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## Black African Nurses' Experiences of Equality of Opportunity, Racism, and Discrimination in the NHS

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### Abstract

As the workforce in the British National Health Service (NHS) has become more diverse, several researchers have reported that experiences of overseas' nurses have been largely negative. This paper explores black African nurses' experiences of equal opportunities, racism, and discrimination in four NHS trusts in the North East of England. Thirty nurses from sub-Saharan countries working in four NHS trusts were interviewed between 2006 and 2008 using semi-structured interviews and focus group discussions to gain an insight into their experiences in the NHS. This study suggests that black African nurses experienced discrimination and racism emanating from white colleagues and other overseas nurses, managers, patients, and their relatives, as well as lack of opportunities in their workplaces. Managers seemed to be treating British and other overseas nurses more favorably than black African nurses. Although much progress has been made in valuing and embracing diversity in the NHS, this paper highlights areas in which more work is required.

## **Introduction**

The nursing workforce in the British National Health Service (NHS) has become more diverse because of heavy international recruitment driven by the Labour government agenda from 1997 to 2006. During this period, large numbers of qualified nurses were recruited from outside the UK and those from outside the European Union were referred to as overseas nurses. This diversity has brought some positive effects to the NHS, not least the relief on chronic nurse shortage that characterized the NHS throughout the 1980s. However, these overseas nurses have frequently cited racism and harassment as distressing experiences in their working life in NHS hospitals, as well as in the private sector, in terms of career opportunities (Beishon, Virdee, & Hagell, 1995; Culley, 2000; Lemos & Crane, 2001; Shields & Wheatley Price, 2002; Allan & Larsen, 2003; Alexis & Vydellingum, 2004; Allan, Larsen, Bryan, & Smith, 2005; Taylor, 2005; Herbert, Datta, Evans, May, McIlwaine, & Wills, 2006; Likupe, 2006; Larsen, 2007; RCN, 2008; Archibong & Darr, 2010; Nichols & Campbell, 2010).

Racism refers to the discourse of beliefs and practices that legitimate racial inequality (Pilkington, 2003). These beliefs can be hereditary, such as skin color or cultural differences that postulate the superiority of certain groups of people over others. Racial discrimination can be direct, indirect, victimization, and harassment, and it refers to receiving less favorable treatment from employers or colleagues on racial grounds than others in similar circumstances (Equality Act, 2010). Racism is directly related to discrimination, as racism creates and justifies unequal relationship between groups (Pilkington, 2003). The most common forms of harassment in the above studies were racism and denial of training and career development opportunities, and overrepresentation in disciplinary proceedings.

Shields and Wheatley Price's (2002) study found that 50% of ethnic minority nurses who had reported no harassment were not satisfied with their jobs in the NHS. In addition,

Archibong and Darr (2010) found that ethnic minority staff (including nurses) tended to downplay their perception of discrimination for fear of losing access to internal support. This could suggest that the absence of reported discrimination cannot be equated to its eradication in the workplace. The authors concluded that perceived racial harassment at work has the largest detrimental effect on job satisfaction levels in increasing staff intention to quit their jobs.

Other studies found that stereotypical assumptions about the role of black nurses has categorized them as not having the potential to achieve supervisor or manager status and that procedures for promotion were more rigorously applied to black nurses than to white nurses (Allan et al., 2005; Alexis & Vydelingum, 2005; Pike & Ball, 2007; RCN, 2008). These nurses also experienced inequality of opportunity for skill development within the NHS (Allan & Larsen, 2003; Withers & Snowball, 2003; Allan et al., 2005; Alexis, Vydelingum, & Robins, 2006; Alexis & Vydelingum, 2009). Hunt (2007), however, found that managing a diverse workforce is challenging for managers.

Some studies reported that nurses recruited from overseas experienced loss of status and discrimination (Allan et al., 2005; Taylor, 2005; Larsen, 2006, 2007; Smith, Allan, Henry, Larsen, & Mackintosh, 2006; Alexis et al., 2006; Alexis, Vydelingum, & Robins, 2007; Allan, Cowie, & Smith, 2009). However, Alexis et al. (2007) reported that, although overseas nurses experienced mostly negative experiences such as lack of support, they appreciated the fact that they had built ties with other overseas nurses. Some had even benefited in terms of personal and professional development.

Smith and Mackintosh (2007) reported that overseas nurses are disadvantaged within UK nursing and that this disadvantage exists across gender, class, and race. International disadvantage through migration reinforces this status. Smith and Mackintosh's (2007) results point to a pecking order in this hierarchy, with black African nurses at the bottom. In

addition, Smith et al. (2006) argue, “overseas nurses are not recognised because they are not British and therefore not ‘safe’ until credited against British standards” (p. 48). Sheffield, Hussain and Coleshill (1999) cited inconsistencies in the treatment of ethnic minorities in the Scottish NHS, blaming management policies for racism and inequality of opportunity. Sheffield et al (1999) suggest that barriers are a result of a lack of awareness and a failure to recognize that differences can exist and allow for competence. Archibong and Darr (2010) reported similar findings in their study on the application of disciplinary procedures among black and ethnic minority staff in the NHS .

Smith et al. (2006) reported that some overseas nurses felt that discriminatory attitudes could be provoked when they took on more senior roles than British nurses and proposed a link between British discriminatory attitudes and an apparent perception that overseas-trained nurses should work at lower grades. The Equality Act (2010) specifically addresses race issues that include color, nationality, and ethnic or national origins and prohibits discrimination on these grounds.

The literature has tended to study overseas nurses as a homogeneous group, yet acknowledgment exists that their experiences may be different depending on race, ethnicity, nationality, and other factors (Shields & Wheatley Price, 2002; RCN, 2008). Shields and Wheatley Price (2002) reported that black African nurses were the most likely to have been racially harassed by work colleagues, which demonstrates that black African nurses face more discrimination than other overseas nurses. Goodland (1965) supports this in noting, “... but it is often nurses who come from Africa who find themselves very much up against it” (p. 241) when describing experiences of overseas nurses recruited to train for nursing in the NHS at the time. Racism is a dynamic concept. It is dynamic in different contexts, and in terms of causes, excuses, or justification. Racism also changes with time and place (Cashmore &

Jennings, 2001). Phizacklea and Miles's (1980) migration framework is a good example of how racism reinvents itself depending on the situation.

However, some authors point out that it is almost always presumed that overseas nurses are victims of racism, and that either patients or the nursing management are the perpetrators. This ignores the possibility that migrants bring with them racial prejudice against other overseas nurses or against black patients and managers (McNeil-Walsh, 2004; Raghuram, 2007). In the present study, the term "black African" refers to nurses who were recruited from sub-Saharan Africa and had their nursing education in Africa. The definition of black is consistent with the UK census (2011).

### **The Present Study**

This study aimed to explore experiences of discrimination, racism, and equal opportunities for black African nurses in the UK, underpinned by Phizacklea and Miles's (1980) migrant workers framework.

Phizacklea and Miles (1980) argue that black people's experiences in Britain are best understood first as migrant laborers in a capitalist society. They argue that the individual's economic place in a capitalist society plays a principal role in determining social class. The authors introduced the concept of class fraction as a means of identifying the base stratification within classes.

The concept of fraction in Phizacklea and Miles's (1980) view refers to an objective position within a class boundary, which is in turn determined by both economic and politico-ideological relations. In the case of black migrant labor, Phizacklea and Miles (1980) argue that it constitutes a distinct fraction of the working class. Black migrants constitute a class fraction not only because of their position in political and economic relations, but also because of ideological relations. Phizacklea and Miles (1980) consider two levels of this position, which are connected in reality. First, the arrival of black migrant labor to Britain is

said to have produced a “race relation” situation—that is, migrants are perceived to belong to “races,” which, by implication, are distinct from the “race” of the perceivers (Phizacklea & Miles, 1980, p. 21). The second is racism, which they define as

“those beliefs and arguments which give rise to the identification of a negatively evaluated racial category. Negative beliefs held by one group identify and set apart another by attributing significance to some biological or other ‘inherent’ characteristic(s) which it is said to possess, and which deterministically associate that characteristic(s) with other (negatively evaluated) feature(s) or action(s). The possession of these characteristics is then used as justification for denying that group access to material and other resources and/or political rights.” (p. 22)

Phizacklea and Miles (1980) contend that there is evidence to demonstrate that

governments, individual politicians, neo-fascist political organisations, the mass media, employers, institutions of the labour movement and sections of the working class in Britain have all acted and articulated racist beliefs which have identified migrant black workers as an excluded racial category (p. 23).

The authors posit that the political belief and practice of black immigrant workers is explicable in terms of both their class position and as a racialized and/or sexually categorized fraction of that class. Black African nurses are professionals as opposed to unskilled workers; as such, they are employed within the professional hierarchy of nursing. It is therefore progression in the profession that may be important in Phizacklea and Miles’s (1980) framework because it can be argued that immigrant nurses will be found in the lower grades as these are the grades that are less appealing to British nurses.

However, Pilkington (1984) states that in Britain black people are also discriminated against based on skin color, and not just because they are immigrants. Two studies of political planning, one by Daniel (1968) and the other by Smith (1977), support Pilkington,

stating that black immigrants are discriminated against based on their skin color. Later studies (Brown, 1984; Brown & Gay, 1985) arrived at similar conclusions. Furthermore, Smith (1977) conducted the study after the Race Relations Act of 1968, which outlawed discrimination in housing and other commercial services, indicating that the Race Relations Act had had little effect. Since then, successive acts, such as the Race Relations Act 1976, amended in 2000 and 2004, have had limited success. The Equality Act 2010 has not been in operation long enough to have its impact assessed, but the above review suggests that racism and discriminatory attitudes persist in the workplace.

### **Research Design**

This study is part of a larger qualitative study aimed to explore the experiences of black African nurses in the UK. Data for this part of the study were collected between 2006 and 2008. A qualitative research design was adopted for this study using focus group discussions and semi-structured interviews. This allowed for a fuller exploration of the reasons why nurses from sub-Saharan Africa moved to the UK and allowed for responses to be probed and explored fully (Legard, Keegan, & Ward, 2003). Four focus groups comprising a total of 15 nurses were conducted in this study. This enabled each participant to have an opportunity to share his or her experiences (Stewart and Shamdasani, 1990; Morgan, 1997; Krueger & Casey, 2000). The remaining 15 nurses were interviewed individually.

### **Sample**

Thirty nurses from sub-Saharan Africa working in four NHS trusts in the North East of England took part in the study. The participants were from Malawi, Kenya, Ghana, Nigeria, South Africa, Zambia, Zimbabwe, and Cameroon. They had been in the UK between 2 and 5 years. They were all at staff nurses grade. There were 26 females and 4 males; 27 were

married with children. one was a single mother, and two were single. Participants were aged between 25 and 48 years with an average age of 35 years. Nurses had experiences ranging from 5 to 20 years from their home countries. Two nurses had been lecturers in their country of origin, and the rest had been sisters and staff nurses.

Nonprobability or purposive sampling was employed at two levels. First, NHS trusts in North East England known to have high concentrations of ethnic minorities were chosen. Second, black African nurses from these NHS trusts were invited to join the research. Advertisements in various wards in the selected NHS trusts asked black African nurses to come forward and talk about their experiences of working and living in the UK. Focus group discussion participants were those who could manage to meet the researcher on a given day. Those who could not make it to the focus groups were interviewed individually.

### **Data Collection**

Data were collected using focus group discussions and semi-structured interviews that lasted 90 to 130 minutes. These were tape-recorded. Fifteen nurses were interviewed in three focus groups, while the remaining 15 were interviewed individually. For both focus group and individual interview participants, interviews took place at the time and place selected by the participants. Some interviews were carried out in participants' homes, others in hospital common rooms, and others took place in restaurants. This meant that the participants were comfortable with the environment and their work schedules were not disrupted.

Interview guides were developed to help focus on the issues to be covered and to guide lines of inquiry questions designed to encourage participants to talk about their experiences. Interviews started with the question "What have been your experiences of working in the UK?" Subsequent probes were related to the answers given to this question.



Participants were encouraged to talk about sensitive issues by relating their stories, which created an atmosphere that was less threatening (Stewart & Shamdasani, 1990).

The tapes were transcribed verbatim before the process of theme formation could begin. During the process of theme formation, the tapes were listened to several times before comparing them with the transcriptions to ascertain accuracy.

### **Managing Sensitivities and Ethical Considerations**

The topic of the study needed to be examined with great sensitivity, given the possibility that the black African nurses could feel reluctant to discuss their experiences of discrimination, racism, and equal opportunities in the UK. The request for study participants to provide information on this subject could also have been considered an invasion of their privacy (Lee, 1993). Given these possibilities, the study was designed using a diversity competent research approach with sensitivity to the experience of research participants being of paramount importance (Archibong et al., 2009).

To acquire a genuine and deep understanding of the issues affecting members of minority communities, cultural knowledge must inform the entire research process. Merely including a particular underserved population in the sample or targeting an underserved population does not make a study cross-cultural (Okereke, Archibong, Chiemeka, Baxter, & Davis, 2007). Cultural competence must infuse and suffuse the entire research process of planning, theory development, instrumentation, analysis, and interpretation to ensure cross-cultural validity and reliability' (Brandt, Ishida, Itano, KagawaSinger, Palos, & Phillips, 1999). In this respect, the authors were mindful that those being researched should acquire a shared understanding of the study and have trust and confidence in the research process and its expected outcomes. The ethnic and professional backgrounds of the researchers helped facilitate this rapport by "reducing inter-subjective distances" (Papadopoulos & Lees, 2002) and promote a sense of commonality. It also ensured that information was collected both sensitively and accurately.

Before commencement of the study, a protocol detailing the aims and objectives of the study as well as the method of investigation and dissemination of the results was sent to Central Office of Research Ethics Committee (COREC) and Multi-Centre Research Ethics Committee (MREC), and it received approval as a justified investigation. After this approval, the protocol was sent to research and development committees of the four selected trusts and received approval in all four cases.

Before the commencement of interviews and focus group discussions, an information sheet was given to every nurse who showed willingness to participate in the study. Participants were given at least a week after reading the information to decide whether they wanted to participate in the study. This meant that they could discuss their participation with friends and family, but it also gave them time to ask questions if they wanted any clarifications.

On the day of the focus group or individual interview, participants signed consent forms as an indication that they had agreed to participate in the study. Before the interview, nurses were reminded that interviews would be audio-recorded and that their consent included this recording. They were assured that the tapes would be destroyed after transcription.

### **Data Analysis**

Van Manen's (1990) selective or highlighting approach was used to isolate themes. The analytic hierarchy described by Spencer, Richie, and O'Connor (2003) was used as a platform for initial ordering of the data. Because the process is not linear, the researchers' thoughts were able to move forward and backward in the initial process of data analysis, which involved assigning data to refined concepts, refining and distilling abstract conceptions, assigning meaning, and generating themes and concepts. This process helped

refine the analysis. The Spencer et al (2003) analytic hierarchy can be used to analyze any qualitative data. In this study, participant-based analysis was used (see pp. 258 and 260). Data from focus group interviews were integrated with that from individual interviews during theme formation.

### **Findings**

Black African nurses reported experiencing racism and lack of opportunities in their workplaces. They perceived racism as emanating from white colleagues and other overseas nurses, managers, patients, and their relatives. Discrimination was mainly concerned with equal opportunities and the daily work of nursing on the hospital wards. The racism perceived by nurses was covert in most cases, but in some cases it was quite obvious, and it caused them considerable distress and confusion.

#### **Perceived Racism from White British Nurses and Other Overseas Nurses**

Racism from colleagues did not just emanate from white British nurses but from other overseas nurses as well. Black African nurses felt that their experience and knowledge in nursing were not respected. Nurses blamed this partly on ignorance and also on inaccurate portrayal of Africa by the media. This view was illustrated by statements such as the following:

It could be anybody from Hungary, the Philippines it could be someone, but because you are coming from Africa there's lack of respect. We are all professionals trained and if someone comes to a ward and doesn't know the ward, the way it works, obviously the person will ask some questions.

Africans are treated not nicely at all. (M, Zambian, 40)

Another nurse added:

We had one Hungarian lady who was working with us, but you won't believe this lady was treated differently. At the end we say the work she was doing wasn't the right thing, but she was treated like... you know, because of the color, as if she knows what she is doing. (M, Ghanaian 25)

Black African nurses felt that they were the object of racism from other overseas nurses as a result of recruitment practices that favored nurses from the Philippines and India. The Code of Recruitment Practice (Department of Health, 2001, 2004) advised against recruitment of nurses from countries with nurse shortages of their own. Most of these countries were sub-Saharan countries, although the Caribbean was also included. The code was advisory and not prohibitive; therefore, recruitment agencies continued to recruit from Africa, and some African nurses were recruited from individual applications. Through the code, government policies created a division among overseas nurses that seems to have left African nurses feeling inferior to other overseas nurses.

Some nurses appeared to have lost confidence in their abilities because they were told that they were not good enough, and some even internalized this and accepted that there must be something wrong with them. Some doubt still remained as articulated by this Kenyan nurse:

It's really bad. You feel pain that a colleague of yours from home is being told that they need to look for a job elsewhere because they are not catching up! When you know back home, you and me, what do we do? You have no doctor around, but you have to go through a hundred patients, IVs and everything, then how come the same person cannot function? There has to be something wrong, and then it will affect the quality of work that they give out. Somewhere so I think they need to know that and they need to know that we are smart like anybody else. (F, Kenyan, 44)

Some nurses thought that the negative experience they got from their colleagues was a result of jealousy as British nurses were academically less qualified compared to their African counterparts:

And if they get to know that you know, that's when the problems start. Wait a minute. I did not have this problem at first until she knew that I have a master's. That's when my problems started on this ward. I never told anyone. I don't know how they knew— maybe they saw my CV. I don't know. (F, Nigerian, 40)

Another participant added:

I worked on this ward, the sister sat down with me at my appraisal and I said this is what I can do, I know how to do it, if you need documents, I can try to get them for you. She never believed. (M, Ghana, 25)

Black African nurses were perceived as arrogant if they voiced any dislike of their treatment by their colleagues, confirming the stereotype that an assertive attitude is not expected from Africans (Hall, 1999), or misconstrued as aggressiveness (Archibong and Darr, 2010). Marks (1994) described how black South African nurses were disciplined and even dismissed if they voiced their concern at their treatment by white administrators. One of the nurses put it this way:

It's like that because we as Africans, we are not like Filipinos and Indians who are very gullible because we fight back, they don't like that. And they term that as arrogant. (M, Ghana, 25)

Black African nurses reported a strained relationship with nursing auxiliaries (health care assistants). They said managers relied on these auxiliaries to carry out their agendas. Black African nurses perceived that as a result of the power auxiliary nurses were given by managers; auxiliary nurses were not willing to take instructions from black African nurses. The context of this power struggle relations can perhaps be understood on two levels. First, as

a result of nurse shortages, the NHS implemented various types of skill mix in the 1990s that were designed to provide effective care on hospital wards. As a result, unqualified caregivers found themselves doing similar tasks to qualified nurses and thus felt a form of empowerment. Second, black African nurses may have presented a particular problem, not just as migrant workers, but as inferior migrant workers because of stereotyped ideas discussed above. Managers legitimated nursing assistants' feeling of superiority by assigning them to supervise black African nurses:

Here it's the auxiliaries who run the wards, not managers, I tell you. If the auxiliaries don't like you, you are finished. Cos they say things to your manager and the managers take them seriously. If I'm on night duty and my colleague goes on break, I should not get instructions from an auxiliary. (F, Nigerian, 42)

However, some nurses thought that conflicts came as a result of not understanding the role care assistants, as most African countries do not use care assistants for nursing duties. Ward assistants used in African countries are mainly assigned to cleaning duties on the ward.

You could read about carers back home, you cannot really explain what carers are; you may not be using the word carer back home. We use the word ward assistant. And then in shift planning you have to come across that carer. But how do you explain who a carer is, but if you are here, where the textbook is written, you know who a carer is and you can really apply what you are reading to your environment. (F, Nigerian, 44)

Some nurses spoke of how they were made to look stupid if they asked for help with new procedures and believed that this was a result of racism:

I once gave an example to one of the nurses, I said you have been a nurse here for some time, if I take you home and just dump you in my ward, would you be able to perform the way you have been performing? She said no, you must be very courageous to come here. But, you see, instead of giving us support

even to show us, but people look at us if you fail to operate a hoist. (F, Zambian, 35)

By withholding information, some British nurses may have been given some authority and a sense of superiority because it is acknowledged that knowledge is power. However, this can sometimes backfire when patient care is compromised as a result and the whole nursing team is held to account. Some nurses were able to assert their authority and were able to perform their duties as illustrated by this male Zambian nurse:

I had some problems (auxiliaries) with them but I just tell them I am the registered nurse, you are the auxiliary therefore you are under my instruction. I don't care if I am black or what, but I am the registered nurse. (M, Zambian, 40)

It is interesting to note that this is a male nurse, which means he may have used his gender as an advantage to assert his authority over the auxiliary nurses. Some nurses attributed the lack of respect from their colleagues to lack of exposure to other cultures:

Again most of them don't know where we are coming from and what we have learned. For those who have worked outside they have a lot of respect. When you work with them you can tell the difference from those who have always worked here. I think it depends on their exposure and their culture. Those who are exposed to other cultures are different. Those who are not exposed, I guess, you can't blame them. (F, Kenyan, 34)

On the surface it may seem that a simple difference in culture is in operation, but a deeper examination reveals that ideas of superiority may be at the root of this lack of respect.

Pilkington (2003) contends, "the relationship between the British and people from former colonies has entailed simple representations such as White/Black... in which one pole of the binary was clearly dominant" (p.179). The consequence of this representation was the

emergence of a discourse that represented the world as divided according to a simple dichotomy: the West versus the rest (Hall, 1992).

### **Perceived Racism from Patients and Relatives**

Black African nurses described racist attitudes toward them from patients and their relatives.

Elderly patients were especially singled out as having the most racist attitudes:

The most difficult age group I would say are the elderly because those are the people who have never even seen the blacks. Because in their time there were only whites, it's only now that there are a lot of blacks around. (F, Zambian, 31)

It is probably true that the elderly have had the least contact with black people, but have had the longest exposure to stereotyped images of black Africans and are more likely to display racist attitudes. Nurses recounted how racism from patients led to role confusion on their part as they did not know how to respond when patients were in need of their skills:

It was very strange because I didn't know what to do. One of the residents became poorly and the care assistant told me so-and-so is poorly in room 18. When I went, she refused for me to get into the room, so I had to call the ward manager to come and sort her out and take her to hospital, so it was very difficult. (F, Malawian, 31)

A colleague added:

Even relatives, a relative will come and visit, they see that you are the nurse; they have seen your badge, because we have similar uniform with the health carers but you can still see the difference. If they are enquiring something about their relative, they will bypass you, they will go to the health carer and then the carer will say no you go to that one, that's when they will come. (F, Zambian, 29)



Nurses perceived this behaviour as racism because they thought that it implied that black nurses were incompetent, which resonated with race theories and representations of the late 19th century (Hall, 1999).

### **Perceived Racism from Ward Managers**

Apart from racism from their colleagues and patients, black African nurses also perceived racism coming from ward managers. They described how other nurses from overseas were allowed to perform certain procedures even when they were not competent, but black African nurses were prevented from performing the same procedures even when they were competent. A Zambian nurse told of how this happened on a ward where he was working:

Someone had chest pain and we had to do an ECG and I did it, because I know how to do it, although there is a pack that you should have which I don't have. She said what you did was wrong and you don't have the pack, so don't do it again. She called an Indian lady to do it and she said, "Sister, but I don't have a pack as well, and she said go and do it." I said, "What you are doing is discrimination." (M, Zambian, 40)

In some cases, the nurses felt that their experience was not recognized, and if they voiced this to their managers, they were labelled confrontational:

As long as you come from Africa, you are not one of them, you are not a white person, you are looked down upon in every way. There is racism, even when you are in a meeting, like a suggestion, they won't take it into account because to them you are black and you don't know anything. (F, Zambian, 31)

These statements demonstrate that stereotypes of black Africans described above may not be a thing of the past. Nurses said that allocation of responsibilities reflected managers' lack of

confidence in black African nurses. Nurses were perceived as lazy when they were sick and some were not paid:

I was supposed to report for late shift, but I was sick, but the Sister wouldn't change the shift. The next time three staff nurses friends working on the same shift, the others wouldn't help me, so I went to lift this patient and I injured my back so the following day I called in sick and they said she's too lazy, because she moved two beds she called in sick she couldn't come to work. (F, Nigerian, 44)

It seems nurses were not trusted and were therefore denied their employment rights. Nurses were given labels of indolence and laziness consistent with those explained by Hall (2000). Black African nurses noted that ward managers were partial in the way they allocated leave for family reasons. They were thought to be insensitive to the culture of black African nurses, and this behavior was perceived as racist.

One experience I had at the hospital I was working in, I lost my mum, so I couldn't go to work for a few days. Although there is compassionate leave, I was given unpaid leave. Another lady lost her father and she was given compassionate leave. So, I asked my friend and said who is given compassionate leave? And she said it's at the discretion of the director. (F, South African, 30)

The NHS introduced several initiatives designed to encourage nurse recruitment and nurse retention. These included family-friendly policies such as maternity leave and child care (Department of Health, 2005). NHS staff members have always been entitled to compassionate leave; clearly, the manager described above was being discriminatory.

Black African nurses in this study felt that racism was worse outside London, where black African nurses and other ethnic minorities were few in number:

In London it was really very good because people from the outside, most of them were from Sierra Leone, Portugal, and the Irish, only two of them were from here, one from Pakistan. When I came here for the past four years, I have been the only black. And I feel they do have it really but it's hidden you cannot say it out. Here they can say it but you cannot pinpoint it because you do not have enough evidence, but you can tell especially with individuals. (F, Zimbabwean, 42)

In the North East, where this article's research took place, black nurses are probably more visible and therefore more threatening to the local nurses. On the other hand, it could be that it is easier for white British nurses to take advantage of black nurses because there are more white nurses than black African nurses. This is well articulated by the Zimbabwean nurse below who did not feel she had a sense of belonging. Nurses said they were reluctant to tell anyone when they experienced racism because no one would listen to them and besides it was difficult to prove or feared that their lives would be made difficult:

I don't bother telling anyone because I do not think that people can listen to me. You don't have a sense of belonging. (F, Zimbabwean, 42)

Some nurses claimed that they were so frustrated by racism that they suffered stress as a result, as this discussion from one focus group illustrates:

My experience when I came from (name of hospital) to (name of hospital) in October. Between October and December I was sick for ten times because of the frustration that were here. I wanted to speak to anyone in a higher position, but no one was willing to tell me anything, so through this mechanism, they got me through to the board, that is where I was able to express myself. I said I was sick for ten times for good reason. There is always someone there who will frustrate you. (M, Ghanaian, 25)

I injured myself when I was in the Nursing Home making a bed, I was never told any lifting and handling course and they expected me to do everything. I was never given induction in how to operate the bed, yet they expected me to do everything. (F, South African, 30)

Mine happened just like you. I went to lift this patient, and I injured my back. (F, Nigerian, 44)

The stress of racism is known to affect not only social opportunities, but also physical and psychological health (Hagey, Choudry, Guruge, Turritin, & Lee, 2001; Giga and Archibong, 2006). Physical and psychological effects included cardiovascular diseases and emotional problems such as depression, which can then lead to marriage breakdown, professional difficulties, seeking out new job opportunities, and financial insecurity, all of which can have an impact on the care that nurses give to their patients. The nurse from Ghana did not elaborate on what his particular health problems were, but the effect seems to have been quite adverse as to result in a significant amount of time off for sickness. The other two nurses said they suffered significant physical effects. These quotes also illustrate that nurses may have been denied employment rights when essential training in using equipment was not provided.

### **Discrimination and Lack of Equal Opportunities**

Black African nurses saw racism and discrimination as going hand in hand and described how they were discriminated against in terms of promotion, professional development, supervision of duty rotas, and even the way mistakes were dealt with, echoing Archibong and Darr (2010), who reported that mistakes made by ethnic minority nurses were treated disproportionately and that these nurses were likely to be disciplined. Some nurses said their knowledge and contribution were not taken into account. When it came to off-duty, their

requests were often ignored. A nurse recounted how the off duty book was hidden so African nurses could not make off-duty requests:

When I started, I never used to request—I was just given shifts. I would be given four nights and then you are given one day off, and then you are back again on a long day. Then I saw that I was always rundown, stressed all the time, and not getting enough rest. We would work crap shifts all the time so we started requesting until they took away the request book and said it was only for special occasion. (F, Zambian, 31)

Black African nurses described being passed over for promotion. They said that their professional experience was not taken into account, even when they had been on a ward for some time, and promotions were given to junior British nurses instead:

Whilst I have been there more than a year now, but there was a white nurse who came to work there after finishing her training, she just worked for six months and now she has been promoted to E grade. And you can imagine what impact it has on us. (F, Zambian, 31)

Discrimination was also evident in the way that managers dealt with mistakes. Nurses felt that when black African nurses made a mistake, they were blown out of proportion. This reflects the findings of Archibong and Darr (2010), which described black and minority ethnic staff [including nurses] being twice as likely to be disciplined in comparison with their white counterparts. Nurses described feeling under scrutiny, as if managers were just waiting for them to make mistakes:

If you make a mistake, it will be a big issue. With my senior colleagues, there was, of course, that feeling that I was under scrutiny all the time and it took

time for them to understand that I can do the same things they do just as well as they do. (F, Kenyan, 47)

Black African nurses explained that often they were not given information on equal opportunity policies. They were only told that it means everyone should be treated equally. Sometimes, nurses were given booklets to read. Nurses said that managers were especially not forthcoming with information on graduate or postgraduate courses if they were not graduates themselves. This suggests that managers may have been discriminating against black African nurses by withholding information on equal opportunities in addition to not putting the policy in practice. If this is the case, it is direct contravention of the Equality Act of 2010. There was a general agreement among nurses that equal opportunity policy was only on paper and in very few cases was it practiced:

I think the main training that we've had so far are to do with like the ward development, they want to give you knowledge in terms of where you are but then in terms of Master's, I don't know I haven't found an opening. (F, Malawian, 35).

Black African nurses said British colleagues may have resented the fact that at times they (black African nurses) seemed to know more than they did:

And if they get to know that you know, that's when the problems start. I did not have this problem at first until she knew that I have a master's. That's when my problems started on this ward. (F, Nigerian, 40)

Some nurses were denied courses, and they received no support if they chose to pay for courses themselves:

There are times when I have asked to go for a course. She (the manager) just said there are people who have been waiting and they have been here longer than you, so it's not fair. My manager couldn't sign the reference for me. I think they should put equal opportunities in practice, otherwise, it's of no use. (F, Zambian, 29)

Some nurses felt their qualifications and experience were not taken into account when they were employed. This experience may have been the result of lack of information during recruitment. Nurses were not told that they were required to fill the lowest posts in the NHS, so naturally they must have assumed that their qualifications and experience would be taken into account in their employment. Withholding this information could be viewed as exploitative and reducing nurses' choices:

I think with the experience that I have I think I am at a lower grade here than at home. Because at home I did my BSc and I was teaching students and I was supervising in the clinical area. When I came here, I started at the bottom, lower Grade D. When I asked the manager, she said everybody had to start from the lower grade because you need experience from here. (F, Malawian, 31)

It is paradoxical that black African nurses cited advancement of their nursing skills and education as motivating factors for coming to the UK, yet they were resentful of their employment at the lowest grade of the qualified nurses' hierarchy and were not satisfied with the explanation for this grading. It could be that after working in the UK for a while, nurses recognized and indeed some verbalized, that their experience and skills from Africa were better than those of nurses in the UK. Nurses said most of their skills were transferable to the UK nursing situation and that they were not assessed adequately on employment.

## **Discussion and Conclusion**

The findings of this study suggest that black African nurses experienced racism, discrimination, and lack of opportunity in the workplace. Managers seemed to be treating British and other overseas nurses more favorably than black African nurses. This could confirm black African nurses' suspicion that they are regarded as inferior to others. This finding is similar to Goodland's findings (1965) and could also legitimate racism perpetrated by British and other overseas nurses. This practice is a direct contravention of the Equality Act (2010) and the policy of valuing and managing diversity espoused by the NHS. The racism and discrimination described by nurses in this study are similar to that in Goodland's (1965) and Beishon et al.'s (1995) study and demonstrates that it is dynamic concept.

Overseas nurses have always been essential to the running of the NHS since 1948 and have always endured discrimination (Beishon et al, 1995; Daniel, 1968; Alexis & Vydellingum, 2005). These nurses were mostly recruited from the Caribbean and West Indies to train as nurses in the NHS, but a few came from Africa. This research has demonstrated that the situation has not changed much since 1965 when Goodland noted that "there is a tendency among westerners to feel that these nurses come from comparatively primitive backgrounds and that their intelligence may be less than their British colleagues." (p. 241). Goodland notes that these nurses "face prejudice and disbelief or at the very least an intense interest to see if they 'shape up' " (p. 241). He further adds that, they excite curiosity and attention, because their color is even more apparent in the white world of the English hospital. Goodland (1965) noted that African nurses were aware of the intense interest and observation and added that when a person is the subject of that kind of interest and attention, it requires a tremendous act of bravery to carry out his/her normal duties without letting it worry her. Today's racism, of course, is more politically correct and is generally disguised under cultural difference.



Black African nurses migrate to the UK as professionals with recognized qualifications. Black African nurses, like other overseas nurses, join an established nursing hierarchy in the UK. However, these nurses are exploited and downgraded to the lowest nursing grade, regardless of their qualifications or experience. This downgrading may be compounded by racism and discrimination, which ensures that they are forced to take instructions from nursing assistants. Consequently, black African nurses' experiences are shaped by this complex relationship. On the one hand, black African nurses are migrants who are recruited to a subordinate position at the bottom of the nursing hierarchy; on the other hand, they are often better educated and experienced, and they would like to be recognized for their education and experience. This relationship is often resented by nursing assistants and some qualified British nurses (Phizacklea & Miles, 1980). Managers seem to have legitimated nursing assistants' feelings of superiority by assigning them to supervise black African nurses.

Black African nurses described being denied information on development opportunities as one of the hallmarks of discrimination. Managers may have been withholding information because of limited funds for development, which was disputed in one North East trust where a nurse explained that this was not the case. This nurse had been warned by personnel officers that her manager would tell her that overseas nurses were not entitled to tuition fees for degree programs, but she was to apply anyway because the program was free to all NHS employees. It seems plausible that in some cases the primary motivation for denying black African nurses educational development was discrimination on the managers' part and may have been motivated by power relations.

Off-duty rotas were also used as instruments of power to frustrate and exploit black African nurses. Richmond (1994) states that power is implicated in all forms of action, whether cooperative or conflicting, and that it requires mobilization of resources, which may

be material or symbolic as a means of achieving goals. Giddens (1984) states that when resources are not distributed equally between individuals and groups, it gives rise to structures of domination. Exploitation can result where there is a difference in power. This exploitation can be both physical and psychological, implying manipulation of others through ideological indoctrination as well as material deprivation (Giddens, 1981).

These structures influence how people interact with and perceive others. For example, by classifying nurses into EU and Non-EU, and by using different recruitment strategies as well as ascribing an ethnic group to nurses in the form of the NHS equal opportunities monitoring forms, the NHS could be implicitly practicing a divisive practice. This could have an influence on the experiences of black nurses. Classification of people as immigrants, refugees, visible minorities, and, in the case of the NHS, overseas or foreign nurses, is a technique of domination that tends to be reinforced in the individual through the process of internalization. Others' perceptions of the person's identity and place in society are actively incorporated into the subject's self-image (Richmond, 1994).

The fact that black African nurses felt that they were the object of racism and discrimination from patients, British nurses, and other overseas nurses is a cause for concern and may indicate that the government's policy of valuing diversity is not being taken seriously in the workplace. The findings indicated that black African nurses face significant barriers and difficulties that include negative perceptions and attitudes that stem from low expectation of their skills and abilities. This may affect their health, levels of confidence, and self-esteem.

### **Implications for Practice**

The study suggests that managing diversity and equal opportunities in employment policy is still not being adequately implemented in the NHS. The results of this study can be used to

highlight areas where training may be required. Managers need to be equipped with skills, knowledge, expertise, and attitudes to tackle discrimination and racism. The government's policy is that managers must ensure that they are aware of their individual responsibilities and comply with the requirements of the policy. Managers need to ensure that they take appropriate action to eradicate discrimination, and they need to promote equality in the workplace. Managers also need to be trained in promotion and training procedures for staff members, as well as monitoring these efforts.

Individual members of staff need training on what constitutes discrimination according to the Equality Act of 2010. They also need training on the effects of racism and discrimination on colleagues. Black African nurses need to be empowered to report all forms of racism and discrimination, knowing that cases will be handled without retribution.

### **Limitations of the Study**

The findings of this study are of course limited to the four NHS trusts in the North East of England where the study was conducted. The small samples mean that generalizations may not be possible.

### **Future Research**

An exploratory research such as this one raises many research questions. It would be interesting to compare experiences of different groups of overseas nurses. Overseas nurses and in particular black African nurses need a follow-up study of their careers to explore factors viewed as barriers or enhancements to their progress in the British NHS. Managers' attitudes toward valuing and managing diversity also need to be explored.

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