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E. M. Willis & L. D. Xiao

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Abstract

Over the last two decades the flow of Asians to Australia through legitimate immigration programs has accelerated. This is particularly the case for Asian nurses coming from countries that were once subjected to European colonisation. The difficulties encountered by nurses from Asian countries mirror those of earlier waves of migrants. These include navigating the language and differences in cultural mores, values, and beliefs, along with the loneliness that may come from leaving strong family ties at home. While racism has been evident for all earlier waves of migrants, Asians face an additional hurdle linked to the uneasy relationship Australians and the Australian state has with Asia. Australia is geographically in Asia, but culturally Anglo and European. The impact this might have on the working relationships of Asian and Australian born registered nurses is significant given the nature of their work in caring for the sick and elderly. This liminal relationship between the Australian state and Asians provides a theoretical insight into the particular difficulties experienced by Asian nurses and the integration programs that might assist them and their Australian colleagues to develop cohesive working relationships.

Keywords: *Immigrant nurses; Asian Century; liminality; post colonial; third space*

Liminality, the Australian State and Asian Nurse Immigrants

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I. Introduction: Immigrant Nurses in Australia

This paper argues that immigrant nurses from Asian countries such as China, Hong Kong, Malaysia, Korea, India and the Philippines have to navigate a process of acculturation to the Australian context that is different from earlier waves of migrants from Europe. The argument draws heavily on the work of Higgott and Nossal (1997) who suggest that the Australian state's relationship with Asia remains caught in a liminal space and that this makes for a sense of unease for both Asian and Australian born. We argue that resolution of this liminality remains problematic given Australia's unique geographical and socio-political position in the Asia Pacific region. While this does not prevent individual nurses taking responsibility for their own acculturation, or host institutions, through nurse managers and educators, assisting in this process, it does suggest full integration into the host community and the Australian health care system maybe problematic. The paper provides a brief overview of Asian nurse migration to Australia, followed by an examination of the theory of liminality as used by Higgott and Nossal (1997) in their analysis of Australia's relationship to Asia. Higgott and Nossal's argument is critiqued, drawing on political commentators and the work of Bhabha (1996). We then draw on the experiences of 24 immigrant nurses to reflect on their liminal transition as immigrants. We suggest that the Australian state remains caught in a liminal position, at the political and diplomatic levels. This means that opportunities for Asian nurses and their Australian colleagues to transcend and develop cohesive and fully integrated working relationships remains problematic.

Approximately 44% of the Australian population are immigrants or are the children of immigrant parents pointing to a strong multicultural labour force (Australian Department of Immigration and Citizenship, 2011). This is evident for the profession of nursing with around 15.5% of nurses trained overseas with an increasing number coming from non-English speaking countries (National Health Workforce Taskforce, 2009). The percentage of overseas nurses is likely to increase over the next decade given the reduction in the ratio of Australian born nurses to total population and the aging population with Health Workforce Australia demonstrating that any reduction in migration would increase the nursing shortfall by 35% (Health Workforce Australia, 2012, p 12).

International nurses are recruited to Australia via the 'Skilled Migration' and 'Employer Nomination' visa schemes (Australian Department of Immigration and Citizenship, 2011). In order to practice in Australia overseas trained nurses must meet four eligibility criteria. These are current registration as a nurse in their home country, adequate knowledge of English, a pass in a nursing assessment program, and sufficient points to meet the migration test or sponsorship from an eligible employer (Nursing and Midwifery Board Australia, 2010). Data from the 2005 Australian Institute of Health and Welfare data base indicates that approximately 16% of the International nursing workforce come from an Asian country (Australian Institute of Health and Welfare, 2005).

Adaptation to the Australian nursing context is not without its difficulties although it is widely recognised that acculturation to nursing practice in a host country is a key variable for effective workforce integration (Xu, 2007). What is not readily acknowledged is the accommodation required by both Australian born nurses and immigrant nurses in making this transition. The concept of liminality provides a useful starting point for outlining how successful these transitions are, as it provides a theoretical explanation for the process of full

assimilation/acculturation into the host culture as well as the possibilities for rupture or stalling. This is particularly pertinent for nurses from Asia because of Australia's unique geographical position and relationship to the Asian-Pacific region.

II. Liminality as Theory

The concept of liminality has undergone a number of theoretical explanatory transitions and applications. It was first outlined by Van Gennep (1960) and later elaborated by Victor Turner in *The Ritual Process* (1969). Both Van Gennep and Turner suggested that ritual is a signifier of the individual's transformation from one state to another, be it from child to adult, or single status to married. Transformative rituals and ceremonies have three distinct components; i) the initial separation from the old status, ii) the in-between/on the border phase, and, iii) the re-incorporation into the group now transformed into a mature adult, citizen and higher status member of the group (King, 2006). The in-between phase is the liminal space. It is that point in the ritual space, or pause, before the novice transforms to their new identity as a fully fledged adult member. In many ways it represents the death of the old self prior to the transformation into a new self. As a consequence it is a volatile moment in the ritual process with the individual undergoing the transformation in a highly risky state. Because of this, in traditional rituals novices were often taken to a secluded place, or went on retreat away from normal everyday interactions in order to signal their separation from their previous status and to educate them in their new status, but also to protect them during the transitional phase.

The ritual process assumes acceptance, arrival, transformation and incorporation into the community as a new, but fully accepted person. The idea of it being aborted or the individual being caught in between in a permanent state of suspension is unthinkable. Despite this, progress through the liminal space is usually associated with hardship and the possibility of failure. The ritual may require the novice to divest themselves of their former status and identity, to turn their back on family, to perform uncomfortable bodily rituals such as the cutting of hair, or skin, or it may require prolonged times of separation from the community for intense instruction. It is not simply a physical journey, but one of highly intense emotional and psychological stress brought about by the fact that the person is in a temporary state of alienation or non-belonging prior to taking up a new and higher status identity with an adult or more mature group (Gibb, Hamdon et al., 2008). Early anthropological notions of liminality clearly articulate the ritual as a two way affair, but it is the novice who transforms into an adult. There was no expectation that the host might also evolve into something new.

A number of researchers have taken the concept of liminality beyond its direct application to pre-industrial explanations for attaining adulthood and applied it to contemporary groups and situations, and in doing so, suggested the possibility for individuals to be permanently caught in the in between space. Liminal subjects include nation states (Higgott and Nossal, 1997), groups permanently stigmatised through race, physical impairment or mental illness (King, 2006), guest workers (Aquila, 1999) and immigrant professionals such as nurses (George, 2000). In this paper we argue that the management of a cross cultural workforce, in this case Asian nurses, presents all players, nurse managers, and Asian and Australian born nurses with multiple levels of liminality. While both Australian and Asian born nurses, and their managers, must navigate the day to day hurdles of cross cultural nursing practice, they do so in what Higgott and Nossal see as the essentially problematic and liminal relationship of the Australian state to Asia. This is played out through the familiar issues of language, gender, otherness, and racism as Asian nurses seek to integrate their practice of nursing into the Australian context. Effective management of this integration is essential to harmonious working relationships and quality nursing care.

Liminality and the stalled Australian state

One of the unique colonial consequences of Australia is its English heritage and its geographical position in

the Asia-Pacific region. Because of this Higgott and Nossal 1997; p, 169) suggest that Australia is politically, diplomatically, and culturally liminal in relation to identity and place. They make their case by arguing that attempts by the 1983-1996 Federal Labor Hawke/Keating government to relocate Australia economically, militarily, and diplomatically in Asia, away from past British and USA orientations, remain unresolved. In outlining their argument they note the shifts in trade and immigration that alerted the 1983-1996 Federal Labor government to the contradictions in Australia's political and cultural positioning. This included shifts in the balance of trade that moved away from Britain and Europe, firstly towards Japan and North American and then more recently to China, along with shifts in immigration patterns following the removal of the discriminatory White Australia policy in the 1970s. While English speaking migrants remained the major immigrant category, by 1991 over half came from the Asia Pacific region (Higgott and Nossal, 1997, p 174). As a result of these trends the Federal Labor government particularly under Prime Minister Keating, and Foreign Affairs Minister Gareth Evans attempted to strengthen the country's economic and cultural ties with Asia through cooperative forums such as the Asia-Pacific Economic Forum, and increased trade and more open attitudes to migration.

Despite these gestures toward Asia, Australia's defence policy remained firmly focused on security to the north (Higgott and Nossal, 1997). Clearly this sent a message to Indonesia, Malaysia, and China that Australia still regarded them as military threats. Even recent arguments to continue to resource the north and central Australia in the interests of Indigenous development are supported by the secondary gains of securing the Outback against possible invasion from Asia (Dillon and Westbury, 2007). In short, despite our claim to be part of Asia in terms of trade and geography, our defence policy suggests an abiding and deep seated fear of Asia.

For Higgott and Nossal (1997) the 1980/90s foray into Asia was a move by the country's elite, of mainly politicians, academics and some media and business interests. It was not an aspiration of the majority of Australians. This point was forcefully made at the ballot box in 1996 when Pauline Hanson and her One Nation Party became a real threat and challenge to the politics of multiculturalism. While the Howard Liberal/Coalition 1996-2005 government suggested it would continue to engage with Asia when it came to office, in reality it reasserted ties with the US. Higgott and Nossal writing in 1997 suggested that liminality was an apt term for understanding how and where Australia currently sat in its relation to Asia.

The previous Federal Labor Government's commissioned White Paper, *Australia in the Asian Century*, chaired by Ken Henry (2012a) can be viewed as confirming Higgott and Nossal's (1997) thesis. The primary focus of the White Paper seeks to ensure Australia gains access to Asian markets particularly its growing middle class estimated to be around 3.2 billion by 2030 (Henry, 2012a). The paper presents the challenge in terms of the need to ensure government policy maximizes this opportunity through political ties, increased investment, and supporting Australian children to become Asian literate. While there is some consideration given to poverty in Asia, the focus remains on how Australia needs to maneuver its economic policies and diplomatic ties to capitalize on Asia's economic prosperity (Henry, 2012a).

The primary focus on engaging with Asia is for economic gain, with little attention to cultural, social or knowledge exchanges for their own value. This is reminiscent of post colonial discourses that construct Western and Anglo business enterprises as value neutral superior entities, while Asian economic enterprises are deeply entrenched in an *inscrutable* culture that must be learned in order to plunder. In such cases the sole purpose of 'understanding the other' is economic profit- or the continuation of the colonizing project (Westwood, 2006). As Westwood notes westerners often fail to recognize that there may be modes of industrialization or the organization and management of economic enterprises developed by Asian businesses that would enhance our understanding of economic and capitalist theory or service delivery. The problem is that we see capitalism as a Western innovation that must be translated to the colonies in its pure European form. Asian ways of organizing work are constructed as quaint *Orientalist* cultural traits that must be learnt in order to increase our profits. The solution is a cultural tool kit that informs Western businesses on the do's and don'ts of successful interactions with Asians. Unfortunately this

approach stereotypes all Asians, constructing them as a homogeneous groups with little variation, as well as reducing both Asian and Western cultures to binary opposites with little national or individual variation. The approach also fails to capitalize on the possibilities for new ways of conducting business, new forms of knowledge or innovative ways of delivering services. Were this to occur the possibility arises of transition from one culture to another beyond the binary opposites, or liminal, to creating something new, or hybrid, or a third space (Bhabha, 1996). Bhabha's idea of a third space or third culture suggests both groups undergo some transformation, and while not evenly paced, allows for the establishment of new ways of acting, doing business, delivering services and interacting (Werbner, 2001).

Nursing practice, post colonialism, culture, gender and racism

One of the difficulties for Asian immigrant nurses is the assumption that they always comes from a society with less sophisticated approaches to the organisation of work, inferior technology, or simplistic, inefficient, or less productive forms of governance in the workplace. This post colonial view can be internalised by the individual migrant themselves (Aquiliar, 1999) and can carry over into the profession of nursing making it difficult for the nurse to preserve what is valuable about their own models of care, or having to work harder to prove her competence (Xu, 2007). Within the Australian context, this notion of inferiority is played out through the claims that all clinical nursing practice is, or must be 'evidence based'. This claim leaves the immigrant nurse with little room for his or her alternate position, even when they privately think a particular practice is lacking or less than desirable or know their own practice is also evidence based (Uttal, 2010; Xu 2007).

Much is made about the cultural differences between the profession of nursing in Asian countries and Australia, although the Nightingale legacy is part of the nursing traditions for many former British colonies (Xu, 2007). The differences are assumed to establish nursing in the West as more progressive and assertive, particularly in its relationship to medicine (Xu, 2007). While there are many cultural differences, many of these may well have more to do with the structures of health care systems than cultural beliefs. Examples include attitudes to gender and the differences this generates for the nursing professions' relationship to the body and working with doctors. This spills over into nursing practice where activities of daily living, such as bathing, are likely to be performed by family members, rather than female nursing staff. This practice is both a result of cultural views of gender relationships to the body of male strangers, as well as the structure of hospital resources, along with the scarcity of nursing staff. In a similar vein Asian nurses' cultural attitude to authority and hierarchy is seen as problematic to the professionalization agenda of nursing given that it can mean a subservience to the profession of medicine. However, this same attitude to authority can also result in a deepening care and compassion for the elderly, especially when they are sick and frail.

III. Methodology

Data for this study was collected in 2010 over a six month period in two large tertiary public hospitals in a capital city in Australia. Approximately 44 nurses were interviewed either individually or in focus groups. The sample of nurses was purposively selected into two distinct groups; 24 immigrant nurses with at least one years work experience, and 20 senior Australian born nurses with a supervisory role at the ward or hospital level. Data for this paper came primarily from the 24 recent immigrant nurses. Among the immigrant nurses, some had trained before migrating to Australia, while others had done their registered nurse training in an Australian university. Countries represented included: China (including Hong Kong), India, South Korea, Japan, Singapore, Malaysia, the Philippines and a small number of South American nations. Both authors attended the focus groups with one leading the discussion, while the other took notes. Interviews with individuals and focus groups were audio taped and transcribed. Individual interview transcripts were returned to the participants for verification, but not focus

group transcripts. Both forms of data collection took one to two hours. Nurses were granted time during their shifts to attend the focus groups, but a number of the individual interviews were done after hours.

The study was approved by the University Ethics committee. The hospitals' education unit assisted in the study by distributing the letter of invitation from the researcher to potential participants. Those who were interested in the project were requested to provide their contact details to the researcher by filling in a contact form and returning it via a pre-addressed and pre-paid envelope. Nurses were contacted via email or phone by the researchers to arrange either the interview or a focus group based on their choices and available time. All protocols governing informed consent were dealt with prior to the interviews. This included the guarantee of confidentiality, freedom to refuse to answer any question, or to completely withdraw from the study, and the assigning of pseudonyms. Analysis of data was done by reading the literature on migration and liminality and then checking the transcripts for confirmation of the various theoretical insights. This is not an inductive approach where the transcripts are first read for emerging theory, but rather an approach where we cherry picked the literature on liminality in search of explanations for what we were told in the interviews. As a result not all aspects or ways in which liminality or post colonial theory are employed in other studies are found in our accounts. This is to be expected, partly a result of the questions asked, but also because the experience of liminality is multidimensional and not likely to be found in all situations.

Four major themes were identified that provide insight into the liminal and post colonial status of Asian immigrant nurses in the two hospitals. The four themes covered are: communication as a marker of liminality, gender as a cultural marker, racism and discrimination, and nursing practices. The first two themes are experienced by many other non-English speaking immigrant, or individuals from other cultures, but we argue that they take on a particular racist hue for Asian immigrants impacting on the intensity of the second two themes. In presenting the themes with supporting quotes we made the decision to edit the nurse's text converting it to Standard English. This is always a difficult decision. While on the one hand it detracts from the authenticity of the immigrant nurse's voice, not to do so, risks constructing the nurse as child-like and certainly still trapped in a liminal state in terms of expressing complex concepts in English, and reinforcing the racist stance. In taking this decision we have moved the nurse from their liminal position in relation to language and placed them firmly as having arrived.

IV. Results

Communication and Language as markers of liminality

Much research on the immigrant experience rates knowledge of English language as a major difficulty (Xu and Davidhizar, 2004; Xu, 2007). This is of particular importance to nurses in their transition on the ward to competent practitioner. Answering the telephone, responding to doctor's orders, deciphering doctor's handwriting and speaking to relatives are seen as major hurdles. This is partly an issue of accent, a problem with *hearing* the language, understanding the colloquialisms in vogue and interpreting body language. Full understanding requires embedding oneself in the culture in order to pick up the nuances (Xu and Davidhizar, 2004). As Xu (2007, p 251) notes, *this leaves the Asian nurse with a deeply saddened feeling of inadequacy, shame and self pity.... To wonder(ing) "Where am I here?"* All these issues were identified by nurses in this study. At the same time they also identified strategies for moving beyond this liminal state in their endeavours to achieve full language competence. This is outlined in the following three quotes. In the first quote a young Chinese nurse notes:

or...the doctor only repeats a word. At the beginning it's okay, but later when you have forgotten what the word is and they say 'Oh the doctor has given you something, (he has) asked me to do something but I can't remember'. 'Okay how long?'. And they have to find the doctor to repeat what he wanted you to do. Because you can't remember what it was, I mean medical terminology... I mean later on they know what you are talking about, they say "Oh god you didn't know these things?

However, nurses search for ways to transition towards language and cultural competence. In doing so some nurses find the patients themselves assist them;

I do find that patients help,.. they try and accept the international nurses, yes. I mean ...they try and listen to you more carefully so that they can understand you. Yes...a few... also try to slow down their speech so that you can understand more.

Others use TV and radio to teach themselves to hear accents and idiomatic speech, while others tap into social networks such as Christian Churches to improve their language skills;

Because I always have problems trying to listen to their accents, I try and listen to the radio and the television. I try to do that. I can understand more of what they're saying. I mean like, in terms of work I can understand them, but in a social setting, like when they're joking, sometimes you can't understand half of it because they speak very fast, some of them. Almost every week or every couple of weeks we meet together and we do bible study and chatting so I just think it's a good chance to practice my English and to get on

While others are clear that at times they need to revert to their mother tongue, suggesting that they remain emotionally and cognitively liminal:

But at the break sometimes we need to talk in our language. It's a tendency that naturally comes.

Q: Yeah we are just relaxing.

F: And also language is a reflection of culture, that's why we need to talk in our own language.

A key marker of full incorporation into the host culture comes when friendships are established with local residents. Language is a key to this process. A number of nurses used local Churches to find friendships and access social events, however as the quotes demonstrate this was curtailed to some extent by shiftwork, and also by the age differences between themselves and many older congregations suggesting this puts them at odds with their Australian peers. Age differences were also identified as a disadvantage when joining ethnic clubs. Some younger immigrant nurses who had stayed with Australian homestay families when first arriving in Australia maintained these links, substituting these families for their family back home, while others socialised with work colleagues when invited, or established friendships with other immigrant nurses who they met during their University study. This last strategy, while useful for allaying loneliness maintains the immigrant nurse in the liminal space. The quotes below outline the strategies and difficulties in transition moving from engaging in superficial conversions, the loneliness of not being able to express deep emotional thoughts, to the use of ethnic groups and the establishment of Australian friendships:

I tried to speak her language, but it's too difficult (Laughing). Just talking about normal thing like ..., she just moved ... she got a place to rent, so I said ... 'have you found your place?'. She said, 'no, no, I'm still looking for the place'. She needed help moving boxes, and I had just moved as well, so I said to her, 'I can bring that for you tomorrow. I'll get that in my car and then take you home and then give it to you', just normal conversation.

We probably just feel comfortable using our own language. You know our mother tongue, mother language. Sometimes it's still hard to express some emotional things in English.

To me the community group here for Chinese people, the programs that they have are more for the elderly people and besides we work different shifts and they run the programs Monday to Friday. It's hard for us to go, and secondly I think one group is located in XXXX, so for me location wise it's too far, but since my parents are here I socialise with them mostly.

I do have this close Australian family, I used to do home stay with them, that's 7 years ago, but they're really still close. I think she's my Australian mum and sister, so I see them on the weekend and if I have days off, so they're like my family here. They support me if I need help, they help me, and I feel like I have a family here, so it's kind of, that's what keeps me here. I don't want to go to Melbourne or Sydney or the bigger city.

This quote above highlights the importance of social ties to mobility. As this young nurse says, 'I feel like I have family here, so...that's what keeps me here....'. The two quotes below on seeking friendships with one's own ethnic group illustrate the complexity surrounding acceptance. In the first, the nurse socialises with her own group, in the second the nurse has found Australian friends interested in her Japanese culture and they provide the bridge to feeling good about herself and to some form of hybrid sharing of culture:

When I came here I met lots of people from the same area, and then through them ... I joined that community ... They had cultural programmes... like movies, in our own language...and those things.

They know how I speak and what I think, everything, so it's really comfortable to be with them, and also other Australian friends outside of the work. I met them through Japanese festivals or other friends. They are kind of interested in Japan so they, yeah. It's good to talk to them.

Gender relationships as a cultural marker

Gender also impacts on the status of professions. In some Asian countries the status of nursing is low because of its association with bodily or dirty work (George, 2000), although some nurse researchers argue in a similar vein about nursing in Australia (Lawler, 1991). George notes that as a consequence of nursing's link to dirty work it has not always been seen as an occupation desirable for middle and upper class women, but in a number of Asian countries was only taken up by daughters needing to earn money to support their families. The fact that nurses are now in high demand as marriage partners because of their economic value as immigrant labour to the West, has not changed this view, but it does point to shifts and turns in gender power. Wives as nurses become the higher status bread winner, while their husbands who join them later in the host country may experience difficulties gaining employment equal to what they enjoyed at home, particularly if their own professional qualifications are not recognised in Australia. This process of gender role realignment requires both the husband and wife to undergo a transformation within their marriage in the host country that may be painful and confronting. The quotes below highlight some of these issues:

...I have to keep my husband handy all the time. I can't find a thing you know. If there are any questions well I think of myself 'no keep him close'. No kidding, so this is the only way I can solve this problem. Keep all ... of this (all laughing).

Q: 'So mainly your husband looks after you?'

F: Yeah and basically he had to actually sacrifice his choice of career, he could go to Melbourne. He was thinking about going to Melbourne to find a job. His English is not that good, but I heard from a friend, they said 'if you go to Melbourne you don't need it. You can find a job much easier compared to here', but I have to hold him here, he can't go.

Not all immigrant nurses can call on their husbands to take up the new role of supporting their employment. Some nurses spoke of the difficulties of managing child care given the non-standard working hours of nurses and the lack of family support which meant they were reliant on employing carers, who were strangers, to come into their home to mind their children:

My daughter is only 21 months so she is just experiencing a lot a new life, brand new. So I find it sometimes especially with my second one when I'm having her I feel it is difficult to balance the work and the family. Sometimes you juggle work and home and you do sometimes feel you do not know where to put them ... both the day care have an after hours service but unfortunately I had the afternoon shift and, night duty so what can you do. I did go to the Centrelink and asked what are the services you can offer me and whether they had some after hours childcare. So I can organise some afternoon or night time personal care but the thing is that they either come to your place or you have to send your children to their place and sometimes you are not quite sure.

Racism as a marker of liminality

It would be naïve to think that Asian immigrant nurses would not experience some form of racism in their transition to Australia. As we noted above, Australia's relationship to Asia is not straightforward. Australians have engaged in 3 wars against Asian countries; Japan, Korea and Vietnam, and one minor skirmish against Indonesia over East Timor. We have a long history of overt discrimination against the Chinese that was only formally addressed in the 1970s when the White Australian Policy was rescinded. The resurgence of anti-Asian sentiment in the 1990s with the rise of the One Nation Party has already been noted. More recently there has been significant discrimination against Indian immigrants particularly in Melbourne and Sydney. A key observation of this paper is the that full transition and integration of Asian immigrants into the Australian landscape is probably not possible at this point in time if we accept Higgott and Nossal's (1997) argument that our relationship to Asia at the political and diplomatic levels remains liminal, ie, unresolved.

The immigrant nurses we interviewed did not dwell on their experiences of racism, nor did the Australians. For the Australian nurses the issues they voiced were primarily around communication and their perceptions of the impact this had on patient safety and their own workload. There was a view that Asian nurses avoided some tasks, such as answering phones or taking doctor's orders, or speaking to relatives given the difficulties of being understood. Asian nurses, likewise did not dwell on their experience of hostilities from staff and patients, but rather tended to focus on their own deficits. Despite this we did gather a number of incidents of covert racism linked to views about their inferiority as nurses and stories of the difficulties some of the elderly patients who were war veterans had with the care Asian nurses offered. The first quote below captures the tension between appointing immigrant nurses to a position commensurate with their expertise in their home country (and so not practising institutional racism), and their initial capacity to perform at this level:

... I guess we've never opened the conversation on this as it is too sensitive. I think she thinks 'why you are from another country and you come here and all of a sudden you are senior than I', because she's a junior and because the other two nurses who were complaining to me about her they are all senior nurses so that's one thing. Lately I haven't had any problem with her and even we socialised with each other after work but I think the problem with another two Chinese nurses is that they don't want to open that dialogue because I think although you can sense there is some personal things here maybe she doesn't accept the fact that we are just senior. But the issues we're having is about work it's not about our personal life, like they really didn't have any open personal conflict or argument. So I feel if we can sit down and talk about that specific shift like yesterday we had a shift together and I felt if they are able to open up, just break that up and talk through it it might change. But I think from our – it might be a barrier from our culture that we just I think they just don't want to, would rather put up with it than really change it because it might make the future relationship harder. Our intention is to make it better but it might make it worse so anyway my manager is aware of this and she asked me to if they don't want us to do anything we can't do anything so.

One of the major ways Asian nurses attempted to counter racism was through their strong work ethic, the highly developed clinical skills of those trained in their own country, and their responsiveness to authority. Nurse Managers said they found immigrant nurses a delight to work with because of their responsiveness to authority, while nurses on the floor were more critical of their capacity to practice autonomously. We noted above that patients also helped immigrant nurses navigate the language. Clearly they did this as an act of human kindness, but also because it is in their own interests. Despite this, not all patients were as accepting; and we would suggest that language was the vehicle that led to patients thinking Asian nurses were clinically incompetent as the case below illustrates:

F: That's what happened to me in ward X. I was relieving...twice and I found it's a problem. There was a woman there. She was demanding but she wouldn't trust me because I am young. Old people are not likely to trust young people. They think you're less experienced than me. And then she thought 'you were from overseas you have no idea about Australians, how can you look after me'. Deep inside they don't want to trust you. They even question if you give them the right medication. They say 'could you please check with other registered nurse if you're giving me right medication?'

Nursing Practice Transitions

While both immigrant and nurse managers identified language as the key difficulty in integrating into the ward, both groups also made claims to differences in how nursing is practiced across cultures. Identifying exactly what these cultural differences are was difficult. Three that did emerge were differences in who provides intimate bodily care to the patient, being assertive about needing help, and care of the elderly. Many immigrant nurses said that in their own country family members performed a number of the intimate activities of daily living for patients, particularly for elderly parents. This is not necessarily the case in Australia where family members may request that the nurse assist the elderly parent to go to the toilet or wash themselves in order to maintain the child-parent distance. A more difficult issue revolved around their observation that Australian born nurses were more assertive and more comfortable to ask for help. The first quote below highlights the difficulty for immigrant nurses requesting help, partly because of cultural differences, but also because they feel they need to prove their competence:

...I had a lot of problems when I started here in 2007. Normally I wouldn't speak openly because ...culture wise I had to have time to adapt to the culture in Australia. So what happened was that everyone was telling me I worked a lot. I won't talk much. Here it's the opposite. Here they talk, okay. I can't do this so they gave me a lot of work which I did and then I broke my back because I didn't ask for any help. They just passed the work onto me and went and sat in the nurses' station and chatted...and I was told that it was offensive if I called them for help or something like that. Then after that I understood that I needed to speak up otherwise it would affect me. I was very depressed and stressed, it was really hard.

Q: 'So from your story it's cultural differences in your country, normally the nurses want to do more and they never ask for help?'

F: ...In our culture people have to realise the problem then they'll just come and help but we won't normally ask. It's just like team work over there, but here it's just like we have to ask. Only then will we get the help especially our work in ward.

F: I guess it's that proving yourself you know. I think as an international nurse be it a doctor, student, or anyone, I think you always tend to – even from stories of my friends you understand you have to prove yourself.

When we asked Australian nurses whether some of the practices from the immigrant culture might be incorporated into Australian nursing the response was always that it would need to be 'evidence-based'. This statement assumes certain practices from immigrant countries are not evidence-based. It leaves the immigrant nurse with little opportunity to present an alternate position, even when they privately think a particular practice is lacking or less than desirable (Uttal, 2010). In conversation with Australian born nurses they noted the high level of skill of Asian trained nurses and in later research we observed that in some hospitals they have been assigned to perform these specific skills throughout the entire hospital, for example, designated nurses appointed to put in IV lines are often Asian trained nurses. Despite this, Australian nurses tended to suggest that there was little to learn from immigrant nurses because their practice was not evidence based.

As Uttal (2010) notes, the transition to a new culture may never be fully achieved, but be a process of constant negotiation making it an exhausting exercise for the immigrant. The quote below illustrates the continuing nature of transition to the host culture, but also the possibility that there is a limit to what immigrant nurses feel they can accommodate to. This may lead to a conservative approach to their career as outlined below

Yeah I've been here more than 5 years..... Moving is not an easy job, you have little choice. I already feel the move from China to come over here was difficult.. I can see if I move from here to a new environment, a new hospital, a new job, everything will be new ... everything will be too much.

Both hospitals included in this research project had programs to assist immigrant nurses to acculturate to the hospital routines, practices, and cultures. These included designated weekly team meetings during double shift periods, the appointment of liaison nurses to smooth the transition process, additional assistance in adjusting to ward routines and skills, and forums where the nurses were invited to tell their story. This included stories of how or why they came to Australia, how nursing differs in their own country, or some of the cultural differences in everyday life. However, as the quote below demonstrates, sometimes strategies designed to assist the nurse to transition to the ward, have unintended consequences that exacerbate the liminal status of the nurse:

A: Oh we have a coordinator, yeah basically the coordinator's job is they make us as comfortable as we can be and help us to settle in.

Q: You can make an appointment to see the coordinator.

A: Yeah as long as we ring them they'll come down, but the thing is it's not always convenient. You have to ring them and they'll come down. When you do this it makes you feel like you're not involved in the ward as a team. You feel like you are more isolated you label yourself like that ... nurse you are different from the whole team. I don't think that's a good idea though.

V. Discussion

The major difficulty for Asian nurses is language ability and the accompanying acculturation. This impacts on their capacity to perform nursing task safely, but also on their own sense of being heard and understood at a deep emotional level. Closely aligned with this is the immigrant nurse's capacity to enter into the Australian community through strong ties of friendship. Language is one of the keys to this, along with cultural preferences. As noted, while friendships are forged, in the early years following arrival in Australia, these friendships do not reflect their age cohort; they tend to be with Homestay parents, elderly Church parishioners, or elderly members of ethnic clubs illustrating an abiding liminality.

Unlike earlier waves of labour immigrants from the 1950s to 1970s who had to settle for low status work in manufacturing and tended to work closely together in ethnic concentrations, to the exclusion of Australian workers,

Asian immigrant nurses are required to work alongside their Australian counterparts, and to interact with mostly elderly Australian born patients or early post-second world war migrants from European countries who are now old and frail. Navigating the transition is no easy task and to some extent we are arguing that this transition is more difficult to complete than earlier waves of European migrants given they are Asian, and patients are elderly with histories of conflict with Asia.

Assistance from hospitals by way of organised support was evident in this study. However, as we note, it is two edged. It singles the immigrant nurse out in a way that may make them uncomfortable. There were also examples of racism within the hospital setting. Patients are at times discriminatory, but they also assist immigrant nurses with language acquisition. While both the hospitals and patients have accommodated to the increase in immigrant nurses there is still a strong expectation that in the long run they will become 'just like us'.

Three theoretical positions are available for progressing this situation. Firstly, Higgott and Nossal's (1997) theoretical work suggests that Asian immigrant nurses will remain forever liminal outsiders given the nation-states geographical and political relationship as a European/Anglo nation in the Asia Pacific region. Moves by the previous Gillard Federal Labor government to address Australia's relationship to Asia are timely, but the current focus is primarily on capitalising on the economic success of Asia, China and India in particular. There is little in the White Paper to date (Henry, 2012a) about Asian immigration into Australia, and what cultural benefits this might bring beyond sport, art and language. While the current Federal Coalition Abbott government has introduced the New Colombo plan, that supports travel to Asian countries by undergraduate students, it remains to be tested.

A second possibility is Gibb (2008) and Uttal (2010) concept of the bi-cultural or hybrid immigrant. While both authors employ similar language to that used in post colonial literature their concept of hybridity is a one way affair. In their model the migrant incorporates the host culture into their schema, while the host remains untouched. The third approach offered by Westwood (2006) following Bhabha (1996) and others calls for the emergence of a hybrid or third space. This is the creation of new cultural forms that draw on both the host culture and the migrant guest. This approach would go some way to resolving the claims made by Higgott and Nossal about liminal position of the nation state.

Producing a third space or shared nursing culture will be a difficult project. The challenge is to investigate nursing practices and skills that Asian nurse have that might enrich nursing in Australia. To this end, one of the strategies one hospital in this study has instigated is a series of action research workshops between International nurses and Australian born nurse team leaders. These nurses spend time attending sessions to explore cultural issues as well as instigating activities on the ward as a strategy for sharing culture. Activities include the sharing of personal stories, as well as social events such as ward based dinners, including openly identifying issues of conflict and misunderstanding.

A more radical approach would be to openly explore Australia's relationship to Asia, and to shift ward activities from their current focus on culture and cross cultural differences and similarities, to explorations of race, the politics of race and Australia's relationship to European colonization. This would presumably lead to discussions on Australia's increasing reliance on Asian economies such as China, along with the confronting fact that the nursing workforce is now dependent on immigration for sustainability for the care of our vulnerable elderly and sick (Health Workforce Australia, 2012) and what this might mean for the profession. Such discussions would need to move away from the essentialist claims made by Australian nurses that Australian nursing practice is superior, to a more open approach to how nursing is organised in other countries. It requires overcoming what Westwood (2006) notes is the silencing of the post colonial subject, and allowing them to comment on nursing practice and to offer their critical insights. This approach means abandoning ideas of the superiority of Western modes of nursing practice, and a move away from the globalisation of nursing practice, which should be read as the Westernisation of nursing (Westwood), to a third space or hybrid Australian approach

Such discussions are essential to the development of practical nursing theory in the Australian context if as the predictions illustrate, the percentage of immigrant nurses to Australian born is likely to increase (Health Workforce Australia, 2012). This is what is lacking in the White Paper (Henry, 2012a). Economic growth in Asia may stall the numbers of immigrants coming to Australia, but overcoming our liminal relationship to Asia requires formally opening up to the possibilities that the behaviours, practices, and knowledge of former colonised nations might contribute to our own success. Maintaining the current view of the inferiority of nursing in post-colonial Asian states is risky in the current environment where the predictions are that the ratio of immigrant nurses to Australian born is likely to increase (Health Workforce Australia, 2012). While nurses are highly regarded by Australians (Roy Morgan, 2012), this regard does not extend to sufficient young Australians taking it on as a profession. If the Australian state remains trapped in its liminal relationship to Asia any increase in the Asianisation of the nursing workforce will not be of benefit to the profession, to Asian nurses, or to the patients they care for.

Critics of the Higgott and Nossal argument are many. For example, Capling (2007) acknowledge that the Hawke/Keating government's attempt to forge an Australian cultural identity as part of Asia, was distinctly different from the subsequent policies of Howard or the current Labor Government. She illustrates that despite this Australian economic ties with Asia increased exponentially during the Howard government, accompanied by a strong argument that we did not need to become Asianised or to deny our European heritage in the process. She also points to various public opinion polls that report that while Australian's think economic ties with Asia should be strengthened, deep anxieties persist about changing the racial composition of Australia with Asian migration. Our own critique takes a different tack. We would argue that Higgott and Nossal did not go far enough in spelling out what Australia would look like culturally if it was to go beyond its liminal state. They surely are pointing to something akin to Bhabha's third space or hybrid culture.

We argue that despite the more recent critiques of Higgott and Nossal's work (Capling, 2007), serious consideration should be given to their proposition. If our engagement in Asia was limited to trade, this would not be necessary, but it is not. As we have demonstrated above, a significant number of Asian nurses now form part of the Australian health care system. A key point we wish to highlight in this paper is that in recruiting Asian nurses we are handing over the care of our sick and vulnerable to women we are not totally culturally comfortable with. In our view this signals something deeply problematic and contradictory in our stance. The way forward is beyond economic engagement in Asia. It is in embracing a third way or hybrid approach to the professional care of the sick that creates a shared understanding of nursing.

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