusion (Miles and Brown, 2003). As an alternative, Miles and Brown (2003, p. 109) suggest a 'deflated' definition of institutional racism:

> exclusionary practices which arise from a racist discourse which either exists or has existed.

In other words, institutional racism is the manifestation of a racist ideology, examination of which may help us to determine which actions might be racist and in what conditions. The concept of institutional racism informed the Race Relations Amendment Act (2000). This is concerned with outlawing discrimination on the grounds of race in *public* life. It extends the Race Relations Act (1976) by emphasising the responsibility of public bodies to tackle institutional racism. We understand racism and institutional racism as forms of discrimination that are linked to IRNs' identities as foreigners as well as ideologies which pervade the British health services.

There is an acute shortage of qualified nurses in the UK (Royal College of Nursing, 2002, 2003a, 2003b; Department of Health, 2003). It is expected that the problem of skills shortages will be aggravated in the future by an increased demand for healthcare, mainly as a result of an ageing population (Royal College of Nursing, 2002). Apart from strategies to increase the number of 'home-grown' nurses, government initiatives seek to meet present and future service demands by recruiting them from overseas (Department of Health, 1999; Buchan, 2001; Kingma, 2001). In an

[1] We have used the term 'Black and minority ethnic' as it is used in the Race Relations Amendment Act (2000). However, the research participants were also given the opportunity to self identify their ethnicity.

Following Bhopal (2004), we use the term Black to describe a person with African origins who self identifies as Black, African or Afro-Caribbean. South Asian is used to describe a person from the Indian subcontinent. Asian is used to describe a person from the Far East although in practice, the only group of Asian people came from the Philippines and self-identified as Filipino.

increasingly competitive global labour market, where more and more countries with nursing shortages are recruiting from abroad (Kingma, 2001; Royal College of Nursing, 2002), a better understanding of IRNs' expectations and motivations is needed in order to develop ethical recruitment, ensure good employment practice, develop career pathways and ensure that skills learnt in the UK can be utilised when individuals return home (Hawthorne, 2001; Oulton, 2001; Kingma, 2001; Department of Health, 2003; Woods 2003). This research was commissioned to address these issues by The Royal College of Nursing (RCN). The College is a professional body that represents nurses and nursing throughout the UK.

Study design and methods

A qualitative approach was selected and data were collected during the winter months of 2002 by means of audio-taped focus group interviews. This type of interview has been defined as 'a discussion in which a small group of people, under the guidance of a facilitator, talk about topics selected for investigation' (Howard *et al*, 1989 cited by Macleod Clark *et al*, 1996, p. 143). Two researchers undertook each focus group interview either as moderator or observer. Ethical approval was gained from the University of Surrey Advisory Ethics Committee and informed, signed consent from each individual IRN was obtained prior to each focus group interview. Participants for each focus group were selected purposefully to represent nationality (see Table 1), ethnicity (see Table 2) and sex (see Table 3). Each was asked to record demographic and professional information prior to the interview.

The focus group interview utilised opens questions to elicit as broad a picture as possible about IRNs' experiences:

1 what are your experiences of working as a nurse in the UK?
2 what has been done to support you in your work as a nurse in the UK?
3 what expectations have you had of work and life in the UK?
4 how does the role of the nurse in the UK compare to your home country?
5 what would motivate you to stay and work in the UK for a longer period?

A clerical assistant transcribed the audio-recorded focus group interviews. Confidentiality was assured by the allocation of a participant identification number and restricted access to data following data protection legislation. The data was coded using broad empirical themes and by specifying individual participants. The coding was verified and supplemented by both researchers, who shared progress throughout the analytic stages to ensure rigour and an audit trail in the study. Data coding and analysis was conducted using NVivo, version 1.3, (Richards, 1999) allowing strategies

Table 1 Nationality of focus group participants

	Cardiff ($n = 15$)	Leeds ($n = 25$)	London ($n = 27$)
Australia		1	3
Canada		1	
Ethiopia			1
Finland		1	
Germany			1
Ghana		2	1
India	1	1	
Kenya			1
New Zealand			1
Nigeria	3	4	10
Pakistan		2	
Philippines	2	4	1
South Africa	4	4	4
Sweden	1		
Ukraine			1
USA			1
Zambia	3	2	
Zimbabwe	1	3	2

Table 2 Ethnicity of focus group participants

	Cardiff ($n = 15$)	Leeds ($n = 25$)	London ($n = 27$)
Black	10	15	16
White	2	3	8
South Asian	3	7	1
Mixed race	0	0	2

Table 3 Sex distribution of focus group participants

	Cardiff ($n = 15$)	Leeds ($n = 25$)	London ($n = 27$)
Male	1	6	2
Female	14	19	25

of both case analysis and cross-case analysis to be performed by both researchers (Patton, 1990, p. 376). The analysis presented in this paper is based on the empirical themes of racism and discrimination. As indicated in the interview questions, racism and discrimination were not addressed directly. Rather, these concepts emerged as 'emic' concepts during the discussions and exchanges of experiences by IRNs. Analysis revealed several distinct themes, each of which is presented in this paper.

Participants

Sampling was a two-stage process. Firstly, in order to include the experiences of IRNs in different geographical areas in the UK, 2200 IRNs were selected from the RCN database in three different regions: Cardiff, Leeds and London. These sites were selected by examining the concentration of IRNs in RCN membership by region. The 2200 selected IRNs were sent a letter by the RCN detailing the purpose of the study and information about the research. Those interested in taking part were asked to either contact the researchers by telephone or return a slip with their contact details. One-hundred and eighty-seven IRNs contacted the researchers. Details about the IRNs who contacted the researchers were recorded on the Access database to facilitate purposeful sampling following a maximum variation strategy (Patton, 1990, pp. 169–83) to include IRNs with different backgrounds, experiences, views, nationality, ethnicity, sex and current nursing grade. Different attitudes were also considered in the sampling to include both those with primarily positive experiences and those with primarily negative experiences. Secondly, when selecting participants for the focus groups, maximum variation was sought with regard to nationality, ethnicity, sex and current nursing grade. The selected participants were then sent a letter inviting them to take part in a focus group on different days and at various times; the letter also included details of the venue (the local RCN office) and how to get there. The invited IRNs were requested to call back to the researchers detailing the time of their choosing. Forty invitation letters were sent out in both London and Leeds, and all agreed to take part. The same approach was used in Cardiff, but the response was much lower with only 27 calling or writing to express their interest in taking part in the study.

The average age of the participants was 41 years, of whom nine (13%) were male. The average annual salary was just above £18 000. More than half had held senior nursing positions in their home countries before coming to the UK. On average, participants had 14.1 years of nursing experience and, at the time of this research, been working as nurses in the UK for 3.8 years.

Findings: experiences of racism

The key themes that emerged from the data were racism as difference, defining racism, being white or foreign, defining discrimination, and coping with racism.

Racism as difference

Some IRNs felt their 'difference' acted as a social marker (Banton, 1994) or a determinant for racial harassment (Shields and Wheatley Price, 2002) which affected their relationships with British nurses before their personal attributes could be judged. Their 'difference' could be colour, culture, language or foreignness and, at times, it made them question whether they were viewed empathetically as fellow human beings:

> No matter if they know you are an overseas qualified nurse, the way you are being approached or addressed is quite different completely from the so-called UK-trained nurses because they look at you as if you don't have anything upstairs at all. They look at you as if you don't know anything relating to nursing. So such attitude [can] actually demoralise [a] human being. (Male, 39 years old, Nigeria, Black)

For many IRNs, the impact that colour made on their experience and relationships was unexpected and shocking:

> But here I think you are made to realise what colour you are, something that you never thought about at home, but here you know 'I'm Black'. Even my son who is eight years old knows that he's Black and he [said to me] 'we are slaves'. I don't know where he got that from but he knows. (Female, 35 years old, Zambia, Black)

Defining racism

Racism was described by different participants as resentment to foreigners and internationally recruited nurses generally. Racism affected individuals, for

example by social excluding foreigners and blocking career progression. Racism was described as an attitude that was expressed covertly, and could make the IRN feel that their skin colour determined what their colleagues thought of them. These experiences suggest that racism and institutional racism influence Black and minority ethnic workers' place in nursing hierarchies and their career progression, as well as their daily working relationships with colleagues and patients (cf Wight, 2003). These racist experiences show that attitudes towards foreigners in the UK are challenging:

> They [patients] can make your life miserable. They can easily [say] 'No, I don't want you to care for me' and you feel bad. One or two got this Black thing ... (Female, 46 years old, Zimbabwe, Black)

The extent to which discrimination can be based on attitudes and meanings attached to nationality which may be held by British patients over a lifetime came as a shock to a Ukrainian nurse:

> I was looking after one gentleman who's 91 years old and he was telling [me] about the world war [and] he met some Russians. When he was going home he walked up to me, and he admitted that when he first saw me, he thought, 'What can this stupid Russian do?'. And he said that he thought in his mind how desperate the NHS should be to employ me. It's what he thought, but by the end of four months he said 'You're most efficient nurse I met, I ever met'. It's exactly what he was thinking when he saw me first time and when he told me this I was like, you know, after what good he said about me I couldn't hear any more. (Female, 32 years old, Ukraine, White)

While there were challenges to interpreting some examples of discrimination as racism within the focus groups, IRNs agreed that discrimination existed and that it could be based on colour and ethnicity but that it was as likely to be due to being a foreigner or having a different cultural background. Their understandings of racism as being caused by more than a person's ethnic origin are consistent with the literature on racism discussed above (Anthias, 1999; Miles and Brown, 2003). These data also confirm previous findings from Shields and Wheatley Price (2002) that White overseas workers can experience racism in the UK context simply because of their accent or their country of birth.

Being White or foreign

One Black IRN experienced racism but described this as being caused by being foreign rather than Black. This IRN's position as a manager did not protect her from 'resentment' by colleagues:

> I even get this resentment from some of the managers and some of the unit managers who are English. They don't see why they should give me the position [the only Black G grade in the independent home] they've given me now. Number one I'm a foreigner. (Female, 46 years old, Ghana, Black)

The data also showed the complexity of colour for White IRNs who experienced some sense of discrimination while at the same time being aware of racist attitudes towards their Black colleagues. In the following quote, a White, Zimbabwean IRN shows that she is aware of her own favourable treatment in comparison to her Black colleagues but feels, nevertheless, that she is treated differently because she is foreign:

> I also had a British passport, which I had got before I came, and that also helped such a lot. But I lived in a nursing home where all the immigrant nurses went and ... I was the only White and I listened to the stories of what these girls had to go through and, you know, I just thought I've lived in a continent where I've been privileged all my life just by being English speaking and White and now I come back to Britain, which is meant to be so emancipated and so progressive, and yet I saw exactly what was happening. I was put into the ward where I chose to be, they were put into the ward where they [employers] wanted them to be, so it was, it was very different, it was, and it was a strange thing because I wasn't accepted by the English people because of my accent and because they also didn't know whether I was what I said I was, you know? (Female, 55 years old, Zimbabwe, White)

Defining discrimination

Others argued that IRNs experienced discrimination because of the hierarchical nature of British nursing and the grading system. Their argument was that there may be racism but that British nurses are also uncaring and unsupportive to each other whatever their colour:

> I think nursing is very hierarchical and I think people who are highly graded like to throw their weight around, and I think it's personalities sometimes, it's not just racism. It could be racism; it could just be that that person is a nasty person. I started off doing agency work, people aren't very friendly or helpful and I mean I come from an English-speaking country, I am Australian. (Female, 30 years old, Australia, mixed race)

In this way, IRNs' experiences of discrimination were related to nationally specific healthcare practices and staff interactions. One Black IRN, who quite clearly felt that racism was due to colour and not culture, further illustrated the complexity of ethnicity and colour. She made a clear link between her experience of racism as a non-British Black nurse and the experiences of Black British people in society more generally:

> I think it's the colour because the culture has nothing to do with it [racism]. My culture is my problem, it's nobody's problem because I don't display my culture here so it's got nothing to do with here at all. It's only that I'm Black. The

> Black British still experience the same problems anyway. (Female, 32 years old, Nigeria, Black)

Coping with racism

Many IRNs expressed anger and frustration over the racism they experienced. However, the following quote is from an IRN explaining how she had been able to deal with racism by trying to understand it in the context of her own cultural experience:

> My [IRN] colleagues [they asked:] 'Why do you get on so well with them when they are nasty to you?'. I was thinking of back home in the village, when a White person comes, the way the children will run away ... because they've never seen ... a White and then when they come closer they will come close and touch, you know, touch. So I put it in that situation. So I said 'Have you considered that maybe they have never worked with Black people before? And so they are not sure how to relate to us and, uhm, we have to help them'. (Female, 46 years old, Ghanaian, Black)

Other IRNs explicitly stated that their experiences of discrimination were examples of racism, that is, they felt that their colour and ethnic origin as overseas, Black and minority ethnic nurses affected how they had been treated in job selection, within ward teams and on adaptation courses (Miles and Brown, 2003).

> The respect is not just there and the racism, as I recall it, it's existing because they have no choice, that's why they accept us. If not for the parliament that passed that issue allowing nurses to come to UK and be working so, they wouldn't have accepted us. So the racism is there, we are just fooling ourselves. We know it is there and they are not accepting us. (Female, 54 years old, Nigeria, Black)

The difficulty of talking openly about racism gave the following South African IRN the feeling that racism was worse in the UK than in her home country. She explained that in the UK the racism is silent, in the hearts and minds:

> I even said 'Oh, in South Africa it was better'. This thing was documented, everybody was aware that I can't mix with [White people] ... because it was illegal. Here it's not legalised but it's deep down in the hearts or in the mind. (Female, 52 years old, South African, Black)

Goldberg suggests (1993) that racism is difficult to prove from the oppressed person's viewpoint because of its contextual and fluid nature. The following quote shows how contextual and open to interpretation IRNs' feelings of racism and discrimination were:

> The job description was there. I felt I qualified for it and then, they said I did very well, my presentation was very good and I'm highly qualified, but they were sort of degrading the post, they wanted somebody sort of [more] junior than me ... I was too overqualified for the job ... So I don't know whether I wasn't given that job because I come from Africa ... So I don't know where to go, whether it's me as a Black African or it's me [being] too overqualified. (Female, 40 years old, Zambia, Black)

These findings indicate that these IRNs experienced both racism and discrimination. The implications of these data are now discussed in the context of institutional racism and equal opportunities.

Discussion

This study demonstrates the ways in which racism and institutional racism work in healthcare practice from the perspective of IRNs and how they cope with these negative experiences. The data suggest that racism and institutional racism are understood in more complex ways than previously reported, and that institutional racism may be reproduced through negative stereotypes of foreigners and professional hierarchies which are forms of structured social relations (Wight, 2003). These structured social relations are reproduced in complex professional relationships and hierarchies, in the meaning of ethnicity and stereotypes for individuals and the relationship between racist attitudes and racist behaviours. It is acknowledged that the small sample, exploratory nature of the research aims and the absence of the views of White British healthcare staff place limitations on this study. However, we argue that the data contribute to the understanding that the health services are implicated in the racism described in the report of the inquiry into the death of Stephen Lawrence (Home Office, 1999) and elsewhere.

Our data suggest that IRNs experience discrimination and racism in both the NHS and the independent sectors, although our research methodology does not allow us to indicate the extent or distribution of these experiences. However, there is evidence to suggest that these IRNs' experiences of discrimination and racism are likely to be shared by asylum seekers and refugees as well as by Black and minority ethnic British people (Anthias, 1999; Home Office, 1999; Yuval-Davies, 1999; Randle, 2003). Our data confirm and add to the small number of investigations into workplace racism in the health services. The IRNs' experiences of discrimination, based on their being foreigners in the UK, reveal the powerful ways in which different forms of discrimination and racism shape professional and clinical relationships to impede equal opportunities in the British health services.

There was evidence in the data that racist attitudes and racist behaviours towards IRNs were motivated by racist beliefs about skin colour, ethnicity and nationality. This suggests that the relationship between racist ideology and the individual's prejudice needs further investigation, as it does not seem sufficient to argue

either that racist ideology alone produces social exclusion and discrimination, or that racist individuals are responsible for racism within institutions (cf Anthias, 1999; Miles and Brown, 2003).

This study (cf Wight, 2003) demonstrates how racism and institutional racism work in practice. The experiences described, and the IRNs' explanations for them, show the complex relationship between agency and structure that is unresolved in the MacPherson report (Wight, 2003). The data also assist in delineating the actions that might be perceived as racist, and the conditions in which such racism occurs, for example in relationships with patients and staff (Solomos, 1999).

There were differences between IRNs' interpretations of shared experiences of discrimination, suggesting that racism is not easily defined in practice for Black and minority ethnic people. Goldberg (1993) argues that these differences arise because racism is fluid and contextual and therefore specific to a situation. His view supports that expressed in the report of the inquiry into the death of Stephen Lawrence, that any incident may be defined as racist 'by the victim or any other person' (Home Office, 1999, para. 47.12). Our data suggest that the IRNs allowed each IRN to define an incident as discriminatory but argued that discrimination could not be understood solely as racism. While they acknowledged that the individual could interpret incidents as discriminatory and, indeed, racist, they suggested that such incidents could be caused by factors other than ethnicity or colour, such as being a foreigner, or that the hierarchies within nursing culture might be the cause of discrimination. Some IRNs believed that their presence in the UK was viewed as a problem and that, unless this was addressed, racism and negative stereotyping would continue.

Career progression and job selection are two examples in the data where it is difficult to tease out whether individual and institutional racism were the reason for experiences of discrimination (Anthias, 1999). This indicates that the terms 'racism' and 'institutional racism', as used in the Stephen Lawrence Inquiry (Home Office, 1999) and as they guide equal opportunities policies, have limited analytical strength to assist in understanding the racist experiences of the IRNs in this study. They appear to restrict both theoretical and practical understandings of racism and institutional racism in the workplace. The data suggest that racism and discrimination exist despite the equal opportunities policies. We argue, therefore, that these policies are not sufficient to bring about equality in the workplace because they are not grounded in empirical understandings of racism (Solomos, 1999; Gilroy, 2000) based on emic experiences and understandings of the victim's perception of a racist, and we would argue discriminatory, incident.

These data raise questions over the current approach of using legalistic frameworks such as equal opportunities (Culley, 2001) to tackle racism in the health service. Culley (2001) argues that such policies do not offer a useful or theoretically sound way to tackle racism because they fail to address the fundamental values and racist attitudes that prevail in the health service. Equal opportunities policies are based on notions of racism which fail to acknowledge structured social relations in professional relationships or the fluidity and contextual nature of racism. This study confirms that while such policies exist, they do not prevent racism towards IRNs from either colleagues or patients. The quotation about racism being in the 'hearts and in the mind' (Culley, 2001, p. 12) is a good example of how IRNs were aware of racism despite working in organisations which espoused equal opportunities and non-discriminatory policies. Culley (2001) goes on to argue that the health service has failed to introduce anti-racist policies that do address such underlying issues and, consequently:

> this means that racism, as a complex phenomenon, is much less amenable to change, particularly through rationalist policy interventions than has been anticipated. (Law, 1997, p. 191)

This study adds to our understanding of race relations as a complex area that is not resolved by quick-fix solutions imposed from above (Commission for Racial Equality, 2003). IRNs who experienced discrimination are aware of the complexities of race and are prepared to adapt their behaviours in order to cope with negative situations at work. The most telling message from the IRNs themselves was that their status as qualified nurses should be recognised, that their different cultural backgrounds should be acknowledged and that they, more fundamentally, should be 'respected as human beings'.

> When I came here I have to make them realise in my environment that, put yourself in my position, I want empathy, I don't want sympathy. And respect ... we need respect from our colleagues or whoever. (Female, 46 years old, South Africa, Black, D grade)

Conclusions and recommendations

This study shows that IRNs experience discrimination and racism while working in the British health services. In explaining and making sense of these experiences, IRNs are expanding the meanings of the complex concepts of racism and discrimination that both confirm and contradict the literature. Their responses to these experiences also show that they are coping with, and accommodating to, working in the British health services in the host country. In this paper we have provided empirically grounded accounts of

racism and institutional racism with the British health services. We have considered how institutional racism is reproduced through personal and interpersonal as well as structured social relationships.

We recommend that, if IRNs are to be given respect as both human beings and professionals, the health service needs to examine the suitability and effectiveness of equal opportunities policies in addressing institutional racism. In addition, we recommend that policies and procedures be reviewed to include monitoring of career trajectories and enhancement of career choices for IRNs. Alongside these proposals is the issue of education for British staff, to enable them to engage in a free debate about the impact of culture, race and ethnicity on healthcare and to better understand and value their colleagues from other countries.

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REFERENCES

Anthias F and Yuval-Davies N (1993). Racialised Boundaries: race, nation, gender, colour and class and the anti-racist struggle. London: Routledge.

Anthias F (1999). Institutional racism, power and accountability. *Sociological Research Online* www.socresonline.org.uk

Banton M (1994). *Discrimination*. Buckingham: Open University Press.

Bhopal R (2004). Glossary of terms relating to ethnicity and race: for reflection and debate. *Journal of Epidemiology and Community Health On-Line* 58:441–5.

Buchan J (2001). Nurse migration and internaitonal recruitment. *Nursing Inquiry* 8(4):203–6.

Commission for Racial Equality (2003). *Towards Racial Equality*. www.cre.gov.uk

Cortis JD (1996). The future of ethnic minority nurses in the NHS. *Journal of Nursing Management* 4(6):359–70.

Culley L (1996). A critique of multiculturalism in health care: the challenege for nurse education. *Journal of Advanced Nursing* 23(3):564–70.

Culley L (2001). Equal opportunities policies and nursing employment within the British health service. *Journal of Advanced Nursing* 33(1):130–7.

Department of Health (1999). Guidance on International Recruitment. London: HMSO.

Department of Health (2003). Statistical Bulletin, NHS Hospital and Community Health Services Non-Medical Staff in England: 1999–2000. London: HMSO.

Gerrish K (1999). Inequalities in service provision: an examination of institutional influences on the provision of district nursing care to minority ethnic communities. *Journal of Advanced Nursing* 30(6):1263–71.

Gilroy P (2000). Between Camps: nations, cultures and the allure of race. London: Penguin.

Goldberg D (1993). *Racist Culture*. Oxford: Blackwell.

HMSO (2003). Race Relations Act 1976 (Amendment) Regulations. www.hmso.gov.uk

Hagey R, Choudry U, Guruge S *et al* (2001). Immigrant nurses' experiences of racism. *Journal of Nursing Scholarship* 33(4):389–94.

Hawthorne L (2001). The globalisation of the nursing workforce: barriers to confronting overseas qualified nurses in Australia. *Nursing Inquiry* 8(4):213–30.

Home Office (1999). The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William MacPherson of Cluny. London: The Stationery Office.

Howard E, Huble Bank J and Moore P (1989). Employer evaluation of graduates: the use of the focus group. *Nurse Educator* 14(5):38–41.

Kingma M (2001). Nursing migration: global treasure hunt or disaster-in-the-making? *Nursing Inquiry* 8(4):205–305

Law I (1997). Modernity, anti-racism and ethnic managerialism. *Policy Studies* 18:189–205.

Macleod Clark J, Maben J and Jones K (1996). The use of focus group interviews in nursing research: issues and challenges. *NT Research* 1(2):143–53.

McLaughlin E and Murji K (1999). After the Stephen Lawrence Report. *Critical Social Policy* 19(3):371–85.

Miles R and Brown M. (2003). *Racism* (2e). London: Routledge.

Oulton JA (2001). At issue: ethical recruitment. *International Nursing Review* 48(2):78.

Patton M (1990). Qualitative Evaluation and Research Methods. Second edition. Newbury Park: Sage.

Puzan E (2003). The unbearable Whiteness of being (in nursing). *Nursing Inquiry* 19(3):193–200.

Randle J (2003). Experience before and throughout the nursing career: bullying in the nursing profession, *Journal of Advanced Nursing* 43(4):395–401.

Richards L (1999). *Using NVivo in Qualitative Research* (2e). Melbourne: Qualitative Solutions and Research.

Royal College of Nursing (2002). International recruitment: United Kingdom case study. www.rcn.org.uk

Royal College of Nursing (2003a). *Here to Stay? International nurses in the UK*. www.rcn.org.uk

Royal College of Nursing (2003b). *We Need Respect: experiences of internationally recruited nurses in the UK*. www.rcn.org.uk

Shields MA and Wheatley Price S (2002). The determinants of racial harassment at the workplace: evidence from the British Nursing Profession. *British Journal of Industrial Relations* 40(1):1–21.

Solomos J (1999). Social research and the Stephen Lawrence Inquiry. *Sociological Research Online* 4(1) www.socresonline.org.uk/socresonline/4/Lawrence/solomos.html

Wight C (2003). The agent-structure problem and institutional racism. *Political Studies* 51:706–21.

Woods C (2003). Reciprocal agreement. *Nursing Standard* 17(21):58–9.

Yuval-Davis N (1999). Institutional racism, cultural diversity and citizenship: some reflections on reading the Stephen Lawrence Inquiry report. *Sociological Research Online* www.socresonline.org.uk

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

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