Staying Power: The Career Journeys of Leading African, African-Caribbean and Asian Nurses in England

By

Vina Mayor

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Dedication
This thesis is dedicated to the memory of my late father, **Bikram Singh Puri,** and my late father-in-law, **Dharam Dev Mayor.** Both men were pioneers, mentors, life-coaches and leaders in every way.

Declaration and Inclusion of Published Work

I confirm that this thesis is my own work and that it has not been submitted for a degree at another university.

Any own-publications referred to in this thesis are not reproduced within it.

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To protect the anonymity of respondents, pseudonyms have been used.

In certain parts of the thesis, where I have included names of Black and Asian nurses, the information is derived from the public domain, that is, nursing journals and national newspapers.

Vina Mayor
31st January 2002

ABSTRACT

This thesis is the first research of its kind to examine the career journeys of leading African, African-Caribbean and Asian, male and female, nurses' careers in England, and adds substantially to our extremely limited knowledge concerning the black professional class in Britain. It examines the barriers, the career opportunities, personal motivations and cultural capital that the respondents drew upon to negotiate and deal with racialised social and professional structures from the entry gate into nursing to their current appointments as senior managers in nursing, nurse management, research or nurse education. This study has considerable policy relevance in view of the National Health Service (NHS) commitment to recruit qualified nurses from overseas to combat the nursing labour market shortages. The research was conducted in three phases over a period of six years using an oral biography / life history approach to obtain narratives from eighty-eight black respondents working and domiciled in England. It revealed that the group of black nurses who had reached senior levels had became highly qualified and had contributed to service, policy, education and research development at the local level. There is also substantial evidence of their contribution to nursing at national and international levels. The findings also reveal that respondents experienced self-reported unequal treatment at the entry gate and throughout their career. The staying power and career journeys of these respondents show that the intersection between social structures of class, 'race' / ethnicity and gender, and personal agency is important in shaping careers and is influenced by social, professional, political shifts and constraints, suggesting that how individuals negotiate and deal with racialised barriers is linked to both their 'stocks' of cultural capital and their personal motivations and determinations. This structure-agency relationship counters much of the research on 'race' and occupation which has looked primarily at racialised structural barriers to advancement.

List of abbreviations

Abbreviation	Full detail
APR	Annual performance review
'A' level	Advanced level school leaving certificate qualification.
'O' level	Ordinary level school leaving certificate qualification.
BSA	British Sociological Association
CBE	Commander of the Order of the British Empire
CEO	Chief Executive Officer
CETHV	Council for the Education and Training of Health Visitors
CNS	Clinical Nurse Specialist
CON	College of Nursing
CPHVA	Community Practitioners and Health Visitors Association
CPN	Community Psychiatric Nurse
CRE	Commission for Racial Equality
CV	Curriculum vita/e
DBE	Dame Commander of the Order of the British Empire
DC Test	Dennis Child Test: replaced the GNC Test. More elaborate in structure and scope.
DN	District Nurse
DNA	Deoxyribonucleic acid
DNO	District Nursing Officer
DoH	Department of Health
EC	European Commission
EN	Enrolled Nurse
EN – G	Enrolled Nurse – General
EN – M	Enrolled Nurse – Mental
ENB	English National Board for Nursing, Midwifery and Health Visiting
FETC	Further Education Teaching Certificate
FRCN	Fellow of the Royal College of Nursing
GCE	General School Leaving Certificate
GCSE	General Certificate of Secondary Education
GNC	General Nursing Council for England and Wales

GNC Test	General Nursing Council for England and Wales test for entry to nursing for applicants without entry qualifications.
HE	Higher Education
HEI	Higher Education Institute
HIV	Human immunodeficiency virus
HND	Higher National Diploma
HSA Award	Hospital Saving Association Award
HV	Health Visitor
HVA	Health Visitors Association (renamed as CPHVA)
ISNHE	Incorporation of Schools of Nursing into Higher Education
ITT	Initial teacher training
ITU	Intensive Therapy Unit
LD	Learning Disabilities
MBA	Master of Business Administration
MBE	Member of the Order of the British Empire
MSF	Manufacturing, Science and Finance trade union
NHS	National Health Service
NHSE	National Health Service Executive
NHSME	National Health Service Management Executive
NO	Nursing Officer
NT	Nursing Times
OBE	Officer of the Order of the British Empire
ONC	Ordinary National Certificate
P2000	Project 2000
P2K	Project 2000
PgD	Post Graduate Diploma
PhD	Doctor of Philosophy
PREPP	Post-Registration Education and Practice Project
Pro-VC	Proposed Vice Chancellor
PRP	Performance Related Pay
PTS	Preliminary Training Scheme (was normally 12 weeks of initial training on entry to the EN / SRN training pathways).
QAA	Quality Assurance Agency
RAE	Research Assessment Exercise
RAF	Royal Air Force

RCM	Royal College of Midwifery
RCN	Royal College of Nursing
RGN	Registered General Nurse
RHAs	Regional Health Authorities
RHV	Registered Health Visitor
RLDN	Registered Learning Disabilities Nurse
RM	Registered Midwife
RMN	Registered Mental Nurse
RMSN	Registered Mental Subnormality Nurse
RN	Registered Nurse
RNMH	Registered Nurse Mental Handicap
RSCN	Registered Sick Children Nurse
SAS	Special Air Services
SCM	State Certified Midwife
SEN	State Enrolled Nurse
SNO	Senior Nursing Officer
SNP	Specialist Practice Nursing
SON	School of Nursing
SON&M	School of Nursing and Midwifery
SRN	State Registered Nurse
SsON	Schools of Nursing
TB	Tuberculosis
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
UN	United Nations
UNISON	Trade union representing employees in the health service and public sector.
USA / US	United States of America
VC	Vice Chancellor
VSO	Voluntary Services Overseas
WHO	World Health Organisation

LIST OF RESPONDENTS

African Respondents		
Pseudonym	**Country of Origin**	**Field of Practice**
Bert	Ghana	Senior nurse surgical
Bridget	Sierra Leone	Nursing Officer midwifery
Cici	Nigeria	CNS haemoglobinopathies
Erica	Nigeria	Research and education in haemoglobinopathies (reader & above)
Erin	Nigeria	Nursing Officer community
Jane	Ghana	Reader or above
Margarita	Sierra Leone	Day care manager
Meg	England	CNS - Forensics services
Patience	South African	International community development, researcher
Nigel	Nigeria	Dean & above
Pierce	Ghana	Policy and practice development in forensic mental health
Rob	Nigeria	Principal lecturer and professional lead mental health
Roger	Ghana	Principal of school of nursing
Samuel	Southern Rhodesia	Senior nurse secure unit
Sarah	Sierra Leone	Unit manager / elder care
Thom	Southern Rhodesia	Section Head, education
Valerie	Ghana	Head of Department - midwifery

African Caribbean Respondents		
Pseudonym	Country of Origin	Field of Practice
Anneka	West Indies	Manager Caribbean stroke project
Betty	Trinidad	Group practice manager
Brenda	Jamaica	Owner / principal/ director of ed & training business
Celia	West Indies	In-service education manager
Charity	West Indies	Project manager & nurse lead for Outreach work
Cheri	Barbados	HOD
Claudia	Jamaica	Nursing Officer policy / quality
Cynthia	Jamaica	Principal Lecturer / section head
Deirdre	Jamaica	HOD Nursing.
Ellie	Barbados	Course director / section head
Emma	Jamaica	Nursing Officer - special com projects
Eric	Trinidad	Educationist: section head
Fred	Jamaica	Senior Nurse Adolescent Unit
Gloria	Jamaica	Assistant director children's nursing
Hilda	Guyana	Manager SCBU
Jacqui	West Indies	Manager OPD
James	St Vincent	Manager elderly care services
Jo-Jo	Jamaican	Clinical services manager
Jolene	West Indies	Senior nurse quality – studying law full time
Julie	Guyana	Principal Lecturer / section head
Laurette	Trinidad	Director of midwifery services
Len	St Kitts	Manager rehabilitation unit
Marcia	Trinidad	Nursing Officer - community nursing
Margarita	Jamaica	Full time student. Former head of quality.
Maria	West Indies	Community nursing manager
Maurice	Jamaica	Educationist (Deputy Head of School)
Maxi	Jamaica	Head of professional development health visiting
Nikki	West Indies	Family planning services manager
Patricia	West Indies	Nurse allocation and recruitment
Rita	Barbados	Principal Lecturer- community Nursing
Rose	Barbados	Nurse advisor public health
Rowena	Jamaica	Equality policy / head of research
Ruby	Trinidad	Head of organisation
Selena	England	Owner / principal/ director of ed & training business
Terrie	West Indies	Senior Unit Manager
Tim	Jamaica	CNS oncology
Violet	Jamaica	Manager equality issues

Asian Respondents		
Pseudonym	**Country of Origin**	**Field of Practice**
Amin	Mauritius	Education policy and standards
Anil	Mauritius	Equalities manager for HA
Anita	Malaysia	PL mental health / mental health commissioner
Althea	Mauritius	SL / Adult nursing
Anthony	Malaysia	Dean & above
Babna	Kenya	Director of midwifery education
Banu	Tanzanian	Assistant general manager / redundant / manager care home
Belinda	India	Head of school / dismissed / SL
Champa	Kenya	Principal Lecturer health studies
Christian / Chris	Mauritius	Locality manager LD
Claire	Mauritius	Joint owner of group of nursing and residential homes
Colin	Mauritius	NO elder mentally infirm
Daniel	Mauritius	Education policy and standards
Faisal	Pakistan	Director learning disabilities
Frank	Hong Kong	Vice principal school of nursing
Harry	Hong Kong	Education policy and standards
Hazel	India	Director of Primary Care
Indira	Kenya	Director Community development - women's initiatives
Jack	Malaysia	Director of education / school
Jamuna	India	CNS women's health
Kiran	Malaysia	Principal Lecturer MH &LD
Lal	Mauritius	Educationist - MH
Liette	Mauritius	Manager outreach services MH
Lucy	Guyana	Community Practice teacher / deputy head of service
Lulu	Malaysia	Nursing Officer delivery suite
Mala	Kenyan	Advisor on ethnic minority health
Mamta	Ugandan	CNS diabetes care for ethnic minorities
Mohan	Mauritius	SNO mental health
Prakash	Kenya	Manager addictions unit
Salim	Mauritius	Nurse manager CPN
Scot	Mauritius	Nurse manager hospice cancer care
Shabana	Bangladesh	Acting locality manager
Shobna	Kenya	NO primary & community care
Veronica	Malaysia	Equalities advisor an trainer

CHAPTER 1

INTRODUCTION

This is an elite study of eighty-eight, male and female African, African-Caribbean and Asian nurses in a marginalized profession, who have negotiated their careers to be appointed in senior managerial, academic, practice or research posts, which aims to:

(a) Understand their staying power in British nursing and a racialised social world,

(b) Celebrate their successes and 'high points' of their career journeys,

(c) Understand how they have managed any challenges, obstacles or barriers along the way.

It is set in the context of nursing as a career in England to map and identify patterns in the experiences of these respondents mainly within the National Health Service (NHS) as an employer organisation, from the decisions relating to entry into nursing to their employment at the point of data collection between 1993 and 1997. A career is defined as the vocational history of an individual (Gysbers, 1987:5), and includes what one does in one's occupation, that is, the course pursued over time to incorporate horizontal and vertical moves within paid work (Super, 1994:115), as well as parallel careers in unpaid work (Robinson et al, 1997:630).

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This thesis offers an opportunity to focus on these individuals' careers and their contribution to nursing but also sets these against the overlapping 'structural' framework of the history of the NHS and the staying power of black people in Britain (Fryer, 1984). The concept of staying power in the context of this study is a reference to the respondents' tenacity to remain in nursing and pursue a successful career path against all odds owing to the structures and racialised barriers in the profession and society.

This research is in the qualitative-interpretive paradigm, using two research approaches for data collection: narratives obtained by topical life history about career decisions, experiences and motivations, and a questionnaire seeking biographical data. This chapter expands on the rationale for undertaking this research, shares the development of the research interest before detailing the aims of the research, and concludes by referring to the fundamental research questions and structure of the thesis.

1.1. Rationale For Pursuing The Research Topic

The NHS as the primary healthcare agency in the United Kingdom (UK) is the largest employer in Europe (Ward, 1993), and the largest employer of black people in the UK (Culley and Leatham, 2001:63). British nursing has a male / female ratio of 1:9 (Beishon et al, 1995) and a virtually identical ratio of ethnic minorities to white nurses. In terms of the international mobility of nurses, the UK

is the second most important destination and source country (Buchan, 2000:24-27, 2001; Kenny, 2001:5).

Like the 1948-60 period, recent British nursing labour shortages have led to a systematic international recruitment from the New Commonwealth countries, the European Union and Eastern Europe (Doult, 2001:8). The Royal College of Nursing (RCN) statistics for new registrants for the period April 2000 to March 2001 show that 7,705 registrants, that is, one third of the total registering, were from overseas, which is ironic for two reasons: firstly because the overseas recruits have been subjected to racism, for example allocated poor accommodation, appointed to lower level clinical grade than in the source country and subjected to insensitive screening for HIV; exploited by employers by being paid at a lower scale than white nurses at the same clinical grade and required to work extended hours. Secondly, research commissioned by the English National Board for Nursing, Midwifery and Health Visiting (ENB) shows that black applicants are racially disadvantaged at the entry point to nursing (Mahoney, 2001:5). Mahoney (2001:5) reported that differentials in training places offered to white and black applicants favor white applicants to a ratio of 2:1 and in some cases 4:1, confirming Culley and Leatham's (2001:63) finding that ethnic minority nurses experience discrimination in employment.

There is a dialectic in the collective position of ethnic minority nurses in the NHS: on one hand they are visible at the lower rungs of the nursing profession (Beishon et al, 1995) but invisible at middle and senior levels of the nursing organization

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(Beishon, et al, 1995; Mayor 1996; Culley and Mayor, 2001); there is systematic racism at the entry gate (Iganski et al, 1998; Mahoney, 2001), and yet NHS employers continue to recruit ethnic minority nurses into the system but to the lower grades of the clinical ladder. My view is that if the NHS is to continue recruiting ethnic minority nurses, then it needs to address inequalities arising from diversity, discrimination and racism to break down barriers and ensure that career progression is not adversely affected. The Department of Health (DoH), the NHS as an employer organization, and nursing organizations must take joint responsibility to examine organizational and professional structures to ensure that institutional racism is eradicated; and ethnic minority staff are fairly and justly treated, so that career development and progression are not marred by racism.

As a profession, nursing has ignored racism (Shaha in Condliffe, 2001:40). Racism like gender inequalities is a structural phenomenon (Hugman, 1991; Porter, 1995; Kirby et al, 19977). Definitions of racism include systematic discrimination; oppression and exploitation of one racial group by another and may operate at one or more levels. Racism can be analyzed using Bhaskar's critical realist approach (1989 in Porter, 1993: 592-593) that attempts to explain the relationship between human action and social structure on three levels of reality: empirical, actual and causal / real. In applying critical realism to racism (Porter, 1998:171-173), the empirical level includes the positivist aspect of observable or experienced events such as racial discrimination at the personal and organizational level/s; the actual refers to racist events and experiences such as a biased line of questioning a black person may be subjected to at interview; and

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thirdly the causal level which consists of deep underlying structural mechanisms that generate non-observable events and exist independent of our knowldege or perception of them. For example, the causes of racism or the root of stereotypes held by white people about black people are often attributed to social structures. The two core features of social structures are relational in that they possess: (a) ontological depth indicated by persistence of the phenomena over time and space, such that it predates people in them and is very likely to continue after them; and (b) power involving relationships between social actions. In the case of racism, the power relationships between black and white people provide conditions for action and at the same time actions are motivated by the actors consciousness and motivations. Critical realism underpins the analysis throughout this thesis.

The research interest developed during my employment at the Princess Alexandra School of Nursing, London, in the early 1990s as a direct result of a group of black pre-registration students, from Africa, Bangladesh and the Caribbean, questioning me about the lack of same ethnic group mentors in the clinical settings and personal tutors for academic support. An initial exploration of nursing literature and anecdotal information from pre-registration nursing students, nurse teachers and practitioners, revealed that information was wholly biased towards an emphasis on the negative experiences of the black nurse. The term 'black' embraces persons of African, African-Caribbean and Asian origin. It emphasized the under or non achieving black nurses, reluctance of the black youth to consider nursing as a career, and that black nurses were clustered in Cinderella services such as elder care, learning disability or psychiatry.

Prior to the Policy Studies Institute research (Beishon et al, 1995) much of the literature (for example Agbolegbe, 1984a, 1984b, 1988; Akinsanya, 1988; Baxter, 1988) was either based on opinions or on small samples. Furthermore, the literature made no reference to the social or political context in which the black nurses were employed, and did not address issues about their entry gate into nursing, domains of practice they were channeled into or their experiences throughout their nursing careers. The literature did not focus on how the black nurses negotiated and managed their career and neither did it make reference to the history of black people in Britain, their social mobility or their contribution to nursing. Instead black nurses were portrayed as being the problem without examining the social and political structures that oppress black people or the role of the nursing labour market in segmenting black men and women in a subordinate position, implying that black people are passive recipients of racism, a fact disputed by Gilroy (1987). Discourse in both media and literature denigrates black people to help embed differences between ethnic groups (Hall, 1992 in Kirby et al, 1997). Other research, for example Daye (1994) and Modood et al (1997), provides a more sophisticated understanding of black peoples social mobility, pointing to the relationship of structures, namely 'class', 'race' and 'gender', but do not illuminate individual processes to explain intra and inter-ethnic group diversity. While Modood et al (1997) and Brah (1992 in Kirby et al, 1997) argue that each ethnic group experiences different patterns of disadvantage and develops distinct responses within their own culture and community, they do not explore the structure and agency in the lives of black professionals.

1.2. Aims Of The Study

The aims of this research were therefore to:

(a) Illuminate and understand the black nurses experiences of nursing as a career beyond the ward manager grade within the social and political context of British nursing, and against an overlapping 'structural' framework of the history of the NHS and of the history of black people in Britain. Respondents' personal experiences were captured through narratives using the oral biography and questionnaire for data collection.

(b) Acquire a greater understanding about the social mobility of black people through professional and academic accreditation, the development of networks and strategies adopted to get to the top of the nursing profession.

(c) Redress the paucity of available research about black nurses in nursing history and broader literature pertaining to social sciences, organizations and occupations by focusing on issues that hitherto had been excluded from the research agenda.

1.3. Research Questions

My thesis addresses the intersection between social structures of 'class', 'race'/ethnicity and gender in nursing career in terms of how these relationships affect the nursing careers of male and female black nurses, from the decisions

informing entry into nursing to their current employment post. These relationships were explored through seven fundamental research questions. These were:

(a) What were the principal push and pull factors that resulted in respondents either selecting nursing or ending up in nursing? I wanted to know the respondents rationale for selecting nursing and gain insight about their decision-making processes. In addition, I wished to know what other career choices had been available to them, and discover links between their personal aspirations or goals and their chosen career. (Addressed in chapter 4).

(b) What were the patterns of similarity and difference between respondents by gender, ethnic group, nursing discipline, recruitment, entry gate and migration pattern? I wanted to discover if there were any inter and intra group differentials that may be explained by the interaction of class, race and gender. (Addressed in chapter 4).

(c) What were the opportunities or barriers to mobility in nursing for black nurses? I wished to know what opportunities were available to or negotiated by black nurses to secure mobility against the odds of social, organisational and professional structures, as well as discover how these structures prevented them from achieving their goals. In addition I wanted to know if there were any differences between the three ethnic groups or between male and female respondents. (Addressed in chapters 3 and 5).

(d) Was the respondents' cultural capital, that is, people's existing 'resources'

and capacities at the entry gate to nursing, an asset or constraint to the nursing career? I wished to examine how respondents used, transferred or adapted their colonial-cultural capital to a British setting, and what impact their cultural capital had in adult life in Britain in relation to career decisions and career journeys. (Addressed in chapters 4, 5, and 6).

(e) **What feelings do respondents have about the costs and benefits of succeeding in nursing as black people?** From this question I wanted to know if respondents who had 'got to the top' thought their efforts and investment in the career had been worth it on personal and professional levels, and whether differential inter-group patterns could be discerned In addition I wanted to ascertain how it related to their identity as black people. (Addressed in chapter 8).

(f) **What does this study contribute to the understanding of black people and their social mobility in Britain?** This question redresses the gap in research about the social world the black nurses live and work in to focus on the processes that allow some people to get on in a world that has rendered black people as invisible in research terms and continued to maintain their subordinate position in the labour market by not challenging the inequities of their working lives. To date there has been a lack of focus on black people rising within structures, as mostly the research focus has been on those at the bottom. (Addressed throughout the thesis).

(g) **What can employers and policy makers learn from the experiences of these respondents?** Given that the NHS is into a second major phase of international recruitment, the research focus provides insights to ensure that overseas nurses are

not discriminated against, and the NHS makes best use of the talents of its workforce. Also, this research has implications for equal opportunities generally, that is outside the NHS. (Addressed in chapter 9)

1.4. Outline Of Thesis

In order to pursue the above issues, Chapter two provides a reflexive account of the **'Researchers Journey – From Literature Review To Research Strategy'.** It sets out to respond to two broad questions about the structural location of black people in the social milieu and British labour market, and the research strategy best suited to obtaining answers to the research questions posed. It examines the links between the subordinate position of black people at the point of their original entry into the British labour market, and collective location to ascertain how social, cultural and professional structures affect their experience of glass ceilings in professions. The chapter also identifies theoretical frameworks and insights to assist the research focus and selection of the research strategy.

'The Social Construction of British Nursing – Barriers and Opportunities for Black People' is the subject of Chapter 3. It explores four principal, inter-related themes pivotal to answering the research questions about the career choices accessible in post Second World War Britain and influences on, or reasons why people selected nursing; examines the structure of the nursing labour in relation to gender and discipline differentials in the profession, the career opportunities

created by the professionalisation of nursing; and barriers respondents would be exposed to. The chapter focuses on the intersection of ethnicity and structural changes in the organisation of nursing, specifically in relation to the opportunities accessed by and barriers faced by black nurses. I then focus on the social context and milieu into which black nurses came to live in and work so as to understand the impact of subsequent Race Discrimination and Immigration legislature of the 1960s on black people. The final section of the chapter examines the nursing contribution of black nurses to the NHS.

From here on, the thesis takes a narrative, biographical logic that draws on empirical data to elaborate respondents' experiences from the pre-entry to post entry and during the nursing career phases. Thus Chapter 4 examines how the ethnic identity and cultural receptivity influence black peoples' selection of nursing as a career choice to understand why respondents selected nursing as a career, and how their personal history may have circumvented their entry into nursing.

Chapter 5, 'Cultural Capital – Assets or Constraints on Career Progression?' examines the resources available from the past, their skills and motivations, to understand how it informed and supported initial career choices, and how it continued to be a resource or constraint through the adult career. It questions the role of collectivism and individualism in determining respondent actions to the structures and processes in career management.

Chapter 6, 'Respondents' Journeys From Entry into Nursing to the Centralization of Practice Domain', examines the organisational structures

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experienced by black nurses during this period to understand how the differential treatment at the entry gate and early year experiences in nursing affected individual agency. The concept of centralisation of practice domain refers to the specialist field of nursing the individual has elected to remain in for their career. It seeks to identify the processes respondents used to acquire resources to pursue higher and further education. Finally the chapter provides a synopsis of their socio-demographic profiles.

The next chapter, **'Becoming Careerist and Growing Support Networks: Structures and Processes'**, explores the reasons why black nurses became careerists, and their links with the respondents' personal ambitions. Following on from this discussion, the concept of 'Growing Support Networks' is examined to ascertain why networks and mentors are considered to be important for respondents. Chapter 8 **'Being at the Top in a Racialised Structure'** examines if the costs and benefits to the respondents of being at the top have been worth it. The respondents' impact on shaping nursing, nurse education, policy, nursing practice, practice development or nursing research is examined against a tapestry of personal and professional power. In Chapter 9, **'Summary and Conclusions'**, I return to the seven fundamental research questions to demonstrate how each has been addressed; the new understanding of the emergent issues related to the questions and the chapter themes; and considers how employers in the public, private and voluntary sectors can use the findings to support the recruitment and retention of black staff.

CHAPTER 2

THE RESEARCHER'S JOURNEY – FROM LITERATURE REVIEW TO RESEARCH STRATEGY

2.1. Introduction

This chapter illuminates the researcher's journey studying the phenomenon as an individual whose own career has been in health visiting and nurse education, and as a member of an ethnic group included in the study. Discussion takes the reader from the selective literature review to the research strategy and its execution. A first person approach is adopted where appropriate.

A broad question, **'what do we know about the structural location of black people, their experiences in the British labour market, and the extent of their social mobility and agency'**, was posed as the initial basis for exploring the explicit issues addressed in this thesis. The term black refers to peoples of African, African-Caribbean and Asian origins. The quest to answer this question evolved into three key cycles of literature searching: (a) the aim of the **initial literature search** was to identify specific literature on black peoples' experiences in the labour market, especially in the health sector and nursing careers, and those in leadership position; (b) **the literature search was extended to identify theoretical frameworks** that could contribute to the research focus selected, and (c) **theoretical insights** from related research studies, with the purpose of assessing the literature in the public

domain and its contribution to the research design. The fourth cycle related to the

research strategy for the empirical work drawing on the findings of the first three

cycles. I will discuss each of these cycles now:

2.2. "Race" and Ethnicity

In order to understand the experiences of black respondents in this research, it is

necessary to understand the terminology used as descriptors for people who are

not white. It also provides the theoretical underpinning for the discussion about

respondents' self definition of their ethnic identity in Chapter 4.

"Race" is not a biological phenomenon but a social construction based on

physical, genetically determined characteristics, such as facial features, skin and

hair types associated, used to differentiate human populations from different parts

of the world (Giddens, 1993; Kemp, 1994). Discussion of 'race' is made more

complex by class based divisions, ethnicity and gender differences (Kemp, 1994).

Generally, it is accepted that the three broad categories in use, Negroid, Caucasian

and Mongoloid, are not useful to explain differences between human populations,

especially with modern DNA techniques confirming that humans cannot be

categorised into racial groups by assessment of their gene pool or blood grouping,

and that differences in physical characteristics are derived from the gene pool mix

over centuries. 'Race' has been somewhat dismissed by social scholars as a

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flawed concept perpetuating racism and prejudices (Cohen and Bains, 1988:24; Gerrish et al, 1996:12-13; Coker, 2001:1).

The term ethnicity has its location in the ancient Greek 'ethnos', referring to people living and acting together (Jenkins, 1997:9) in the belief that they are of common descent. The concept of ethnicity is both multi-dimensional and situational (Gerrish et al, 1996:19), becoming important for certain reasons and normally applied to define people out of their country of origin. At a fundamental level, ethnicity is a political process for defining 'them and us' (Yuval-Davis, 1994 in Bhavnani and Phoenix, 1994:182), equating with heritage of important characteristics that are common between members and at the same time making them distinct from other communities. Ethnicity, like 'race' before it, has developed as a measure of competence and ability. Components of ethnicity differ across the world (Modood et al, 1997) and cannot be considered as fixed because of 'its dynamic relationship to both historical and contemporary experiences of social groups and is related to living conditions of individuals' (Nazroo, 1997:8). Leading sociologists, for example Giddens (1993), Rattansi and Westwood (1994), Jenkins (1997) and Rex (1991), are agreed that definitions of ethnicity incorporate shared meanings and values; that ethnicity is not fixed, and embraces cultural differentiation and identity. Despite the fact that different ethnic groups exist alongside each other or at a distance, their values and beliefs resonate similarities and differences at inter and intra-group levels.

Using country of birth as a determinant of ethnicity has limited use or relevance as it can apply to indigenous and non-indigenous people. Similarly, the formal adoption of citizenship of a given country is an indication of choices made by people but does not negate social exclusion or discrimination. Depending on the country of domicile, dark or light skin colour reflects minority status without distinguishing between minority groups or dealing adequately with people of mixed ethnic group parentage (Modood et al, 1997).

Ethnic identity is both social and pluralistic in origin (Jenkins, 1997:40-41; Modood et al, 1997), being normally defined either by drawing on place of birth, nationality, religion, traditions, language or culture; or subjectively applied by others (Modood et al, 1997:13; Nazroo, 1997; Cohen and Bains, 1988; Gerrish et al, 1996:19). Skin colour is said to be more important to Caribbeans, possibly due to the high status that was given to light skin slaves, whereas, religion is said to be more important to Pakistanis and Chinese (Modood et al, 1997:290). Definitions are variable and renegotiable over time (Bhavnani and Phoenix, 1994:5) and depending on the social setting ethnic identity can shift according to historical situations (Hall, 1993; Modood et al, 1997: 290; Nazroo, 1997: 8).

In recent years, ethnicity has been politicised (Jenkins, 1997) to demonstrate disadvantage or to gain asylum, for example the Bosnians (Yuval-Davis, 1994 in Bhavnani and Phoenix, 1994:183). In the last decade, people from Africa, the Caribbean and Asia have increasingly been referred to as black, a term borrowed from the USA black consciousness movement, to avoid using derogatory labels

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such as Negro, immigrants and coloureds. Use of the term black is problematic, because while Caribbeans and Africans do often perceive themselves as black people, people of South Asian origin, that is Indians, Pakistanis, Bangladeshi, African-Asians, Sri Lankan, Mauritian and Chinese, may not see themselves as being black (Modood et al, 1997: 297). The reasons for South Asian people not identifying themselves as black lie in their colonial relationships with the white British for whom they undertook overseer type duties (Daye, 1994; Smaje, 2000) and the fact that blackness is not necessarily perceived as a fundamental part of the Asian-self. Colonial legacy structured Caribbeans and Africans as servant-peasant class (Graham, 1997; Smaje, 2000), and Asians as administrators, entrepreneurs and overseers, thus creating a hierarchical pecking order about abilities and capacity (Daye, 1994:38), as well as animosity between ethnic groups. For educated middle class Asians, blackness is a concept that applies some of the time either to express solidarity or as a means of articulating an acceptance of their non-white status. While I accept that the term black should not be applied universally to people of colour (Coker, 2001:2; Bhavnani and Phoenix, 1994), it is a term that I use within this thesis for ease of reference, and with the consent of the respondents for this study.

2.3. Initial Literature Search into Careers of Black Nurses and Black Nurse Leaders

A broad literature search of British, Indian, Australian and North American journals, texts and thesis (doctoral and masters), in the fields of nursing, education, 'race',

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psychology and social sciences, published in English, from 1970 onwards, revealed

three things. There was a lack of specific literature on (a) the careers of black nurses,

especially those in leadership position, (b) the intersection of 'race' and working

practices of the National Health Service (NHS), and (c) explanations of who gets to

the top in nursing. This lack of specific literature on nursing careers is arguably a

reflection of the subordinate position of nursing to other professions, such that it has

been largely ignored or researched in relation to other powerful professions like

medicine.

Six research studies (Hardy, 1983, 1986a, 1986b; Torkington, 1985; Baxter, 1988;

Marsland et al, 1993, 1996; Beishon et al, 1995) focusing on nursing careers were

identified: three of the seven (Hardy and Torkington) were undertaken for doctoral

or postdoctoral studies. Hardy conducted both research (1983, 1986a, 1986b)

using peer nomination to identify female and male chief nurses in Britain

respectively. Of the remaining three studies, (Baxter, 1988; Beishon et al, 1995;

Marsland et al, 1993, 1996), only one (Beishon et al, 1995) was a large national

survey of over 14,000 white and ethnic minority nurses in England. Baxter's

research was based on small samples, whereas the third (Marsland et al, 1993,

1996) is a series of longitudinal studies focussing on a particular cohort of

students. Although Baxter (1988) was the first to examine the negative

experiences of black nurses, the report lacks a critical discussion about the

research design or the context of their employment. A recent study by Culley et al

(2001), drew on interviews with fourteen Caribbean respondents, aged 52 –72

years, who came to the UK between 1954 and 1962, to demonstrate the every day work place racisms experienced by black nurses.

Hardy drew on Super's (1963) work on career development as the theoretical framework for both studies, obtaining data using a structured questionnaire and a follow up face-to-face interview. Personal contact with Professor Hardy (in 1997) confirmed that neither research included a black nurse as none were employed at that level at the time. Her 1983 research revealed that the majority of female chief nurses were single women who had made nursing their life-time work, they were middle class, and were older than their male counterparts. In contrast, her 1986 post-doctoral research focusing on male chief nurses, showed that they came into nursing by default, the majority (10 out of 13) having a working class background and were likely to be married with dependant children. These findings have been supported by more recent publications (Dixon et al, 1994; Ball et al, 1995; Disken et al, 1995). Hardy acknowledged that the Second World War brought career opportunities to the British born chief nurse respondents, especially men who were admitted to the general nurse register after the war (Baly, 1995). Although Hardy's research provided a possible template for data collection methods, recruitment of respondents and a theoretical framework, the sociological context has changed; the structure of nursing has become more complex, for example entry gate requirements have changed and there has been a vast growth of new practice domains; there is evidence of social and career mobility of ethnic minority people; and our understanding of career have expanded. The concept of

career theories now includes, for example, the fit between person and organization.

A longitudinal cluster of studies by Kings College University conducted by Marsland et al (1993, 1996), Robinson (1993, 1994), Robinson and Marsland (1994) and Robinson et al (1997), are following a cohort of predominantly white female nursing and midwifery respondents. Their findings demonstrate attrition, mobility between the sub-disciplines of nursing and geographical mobility. In time these studies will provide an in-depth range of findings about nursing careers but at the moment, due to the relatively short length of time respondents have been in nursing, they are not yet in a position to illuminate how the structures, processes and personal agency affect career.

Beishon et al's (1995: 139-143) research comprised of two major aspects: a survey of 14,330 (62% response) white and minority nurses (90%: 10%) in the NHS to obtain career histories and six case studies of nurse employers to discover how the 'policies and practices within the NHS affected opportunities for ethnic minority nurses'. There is no doubt that this research provides the very first research-based description of 'experiences, views and attitudes of white and ethnic minority nurses' (1995:16). In publishing their findings of racial harassment and discrimination in nursing, Beishon et al confirmed anecdotal evidence that had previously been disregarded by NHS employers and nursing elite as being soft and unreliable data. However, there are three fundamental problems with this study: First 25% of the subjects were not qualified nurses but

employed at ancillary grades A, B and C, thus skewing data about the qualified black nurses. It would have been more appropriate to exclude the unqualified labour force and focus on the qualified nurse. Secondly, given the resources at the disposal of the research team and the target selection of the employer case studies, a response rate of 62% should be considered as being moderate rather than being good. A key finding of the study pointed to racism in the work place from employers, peers and, patients and or their carers. Thirdly, the six employer case studies examining the implementation of equal opportunities practice concentrated on areas with known large concentrations of ethnic minorities inferring that these practices were of lesser importance to employer organizations with smaller numbers of ethnic minorities staff. What is of interest to me as a researcher is that the steering group overseeing this research is anonymised by reference to the organizations represented and that the key informants are not names normally associated with the topic of 'race' and nursing careers.

2.4. Black Peoples' Migration into Britain

In order to understand the experience of Black and Asian nurses, it is critical that the debate includes broader historical perspectives. I will do this by first looking briefly at black peoples' migration into Britain generally, and then look at the location of black people in British society. Skellington (1996:66) points out that there were three major migrations to Britain: Irish migration following the potato famine (1840 onwards); East European migration before the First World War, and

the post Second World War migration from the New Commonwealth. In the period 1939 to 1968, Britain saw the introduction of self-government of internal and external affairs by South Africa, Canada, Australia, New Zealand (Coxall and Robins, 1998) and decolonisation leading to the independence of Indian, African, Far East and Caribbean colonies. Black people have been part of the British population for 500 years (Alexander and Dewjee, 1984; Fryer, 1984; Visram, 1986), being brought to Britain as domestic servants or exotic slaves, or to meet labour shortages. Migration in and out of Britain fundamentally altered peoples' lives and had implications for wider society in terms of social relations and economy (Pooley and Turnbull, 1998:19, 257).

During the Second World War, black people from the Caribbean and India joined the British armed forces (Rowbotham, 1999:228; Phillips and Phillips, 1999) but their contribution to the war effort is rarely acknowledged (Phillips and Phillips, 1999). Rowbotham writes that ' a small minority of women in the services were black, officially Britain welcomed black volunteers from the Caribbean but racism was pervasive towards them and black women from Britain' (1999:228). Anomalies such as the British army in India not accepting Indian nurse recruits in non-war years (Somjee, 1991) or black officer airmen not being accepted into the RAF (Phillips and Phillips, 1999:30) are a feature of direct and overt organisational racism. During the British Raj of India, it was reluctantly accepted that Indian judges could be appointed, but could not sit in judgment of white people because it was considered unfitting. Basically, the British ensured that white people were appointed to power positions regardless of the field.

After the Second World War the British government changed the Immigration

Act to allow immigrants from Eastern Europe and the former prisoners of war to

remain in Britain. At the same time, the British government encouraged

immigrants from the Caribbean and the Indian sub-continent to come to the UK as

a means of counteracting unskilled and semi skilled labour shortages (Coxall and

Robins, 1998:73; Phillips and Phillips, 1999); but vilified black people for being

lazy and spongers on the welfare system (Carter et al, 1987: 2, 7). The largest

wave of Caribbean immigration to the UK occurred between 1955 and 1962

(Phillips and Phillips, 1999:120), with numbers varying according to the unskilled

labour needs of particular industries, the NHS and public sector. The 1952

McCarran Walter Act by the USA effectively barred West Indian settlers

(Rowbotham, 1999:30; Phillips and Phillips, 1999:120), whereby the UK became

the alternative option for those looking to improve economic prospects, access

opportunities for education and or wishing to capitalise on their contribution to

Britain's war effort (Phillips and Phillips, 1999: 121). By the mid 1960s, 'the

demand for unskilled had virtually disappeared' (Coxall and Robins, 1998),

limiting immigration to dependants and band B applicants.

2.5. Citizenship and Immigration Acts

Until 1964, people in British colonies had full British citizenship (Phillips and

Phillips, 1999:2-5), therefore, when black people from these colonies came to

Britain, they came as 'citizens of Great Britain and the Commonwealth'.

Immigration from the Indian sub-continent was unrestricted until 1963 (Skellington, 1996:74) when the British government imposed visa requirements, limiting Indian migration to 'the voucher scheme' and those who were classified as 'band B' (62%, compared with 12% of Caribbeans in band B), a group who by virtue of their qualifications, in medicine, nursing or teaching, had specified jobs to go to (Daye, 1994:9-10). The critical difference between Caribbean and Indian migration was that middle class Indians came into Britain as middle class migrants to take up middle class occupations (Daye, 1994: 32), except that they were channelled into lower grade jobs in those occupations (Carter et al, 1999).

Historically, doctors from the former Commonwealth countries, for example the Caribbean Islands, India, Uganda, had enjoyed free movement between their own country and Britain through the reciprical .recognition of their medical qualifications (Holden, 1991; Coker, 2001). In the 1960s, a third of all NHS posts in medicine, specifically in the difficult to recruit areas of general practice, mental health and elder care, were filled by Indian doctors (Decker, 2001:25), but these doctors were vilified for their low clinical and academic standards, and having poor English language skills. Professional concerns about the standard of English eventually led to compulsory language assessment for doctors from non-European Commission countries, under the guise of patient safety. Research (Coker, 2001; Skellington, 1996; Smith, 1980; CRE, 1987a; Decker 2001:24) indicates that overseas doctors experienced racism, harassment and discrimination, and were concentrated in lower grades of the profession. Discrimination in medicine is not confined to promotion or lower status job and pay (McKeigue et al, 1990; Coker,

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2001; Unwin, 2001), but is extended to application and short listing stage for posts (CRE, 1987a) and application to get into medical school (CRE, 1988; Esmail et al, 1996; Esmail, 2001).

In any debate on migration, the focus has always been on immigration from the New Commonwealth countries, that is, about people of colour, whereas, immigration from the old commonwealth countries, for example Australia, is ignored or not seen as a problematic issue. Similarly, emigration from Britain of indigenous white and black people does not receive attention. Through the series of Immigration Acts enacted in the 1960s, citizenship, nationality and 'race' became inextricably linked (Phillips and Phillips, 1999). Skellington (1996:64) argues that 'immigration policy has been central to understanding racism' because with each Immigration Act, black immigration was curbed, for example the 1961 Commonwealth and Immigration Act introduced a system of employment vouchers limiting intake of immigrants. While the 1965 act sought to curb black immigration, Kenyan-Asians with British passports were exempt from the provisions of this Act (Fryer, 1984; Phillips and Phillips, 1999:244), a fact that prompted Enoch Powell to warn British society that an unknown number of Asians could enter the UK unchallenged, whilst choosing to conceal the fact that many of those seeking domicile in the UK would be white patrials. In an effort to keep Britain white, James Callaghan amended the Immigration Act in 1968 so severely that it restricted immigration to dependants of those already in UK (Phillips and Phillips, 1999: 254, 287). It would seem that while the citizenship and nationality status of white people from the former colonies was not

contestable, the reverse was true for coloured populations. Phillips and Phillips (1999:3) have been bold enough to view this phenomenon as 'a matter of political will and argument'. Carter et al (1987: 2, 7) and Fryer (1984) point out that government ministers called for controls on coloured immigration on the basis that the fabric of British society would be impaired. A Government initiated survey of employers of Caribbeans helped to build myths and promote stereotypes of Caribbeans being 'quarrelsome, work shy and lacking discipline', while labelling black women as 'slow mentally ... but okay to give service as domestics' (Carter et al, 1987:7). Black people were touted as being a drain on the welfare state when in fact their commonwealth citizenship required them to be self-supporting (Fryer, 1984).

The Race Discrimination Acts of 1965 and 1968 are acknowledged as defensive actions by the government to appease an anti-racism lobby to show commitment to fostering better race relations by outlawing racial discrimination (Kirby et al, 1997:208). At the same time, the government passed Immigration Acts that perpetuated racist practices and ideologies. For example, medical officers, employed by the immigration service subjected many Asian brides coming to join their husbands, to a vaginal examination (at the port of entry) to check if these women were virgins. Racism including harassment and abuse has continued unchecked in public services, for example police, education, housing, and the NHS (Fryer, 1984; Gilroy, 2000; Bhavnani, 2001). Sivanandan (1981 in Fryer, 1984:383-385) maintains that governments' official response was to protect

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people, their values, property and sensibilities by responding to the racist demands of its white ministers and white citizens (Kirby et al, 1997:208).

Although the period from 1967 to 1970 was a turning point for 'race' relations in Britain, (Coxall and Robins, 1998), there is a danger that black people have been seen as the source of racial conflict. Despite numerous overt declarations of racial hostility Britain chose to ignore the racial tensions until the 1958 'race' riots in Notting Hill, London (Rowbotham, 1999:301; Fryer, 1984). 1967-68 was critical in British 'race' relations for three reasons: the National Front, an anti-immigration and anti-black people party was formed in 1967; Enoch Powell's infamous 'rivers of blood speech' in 1968, expressed hostility towards black immigrants was detrimental to British 'race' relations by inciting hatred (Coxall and Robins, 1998; Rowbotham, 1999:348; Phillips and Phillips, 1999), and James Callaghan acted to restrict black immigration; as these colluded to raise a negative consciousness about black immigration.

2.6. Social Class and Social Mobility

Social classes arise from economic inequalities reflecting a differential access to resources, educational opportunities, social acceptance, life styles, home ownership and opportunities in life (Giddens, 1993; O'Donnell, 1994:128; Calvert and Calvert, 1994: 41–48). Social class has traditionally been derived from the occupation of the male head of the household, regardless of the wife's occupation

- a formula that disadvantages African and Caribbean couples whose lifestyles may not reflect western convention. Thus social mobility becomes a study of male mobility between different occupational strata with barriers to mobility (Giddens, 1993; O'Donnell, 1994) being linked to structural and non-structural processes resulting in differences between people, for example, lack of opportunities in the labour market resulting in differences in employment; lack of motivation; structural factors in education affecting entry requirements to access studies; ethnic origin in relation to stereotypes held by others; and attitudes that are influenced by socialisation processes. At the core of the influences on social mobility is human capital (Becker 1975 in Kemp 1994:69), a source of a person's productivity, acquired as an investment through self-development, education and job training. British social mobility is concerned with movement from one position to another in the occupational hierarchy (Giddens, 1993; Kemp, 1994) and came about primarily because of the expansion of non-manual jobs especially those in the service sector and information technology, contraction of manual jobs (Coxall and robins, 1998:75), expansion of higher education and appointment on merit rather than through family links (Calvert and Calvert, 1994; Modood et al, 1997). Social mobility can be inter or intra generational.

Intra-generational mobility refers to starting off one's working life in one social class and then moving vertically down or upwards, whereas, inter generational mobility normally refers to occupations higher up the scale than that of one's father or mother. Black men and women hold structural class positions in British society that tend typically to be different from the position of their white

counterparts (Kemp, 1994). Their position in the labour market and lower echelons of British society has been structured by their initial incorporation into the post war British labour market (Daye, 1994:269), racist practices that locate black people in lower paid jobs (Doyal et al, 1981) or discriminating against them in employment (Holdsworth and Dale, 1997:437). Daye (1994:272) writes that those doing well tend to be a segment of the black population in services created to serve their own communities, for example, Section 11 positions in education; 'race' relations industry or public sector.

In the early 1980s, a 15-20% reduction in the country's manufacturing industry (Rowbotham, 1999:489) saw unemployment escalate from 1.4 million to 3 million. Male unemployment rose by 146%, and female unemployment by 276% (Rowbotham, 1999:489) adversely affecting black men and women. It can be argued that as a result of black peoples location in unskilled manufacturing industries (Modood et al, 1997), they were unable to transfer skills to other sectors. Between 1987-1990, service jobs expanded and the trend of unemployment reversed as women moved into low paid service jobs, frequently doing multiple part time jobs. Women in management were also affected by the economic downturn in British economy such that the numbers in management fell from 15% in 1986, to 9.5% in 1993 (Rowbotham, 1999:559).

In the 1970s, 'race' emerged as an important issue for the trade unions movement, for two reasons: first trade unions discovered that ethnic minority women especially were becoming a new and dynamic force, and second they were a

potential pool for recruitment into the trade unions to boost membership. Two examples of this are the 1974 walk out, against union advice, by Asian women from Imperial Typewriters in Leicester because the 'pace of work demanded was beyond endurance' (Rowbotham, 1999:415) and the 1977 year long Grunswick (in Dollis Hill) mass pickets by Asian women for the right to unionise (Rowbotham, 1999:411).

A survey by the Economist of 100 top people from politics, business, finance, academia and learned professions (Coxall and Robins, 1998:83) revealed that it had become much more difficult to succeed without higher education. Cultural changes were not just about social class mobility but also embraced changes in gender relations (Rowbotham, 1999:173) bringing educationally mobile women into the sphere of paid and unpaid work (Kemp, 1994). Research (Smith and Tomlinson, 1989; Mac an Ghaill, 1991; Phillips and Phillips, 1999; Mirza, 1992) showed that educational opportunities of large numbers of black children in Britain were adversely affected by racial stereotyping, streaming into the secondary school system, and low expectations of educational output leading to poor performance in school leaving qualifications. The growth of 'black schools for Caribbean children', mainly in the London area, grew out of black–parents' concerns for their childrens' future (Phillips and Phillips, 1999).

2.7. Black Peoples' Social Mobility

In order to understand the social and professional location of black nurses, it is important to look at the social location and mobility of black peoples' from a holistic perspective. Literature informing discussion in this section is related to the social mobility of Britain's ethnic minority population (Modood et al, 1997), and the intersection of ethnicity and employment in higher education (Carter et al, 1999; Osler, 1997; Gregory, 1999). My intention is to show that the triple actions of individual agency, social reproduction and social structures shape peoples' life chances.

Prior to the publication of the Fourth National Ethnic Minority Survey (Modood et al, 1997), many research findings had been articulated in broad categories of black-white, or by pooling data for a given ethnic group, for example Asians who we know have migrated to the UK not just from the Indian sub-continent but also via other countries. By not accounting for the vast geographical dispersal, the impact of different language, culture, food preferences, religion, education qualifications or social class have not been assessed. Thus, the Fourth National Survey of Ethnic Minorities (the survey) provides a much more sophisticated description and explanations of the social patterns of some ethnic groups to enhance our understanding of their diverse experiences in comparison with the white population as well as between ethnic groups.

The survey, conducted in 1994, was based on sub samples of Caribbean, Asian origin, and white respondents, and its findings point to the intra and inter group

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differences and the emergence of a black middle class. In addition, there is other anecdotal information, for example the national broadsheets assembly of new millionaires and wealth, reveal the double numbers of British Asians entering these ranks. The survey is unique because Modood et al (1997) considered the intra-group differences between Bangladeshi, Pakistani, and Indians – sub-groups from the Indian sub-continent, and African Asians. They ascribed the exclusion of other Asian sub groups from Malaysia, Mauritius, Sri Lanka and the Caribbean from their analysis, to their small size. It is unclear why a similar stratification was not undertaken for the Caribbean group, given that the islands of Jamaica, Barbados, St Kitts, and Trinidad and Tobago, each have their own identity and culture. By clustering the islands into a single domain of Caribbean or West Indies, the employment history of Barbadians, Jamaicans and Trinidadians in different labour markets and its impact in creating geographical clusters in UK, has been lost.

Modood et al (1997:1-4) have argued that the inequalities between white and minority ethnic communities were the outcome of structural disadvantages such as different qualifications and skill levels. They show that the various aspects of social life structured by racial exclusion and inequalities do not operate uniformly for all ethnic groups or result in uniform outcomes (Modood et al, 1997: 9). For example, they confirm that indirect discrimination reduces chances of success or appointment of ethnic minorities into specific employment sectors or employment grades through the custom and practice of employers to give preference to recruitment of relatives of existing employees.

The 1994 national survey provides sophisticated analysis at two levels: one being the inter generation changes by using data from previous national surveys, and second the breadth of parameters focused on intra and inter ethnic group differences in educational attainment, marriage rates, migration patterns, kinship patterns, place of birth, inter-ethnic group marriage, linguistic facility, employment patterns, types of work, income, and what being black means to individuals. The survey identified that inter-ethnic group marriage, that is mixed ethnic partnerships were associated with higher socio-economic status (Modood et al, 1997: 29-31). Differences in inter-ethnic group higher education attainment were linked to lack of fluency in English, lack of or level of qualifications on entry to the UK, gender differences and 'ethnic penalty' (Modood et al, 1997:61). Generally, the pattern shows that Bangladeshis were the most disadvantaged and Indian migrants were, on the whole, better qualified on entry to the UK. According to Modood et al (1997:66-67), nursing was a popular choice for Caribbeans and Asians, a finding refuting other literature (Rudat et al 1994; Bharj, 1994). Using statistics for 1994/95 Modood et al (1997:79) showed that most ethnic minorities were over represented in higher education but were less likely to be admitted to more prestigious institutions. The impact of undergraduate qualifications from less prestigious institutions on the graduands' subsequent career trajectory or their mobility was not addressed.

Between 1974 and 1982, the proportion of ethnic minorities entering professional or managerial jobs increased significantly (Calvert and Calvert, 1994) but they were doing so to a lesser extent than whites with the same qualifications (Modood

et al, 1997) inferring class segmentation (Cross, 1994 in Modood et al, 1997: 146). Inter-ethnic group differences in cultural norms affect womens' employment (Holdsworth and Dale, 1997:437), due to racial and class biases, different labour market opportunities, and within occupation differences in types of job, for example, proportionately fewer black women work in middle or senior management (Malveaux, 1992:83; Davidson, 1997, 2000). Most ethnic minorities are under represented in the highest occupational categories but over represented in manual work with the exception of Caribbean women being concentrated in nursing (Modood et al, 1997:99-110). Modood et al (1997:101, 180) confirmed the upward mobility of some African-Asians and Indians, but also showed that they were worse off than the Chinese (Modood et al: 101, 180). They linked the differential inter-ethnic group social mobility to the different socio-economic–education profiles and level of self-employment (Modood et al, 1997:138-141, 349).

It is postulated that in addition to the plural linkages between socio-economic status, gender, religion and culture; the ethnic penalty of racial disadvantage is a further factor to be considered. The racial disadvantage accrues from an amalgam of (a) lack of fluency in English, (b) lack of school leaving qualifications such that ethnic minority graduates are older on qualifying because they have to make good the lack of school leaving qualifications; (c) admission to low status higher education institutions and (d) discrimination at application stage – medicine and nursing being two verifiable examples (Esmail et al 1996; Esmail, 2001; CRE, 1987b; Iganski et al, 1998; Mahoney, 2001:5). Modood et al define ethnic

penalty as 'all sources of disadvantage that may lead to an ethnic group .... to fare

less well in the labour market than do similar qualified white people' (1997:144).

2.8.   Ethnicity and Employment in Higher Education

Ethnicity and employment in higher education became important to this research due

to the transfer of nurse education into the higher education (HE) sector from 1992

onwards. Pre Project 2000 (UKCC, 1986), the bulk of pre and post registration

nurse education was organised in local schools of nursing and midwifery. The two

exceptions to this were a small number of undergraduate pre registration courses and

post registration courses in community nursing, based in HE. One of the

consequences of Project 2000 (UKCC, 1986) was the transfer of all pre and post

registration nurse education into HE by 1998. Incorporation into HE resulted in

dislocation of nurse teachers through down sizing, redundancies and grading

differentials between nurse teachers and HE academics. Respondents of my research

suggested that ethnic minority nurse teachers and education managers were more

likely to experience redundancy or lower level appointments in HE. Information

from different universities highlighted that some institutions, for example,

Manchester University and Nottingham University, chose to apply their lecturer

grade criteria rigorously whereby those nurse teachers who did not meet it were

appointed as 'associate lecturer' as opposed to 'lecturer'; whereas other universities

such as the University of Hertfordshire and City Universities (two places 1 have

worked in), a number of non-graduate nurse teachers were appointed to the academic grade of lecturer.

Carter et al's research on the position of ethnic minorities in academic and related employment was based on four sources of data: Higher Education Statistical Agency data set for 1996-97, a 'race' equality policies survey, a postal survey of staff, and discussion groups with ethnic minority research students and staff (1999:34). They found that 2.5% of academic staff were ethnic minorities, with Asians and Chinese dominating this group (Carter, 1999:11), a finding indicative of a mirror-pattern with the lower levels of education attainment and qualifications of the different ethnic groups described by Modood et al (1997). Gender differences in academia were also evident with just one third of all academic staff, irrespective of ethnic group, being female (Carter et al, 1999:13). We know that gender plays a big part in the opportunities and obstacles in education and employment (Powell 2000) with males having better access. The gender-penalty, like the ethnic-penalty (Modood et al 1997) is not uniformly applied, and may be exacerbated for some groups (Kahn and Meehan, 1992), for example for Muslim women (Runnymede Trust 1997 in Carter 1999:66-67).

Carter et al (1999: 18-19) showed a positive correlation between fixed terms contracts and ethnicity affecting job security, career progression pathways or access to development in post (Powney et al 1997 in Carter et al, 1999:66). In nursing, fixed term contracts are a new phenomenon linked to a market-led provision of education based on securing contracts from both NHS and non-NHS

sectors. Racial discrimination was reported in relation to promotions, at application stage, and harassment in work (Carter et al, 1999: 38, 53). It was galling to discover a ten-fold increase to that reported by Modood et al (1997: 266-273) in reports of racial harassment at work. Discussants in Carter et al's survey believed that for ethnic minority academics to progress, they needed to be twice as good in every sphere of the work as white peers. As is evident from other literature (Mirza, 1992; Collinson et al, 1990), positive and negative stereotypes of different ethnic groups (Jenkins 1986:66; Cohen and Bains, 1988; Bonnett, 1993:66) leads to differential treatment of those ethnic groups without questioning the validity of the basis of those perceptions. The racial experiences and disadvantages of British minority academics are parallel to those of black American academics (Gregory, 1999; Sokoloff, 1992). The location of ethnic minorities in HE in terms of their concentration in the lower grades, mirrors the experiences of Black people in British society as a whole.

The above literature has established that there is a 500-year history of black people in Britain and that post Second World War, and that large-scale immigration was necessary to meet the labour shortages in industry and the public sector. Modood et al (1997) and Carter et al (1999) revealed that the ethnic penalty is an additional factor affecting the life chances of ethnic minorities. The focus on nursing career research showed that a disproportionate number of male white nurses get to the top of the nursing career ladder (Hunt 1991a, 1991b), and that black nurses are concentrated in the lower clinical grades (Beishon et al, 1995). I have established that to date there is no research examining (a) the

careers of leading black nurses in any part of the UK or in any discipline of the profession, (b) the social context the black nurses lived and worked in, and (c) processes adopted to negotiate social and professional structures. Therefore, the focus of my research will address a gap in nursing careers and the mobility of black people in nursing. Having examined the literature on nursing careers and black social mobility, I now move to discuss my research journey, beginning with the research strategy.

2.9. 'The Research Journey' – Moving From the Literature Review to Research Design

An assessment of research strategies employed in previous career research showed a preponderance of quantitative methods adopting postal or face-to-face survey. A trawl of the different research approaches revealed that no single method would provide the range of data required to address the research questions. The methods considered included: a postal or administered survey requiring respondents to write in detailed responses; a comparative study of white and black nurses working at the same level in practice, education, management, policy development or research; a case study approach using a single case of the most senior black nurse in the country; a life history approach, or a combination of approaches.

The most appropriate approach identified for this research was the biographical - oral history approach rooted in social history to enable the career processes and

social changes to be documented (Chamberlayne et al 2000:2) and to provide a holistic approach centred on the subjects knowledge, experiences and feelings. A focus on biography helps us to understand the history of society (Mills, 1959:3) by allowing the analysis of the interplay between the person and society so that the individual can understand their own experience, know the factors that helped to shape that experience through reference to the history of that period. In so doing, the individual becomes cognisant of the experience of others in similar circumstances, and can visualise their own trajectory against that broader tapestry. Biography possesses the capacity to shift from the personal perspective to a societal one, whereby relational aspects of personal actions, context and empirical evidence can be examined to illuminate the phenomenon (Mills, 1959: 3-7) by mapping individual biographies to changing social structures.

The account of the empirical work explains the rationale for adopting a mixed methods approach in which **narrative life history** emerged as the central research approach supported by respondents' biographical data and literature; and then details the **3 phases of empirical work** including **data management.** Although the account is presented in a linear way, the actual process was dynamic and much more fluid, with research stages blurring into each other. An integral aspect of this account is my reflection-on-the research process illustrating personal dilemmas experienced in relation to 'presentation of self' both as a female and as a Kenyan-Indian, Health Visitor-researcher-teacher, interviewing respondents of similar background. My personal status passage through the research process raised awareness and

heightened sensitivity about the every day experiences of black people in one major

sector of employment.

2.10. Research Paradigm

In the study of labour markets, 'careers' are often a central concern for many men

and a growing number of women's life strategies (Super, 1957; Hardy 1983, 1986a,

1986b; Bradby, 1990). Career trajectories encapsulate social mobility, life

experiences, self-identity, intra and inter-group relationships, opportunities accessed

and decisions taken along the route. In order to understand the careers of black

nurses in leadership positions it is essential to do so through the respondents' own

perspective (Strauss and Corbin, 1990; Chamberlayne et al, 2000) rather than

evaluating their careers against the achievements of white nurses in the UK.

The nature of the research questions (detailed in Chapter 1) lend themselves to a

qualitative approach seeking data which is person centred allowing one to capture

and understand peoples' personal experience (Bornat et al, 2000), within social

structural changes (Chamberlayne et al, 2000: 322). This research is essentially in

the interpretive-naturalistic paradigm with people as the central focus of the account.

The emphasis is on generating data to provide descriptions to illuminate the plurality

of their social lives, its meanings or characteristics in three ways: by demonstrating

cases, comparing and contrasting cases, or combining cases as a component of

describing and interpreting data (Noblitt and Engel, 1991). Therefore, the main

empirical phase draws on the **oral history or life history traditions** of qualitative

research to understand and discover the respondents lived career experiences

(Chamberlayne et al, 2000). The principal reasons why life history is important to

this research are that: it avoids reducing or interpreting the black nurses career

experiences in order to fit them into the context of white nurses' experiences or

prevailing European or western career theories; and it allows for interpretation of the

data in the context in which it was collected (Woodhouse, 1992), so that the reader is

permitted to vicariously experience and understand the black nurses meanings of

negotiating their careers (Denzin, 1989).

2.10.1. Life History

Use of life history, derived from the symbolic interactionist theory (Minichiello et

al, 1990; Streubert and Carpenter, 1995) is an established anthropological

approach, contextualised to the time frame of the story, its audience and data

selectivity apropos what is revealed or presented by the participant or omitted

from the research report. Every life history contains a perspective on time - past,

present and future (Bellaby, 1991), as the current self is rooted in the past, thus

the past is rooted in the present. Three theoretical assumptions common to life

history research and symbolic interactionism (Minichiello et al, 1990:152) are that

life history is viewed as a concrete experience occurring within frameworks of

lives of others and is not separate from life in general, thus it cannot be isolated

from philosophical, sociological and conceptual issues of biographical data and

constraining socio-politico-economic domains. It is considered as an ever emerging relativistic perspective (Bellaby, 1991), composed from varied perspectives or for different purposes which shape or constrain its composition, therefore many accounts may be given of the same experience. As humans experience reality through discussion and conceptualisation, their perceptions may alter in relation to ones subsequent experiences of the same phenomena.

Traditionally life history has focused on marginal social groups (Minichiello et al, 1990) and is appropriate for studying sensitive subjects such as racial discrimination, personal agency; understand perceptions about structures, barriers and processes (Pooley and Turnbull, 1998). Certainly within nursing, black nurses can be viewed as a marginal group. The subjectivity of life history illustrates encounters between self, society and life course (Bellaby, 1991:20-21). Traditionally, historians used life history to obtain personal and local histories of events that would otherwise be lost (Caunce, 1994; Chamberlayne et al, 2000). It is also a recognised vehicle for recording life events as a linear personal history or autobiography. More recently, the scope of life history has been extended to other fields, for example life and work history (Dex, 1991); labour markets and industrial structures in women's working lives (Walby 1991); social mobility (Bertaux, 1991); women's studies (Cotterill and Letherby, 1993); and experience of health (Woodhouse, 1992). The success of life history is dependent on the researcher-respondent relationship and rapport (Caunce, 1994).

Within life history researchers may choose to focus on either the complete life story to derive local theory that is specific to the data set being studied or the topical life history that is concerned with a particular phase in the individual's life relating to the research focus (Streubert and Carpenter, 1995). Selection of respondents is critical to gain an appreciation of the events surrounding the phenomena (Streubert and Carpenter, 1995). Therefore the researcher has responsibility for assessing and soliciting potential respondents for narratives, which in turn will illustrate the phenomena under examination (Streubert and Carpenter, 1995; Minichiello et al, 1990; Woodhouse, 1992). Within this study, multiple cases have been studied: the case being defined as the individual respondent providing the story, to increase researcher understanding alongside focussing on the career as the particular phase of the individual's life. Individuals selected for participation in this research are an elite group by virtue of being considered leaders in their discipline of nursing, and at the same time they are also marginalised within society through their membership of an ethnic minority group.

Normally, the multiple case approach requires the stories to be edited thereby making them less detailed but continue to provide for abstraction of common themes between cases (Armstrong, 1987). This raises two fundamental issues related to ensuring that the process of editing does not sanitise the stories to the point that they lose their essence and the need to protect the identity of research respondents who by virtue of being an elite group may be easily identifiable. Normally, the maximum sample size for life history approach is between 5 and 6 individuals involving a series of in-depth, unstructured but focused interviews lasting 2 - 3 hours at a time,

over a period of time. Literature does not clarify if interview for topical life history should involve a single or multiple respondent-researcher contact. A single respondent-researcher contact was the standard approach for this research except that I negotiated to maintain telephone contact to clarify issues or conduct a 'top up interview' if the respondent's job changed radically during the course of the research. It is evident that researchers, (for example Hardy 1983, 1986a, 1986b; White et al, 1992; Marshall, 1984; Dex, 1991) have employed a combination of data collection strategies in life history research without any apparent compromise to the qualitative approach. Dex (1991) confirmed the use of topical life history obtained through either un/structured questionnaire, in-depth interviews and curriculum vitae, to uncover how an individual's actions are reflected in their life history.

Life history recognises the overlap in the chronology between individual's lives and other structures, for example political, social and institutional, and between related individuals. Where recall of data is obtained by oral methods as for in-depth interviewing, there is a good chance of 'recall error' that is greater the further back in time the respondent is asked to go (Dex, 1991). Dex cites the work of Himmelweil (1991:6), who found that the degree of accuracy of recall varied with the effort of re-construction required, its social desirability and association with success. For example, key life events, such as marriage, birth of children, first 'proper' job are remembered with a better degree of accuracy because they are an aspect of the status passage from one role or phase of life to another. In contrast, the events that are more detailed in nature such as reasons why an individual changed jobs when they did are subject to greater degree of error recall. It is also likely that

each time the story is told and re-told there may be a shift linked to new meanings from the insights gained. Quality of data recall can be improved by adopting simple strategies such as ordering of themes, for example going from the general to the specific, so that the story starts with the easiest part and works towards the more complex. A method adopted for this research was the 'bounded recall approach' whereby respondents were asked to use their curriculum vitae to talk me through their career. Though this approach loses some of the spontaneity of the personally constructed story, the oration is linear just as it normally is in autobiography. It was anticipated that agreement to participate in the research and a request for written biographical data would prompt the respondent to reflect on specific aspects of their career journey in preparation for sharing it with me (Cottrill and Letherby, 1993).

Data analysis can focus either on the external factors respondents refer to or on the internal perspectives from which they view the facts (Bellaby, 1991). Both foci were important in this research. In the absence of documentary evidence to verify, corroborate or refute individual data sets, multiple cases of life history were considered to be a more accurate means of triangulation of data at a macro level. Triangulation was assisted by cross-validation of respondents accounts covering the same ground, thus allowing for stories and emergent theories to be tested against each other (Denzin, 1989). The purpose of using a multiple case approach was to acquire different viewpoints of the 'same reality' of nursing careers of black nurses, so as to construct and complete a panorama and reveal the diversity of perspectives of the accounts being constructed (Bellaby, 1991)

2.11. Research Design

This study was structured in three phases: Phase 1 was conducted over six months during mid-1992; whereas Phases 2 and 3 lasted three years from February 1993 to December 1995, and February 1995 to December 1997, respectively. The overlap between Phases 2 and 3 occurred mainly because my timetable for face-to-face interviews was dependant on respondent availability but also took account of cancelled or aborted interviews. Similarly, although December 1997 saw the completion of Phase 3 interviews, the period from January 1998 to July 2001 included follow-up contact with eight respondents (at their instigation), whose employment mobility had undergone a significant upward or downward change, for example, two individuals took ill-health retirement related to stress and depression.

Phase 1, was essentially of an exploratory nature to obtain data in the broadest terms to develop and refine a specific focus of the main empirical phase. It provided the opportunity for narrowing the focus by means of asking questions, developing-in-process answers, re-framing and asking new or modified questions again (Ely et al, 1991). The process of progressively focusing down on the research topic is directly correlated with the understanding that both research questions and answers must be discovered in the social situation being studied (Ely et al, 1991). Data collection strategies employed in each of the three phases of the study evolved during the research as a result of concurrent analysis and reading of literature and respondent feedback. The key similarities in all three phases of the research were (a) the use of the in-depth interview and a questionnaire or pro-forma to obtain person specific

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data and (b) accessing relevant literature to underpin concurrent data analysis. Phase 2 included two focus group interviews with invited audiences of black nurses.

The study was designed to ensure that the empirical work was guided by findings from each of the preceding phases. In Phase 1, ten selected nursing leaders, referred to as consultants were interviewed to establish the issues perceived as critical to their career progression. The single criterion guiding selection of a consultant was that each individual was in 'employment in the most senior tiers of nursing management, nursing practice, nurse education, nursing policy, or research and development'. Table 2.1 details the ethnic group, gender and posts of the consultants and shows that the field of nurse education was dominant.

Of the three dominant interview styles, unstructured interview was chosen because it offered greater potential to obtain in-depth data from respondents, and would facilitate going from the general to the specific. All interviews (in Phase 1) were audio taped, each being opened by a broad question **'can you take me through a journey of your nursing career from the point of entry to the present time so that I can understand how you shaped your career, the opportunities you accessed or refused?** The length of interviews varied from 1.5 to 2.5 hours. Data analysis identified a wide range of common themes ranging from demands from personal domestic considerations, necessity to identify their own professional development and education, opportunistic nature of centralising the practice domain, negative and positive employer organizations and personal qualities. Data were used to develop the research questions, guide the development

of the data collection instruments and identify literature, for example on 'race' and careers, gender and career, leadership and the labour market, to underpin the work in hand.

Table 2.1: Summary Of Consultants for Phase 1

Ethnic Group Of Respondent	Gender	Post Held
White	Female	Principal of College of Nursing and Midwifery
White	Female	Manager of nurse education contracts for a Regional Health Authority
White	Female	Chief Nurse, District Health Authority
White	Male	Director of Research, District Health Authority
African	Male	Dean - Faculty of Health
African	Male	Director of Nurse Education.
African	Female	Director of Midwifery Education.
African-Caribbean	Male	Head of Department: Mental Health
African-Caribbean	Female	Freelance Education - Management Consultant
African-Caribbean	Female	Adviser - Nursing Organisation.

2.12. Sampling

A major difficulty for this study was the absence of an appropriate sampling frame to identify black nurses in leadership positions. As ethnic monitoring by the NHS, the four National Boards of Nursing, UKCC, DoH, and Professional Nursing Organisations did not commence until the mid-1990s, three other strategies were employed to identify respondents. These included a letter in six nursing journals inviting readers to opt into the study; chain sampling by peer nomination; and a

trawl of the nursing press to identify black individuals in leadership position. Of the three approaches, chain sampling emerged as the best method because the other two did not yield sufficient nominations. Publication of my letter inviting readers to opt into the research brought twenty letters endorsing the research topic or offers to participate. Unfortunately seventeen offers were declined because the correspondents did not fulfil the minimum criterion set for inclusion; two subsequently declined to participate because they were not confident about remaining anonymous, leaving one for inclusion in the study. Trawling the nursing / health journals to help locate black nurses in leadership positions was equally unsatisfactory because all but one of the names were already known to me.

In the light of the above experiences, it was concluded that chain sampling would be the best option available to identify respondents. The term **'chain sampling'** was used in preference to **'snowball sampling'** to ensure that it. did not present respondents with problems associated with semantics or metaphoric interpretation; instead it emphasised and made explicit a connection between the nominator and nominee. In hindsight, it is acknowledged that I was over sensitive about the use of snowball sampling because of my own uncertainties. Chain sampling is a non-probability sampling method which does not accord 'units comprising the sample population' an equal chance of being selected. Non-probability samples bring into question generalisability of the findings of the research. The notion of peer nomination ties in with the belief that the names offered are held in high esteem by the nominator, however, the process is open to bias or potential abuse in that personal rivalries or jealousies may be played to. In the absence of a reliable and

relevant sampling frame, chain sampling was perceived to be appropriate for this study.

2.13. Respondent Selection for Phases 2 and 3

A total of 104 individuals of African, Caribbean and Asian origins were contacted: 50 during Phase 2 (34 female and 16 male) and 54 during Phase 3 (35 female and 19 male) of whom 88 participated in the research (34 in Phase 2 and 54 in Phase 3). At the planning stage of this research, I expected that Phase 2 would include a maximum of twenty respondents to allow development of the research design and data collection strategies. The process of refining the research strategy coincided with a large number of peer identifications pointing to new disciplines and broader geographical dispersal of respondents. It was evident that the respondent pool was larger and far more diverse than I had anticipated. At this point, I faced a dilemma: as I could never be certain if the narrative I was seeking would reveal processes and agency to the depth desired of the story, a decision was made to continue interviewing respondents subject to their level of employment being unique.

Respondents were employed in education management, practice and service management, education policy, policy development, research or consultancy. Of the 50 people contacted in Phase 2, eight did not meet the selection criterion in relation to employment, another eight declined to participate for personal reasons

expressed in terms of their painful struggle to get on in their career, threat of redundancy associated with mergers between Colleges of Nursing, the uniqueness of their job and personal profile increased the potential to be identified or they did not wish to commit the time required for the research. Recruitment of respondents began with a core group of Ward Managers or above level (or equivalent) who were known to me personally, who were then asked to identify others at a similar level. Nominations were normally linked to the nominator's professional sphere of practice domain or place of work. Nominators were asked to confirm that the source of nomination could be divulged, as I believed that knowing who had nominated the individual enhanced the chances of that person opting into the research; and furthermore it was courteous and ethically desirable to do so. Ten potential respondents were lost to the research either because the nominee's consent had not been obtained prior to my receiving the information or I was explicitly asked not to divulge the source of nomination. Selection took five key factors into account: ethnic group, employment grade, gender, domain or field of practice, and geographical location.

2.13.1. Respondents' Employment Grade

My original intention was to identify black nurses who were employed at the 'top of the organisational tree' in the NHS, Higher Education (HE), professional organisations such as the RCN, RCM, UNISON or CPHVA, ENB, DoH and private sector. For example, in HE, the 'Dean of the Nursing / Health School or Faculty'

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could be classified as being at the 'top of the organisational tree', whereas in the NHS, at the Health Authority level, the Chief Nurse would fit the descriptor. I realised very quickly, that not one black nurse met the criterion of being at the 'top of the organisation tree'. Therefore, I revised the criterion to include the assistant or deputy ranks of posts considered to be at the 'top of the organisational tree'. Again, it became obvious that there was a virtual absence of black nurses at this level. From a definitional perspective, the task of identifying black nurses at the 'top of the organisational tree' was made more onerous by the diverse titles and different grades of employment in different organizations. For example, in one NHS acute sector, the highest level of appointment was that of 'Director' whereas in another, the post was that of 'Chief Nurse', but their remits were virtually identical. In the absence of a reliable sampling frame, the lack of indicators from other researchers, for example Baxter (1988), the adoption of 'Grade G' as the minimum inclusion criterion was derived from Beishon et al's (1995) research.

The minimum inclusion criterion was reset to clinical grade H, from grade G, prior to the beginning of data collection on discovering that the potential numbers of Grade G exceeded 50 just within the inner London area. Also, if one accepts that the Ward Manager grade (otherwise referred to as ward sister or charge nurse), normally set at clinical grade G, has traditionally been associated as the minimum career grade from which the expert practitioner moved into nurse education, management or clinical specialism such as community nursing, then any meaningful career mobility should be assessed as being beyond that level. By setting the minimum inclusion criterion at grade H, individuals employed at clinical grade G, for example the Ward

Manager or Health Visitor or equivalent levels were excluded. However, discretion was exercised to ensure that individuals who were in unique, non-standard jobs not reflecting traditional clinical grading structure were not excluded. For example, one Regional Health Authority employed an educationist to prepare the employer side evidence for clinical re-grading appeals, while other health districts coined 'Special Projects Lead' as titles for new jobs which did not fit into recognisable portfolios. A new publication (NHS Leadership Centre, 2002:3, 10) supports my rationale for setting the minimum criterion for inclusion as grade H because it estimated that of the 9.3% of qualified ethnic minority nursing staff, 'perhaps 5% (were) at grade G, 4% at grade H and about 3% at grade I.'

2.13.2. Respondents' Ethnic Group

As stated earlier in this chapter, the definition of black was applied to distinguish 'nurses of colour' from white majority and white minority nurses. 'Nurses of colour' included individuals of African, African-Caribbean and Asian descent, from a vast geographical span that embodied a diverse cluster of cultures and people. There was some debate about the inclusion of Chinese people within the Asian group as the experience of Chinese professionals is more closely aligned to the white population than to ethnic minority groups (Modood et al, 1997). Potential difficulties of 'labelling' British born black respondents or those who were of mixed ethnic group were avoided by leaving such decisions to the respondent.

2.13.3. Geographical Context of the Research

The original intention to locate this research across Britain in order to ensure that a 100% sample was accessed was discarded due to lack of time and resources. Empirical work based on a single Regional Health Authority was also considered but rejected as unfeasible. Information from professional officers working within the four National Boards of Nursing, Midwifery and Health Visiting, revealed that very few black nurses were practising in Wales, Scotland and Ireland, but there was a sizeable number practising in English metropolitan areas. On the basis of this information a decision was taken to limit the research to England.

2.13.4. Gender and Age

Both gender and age were retained as free field elements to enhance inclusion in the study. As stated earlier, lack of ethnic monitoring data meant that there was no means of assessing the ratio of male and female black nurses, therefore any attempts to obtain a proportionally representative sample of male: female black nurses was not considered viable.

2.13.5. Domain and Field of practice

At a pragmatic level, nursing fields could be described in terms of their employment in the public, voluntary or independent sector; practice domain selected upon

centralisation of career, that is management, education, policy, research or practice; and domain specialism for example midwifery, community or mental health nursing. Due to lack of definitive data about the fields of employment of potential respondents, selection criterion per field was deliberately broad. Table 2.2 details examples of posts in the different settings and fields of nursing revealing a degree of similarity as well as differences between sectors.

Table 2.2: Examples of job titles used by three different domains of nursing

Examples of Posts in various settings		
Community setting	Acute care sector	Regions and Statutory Organisations
Management Team Leader Locality Manager Nursing Officer Senior Nursing Officer	Management Nursing Officer Senior Nursing Officer Unit Manager Project Manager	Management Nursing Officer Adviser for Ethnic Health Assistant to the Chief Nurse
Education Community Practice or Nu Teacher	Education Nurse Teacher / lecturer (includes unqualified status) Senior Tutor / Principal Lecturer Deputy / Director / Principal Nurse Education Dean / Head of Department	Education Professional Officer Education Adviser
Practice Team Leader Nurse Specialist Health Visitor Charge Nurse	Practice Clinical Nurse Specialists Nurse Adviser Matron Director of Nursing	Practice Regional Nurse Regional Nurse Specialist Regional Nurse Adviser
Consultancy Titles vary according to marketing strategy adopted by individual		
Research Titles vary according to employer organisation: Included, for example senior research fellow, Reader, professor, Director of Research		

2.14. Recruitment Process

Recruitment to the research study began with acquiring the name, brief profile, and contact details to assess the individual's potential for inclusion to the study. This was followed by telephone contact with each name to discuss the research. The initial telephonic dialogue was critical because it was the 'passport' to recruitment. As the process and content of that first conversation were the basis upon which potential recruits made decisions to participate or not participate, a checklist of issues was compiled (displayed in Table 2.3) to ensure standardisation of information to be shared with potential respondents. Presentation of self (Finch, 1984; Oakley, 1987) was an important factor in facilitating respondent recruitment especially in relation to professional affiliations and ethnic identities. Contacting and interviewing respondents from community nursing and or nurse education, was easier due to my familiarity and shared understandings about the disciplines. Initially, I felt uncomfortable approaching individuals from general nursing because I was not sufficiently familiar with the nature of their job, their job titles or the diversity in grade of employment. Interviewing female respondents was more spontaneous and less daunting than interviewing male respondents (Oakley, 1987). I found that many of the men presented their stories as a water tight series of events suggesting a highly planned career trajectory, yet their curriculum vitae clearly showed similarities with the trajectories taken by the women, for example the professional certificates gathered after initial registration. Also some of the men were almost reluctant to share that they had failed to be short listed or appointed on several occasions.

Table 2.3: Issues Addressed with Respondents during Initial Telephone Contact

Key issues for initial telephone contact	Detail of issues included per sub-theme
Reason for contacti individual	• Research topic • Purpose of research • Outline of research • Their potential contribution to the research respondent and gatekeeper • Issues of confidentiality and anonymity
Respondent contribution	• What is required of them apropos data collection (interview, questionnaire, curriculum vitae) • Time frame for data collection
Researcher details	• Ethnic group • Gender • Professional background and current post • Domain of practice • Funding for this study • Research supervisors and University
Future contact	• Contact details • Establish time frame and venue for data collection

2.15. Developing Data Collection Instruments and Piloting

Career concepts and relationships (Super, 1994; Hardy, 1983, 1986a, 1986b) informed the development of the original questionnaire and subsequent proforma used in this research. Data was sought in three fields: personal, career and, decisions and social influences on career development. Furthermore, questionnaire design was underpinned by theoretical principles advocated by Oppenheim (1992) and Boddy (1993) as its success is multi-factorial, being

dependant on the nature of questions (Newell, 1992; Oppenheim, 1992), its format and distribution mode. The original 38-item questionnaire was piloted with 6 respondents who provided invaluable feedback about its length, sequencing, clarity and sensitivity to personal questions such as information pertaining to education levels of parents and siblings. Feedback was used to edit and modify the questionnaire to a more acceptable format. Initially interviews followed receipt of the questionnaire but this was later reversed.

2.16. Data Collection for Phases 2 and 3

In Phase 2, data was collected using a **postal questionnaire** and followed up by **audio taped in-depth interview** to clarify information and explore in more depth issues raised by the respondent or by the data analysis process. Respondents were offered a copy of the transcript, a duplicate of the audio-tape/s, and/or a summary of the findings. All except four respondents opted for a summary of findings. Interviews served two purposes: an opportunity to clarify issues identified from the completed questionnaire and to solicit a full account of the individual's career journey. The ambience of the interview was a 'conversation style' to promote spontaneity and depth. Interview data were listened to and transcribed as soon after the interview as possible so that theoretical notes, observation commentary and my reflections could be captured when the information was 'fresh' in the memory, and in addition acted as a quality assurance mechanism to assess quality of the stories accessed. Questionnaire return and interviews were carefully monitored to maintain

the research momentum. As part of ongoing data analysis I became aware that there was much overlap between the data respondents furnished in the questionnaire and the interview itself. Though the strategy was useful as a means of cross validating information, it prompted a major re-evaluation and shift resulting in a reversal to the sequence of data collection whereby the interview preceded the collection of factual written data. Phase 3 of this research is the point from which precedence was given to the interview and the written data less prominence.

Pre-interview time was used to reiterate the purpose of the research, checking that the tape recorder was in working order, and to discuss the interview process. All respondents were told that they could go 'off record' if they wished. Mala, a Kenyan-Asian took the opportunity of going off record 23 times during the 3 hour interview, leaving a mere 17 minutes of data on tape and no interview notes to fall back on as each time she went 'off record', I was asked to put down my pencil to prevent me making notes.

2.17. Focus Group Discussions

Focus group discussions are commonly used in the fields of nursing social research (Krueger, 1994), education and psychology (Vaughn et al, 1996; Morgan, 1997) as they can serve multiple purposes by providing an opportunity to collect data, check assumptions, cross check data from multiple sources, verify and validate information, serve as a means of aiding analysis and instrument development or

assist with qualitative evaluation strategies such as fourth generation evaluation (Denzin and Lincoln, 1994: 89-90, 533). The skills of managing a focus group draw on traditional interview skills (Morgan, 1997). In the context of this research, the purpose of the focus group differed from the taken-for-granted purposes detailed above for three reasons: (a) essentially, it was seen as a way of bringing together influential black nurses to discuss with them the research focus and the reasons why it was needed, in the hope that they would assist in disseminating information to other black nurses; (b) to negotiate their co-operation in accessing potential respondents; and (c) I needed an opportunity to discuss with 'like minded people' any emergent problematic issues associated with the research, for example the use of the term black, as well as check my assumptions, and validate anecdotal information.

Two group sessions were conducted with an invited audience of black nurses, under the auspices of a professional organisation. The 'guest list' for each meeting was compiled and managed by the officer hosting the meetings. The invited audiences were female black nurses from the Greater London area; working at senior levels in different domains of nursing and as far as can be ascertained membership of the host organisation was not a pre-requisite. Thirteen individuals were present at the first meeting and twelve at the second one. At both meetings, I presented a short paper detailing the 'what, why and how' about the study prior to opening up the discussion to take questions from the floor or for me to raise any issues I needed the group's specific input with. At the first group, conducted prior to commencing data collection in Phase 2, three issues received the most attention: definition of key

terms, such as *'black and ethnic minority'* and *'leadership position'*, anonymity of participants, and research design with specific reference to the difficulties associated with sampling and data collection strategies.

At the second focus group, conducted six months after the first group and coincidentally into data collection for Phase 2, the presentation (as detailed above) was to a different group of black nurses but also included reference to the need to edit the questionnaire items to minimise the overlap with the interview. It was inevitable that this group wished to discuss the analysis or my tentative-findings to date. Both meetings were useful in terms of testing the ideas for the next stage of the research design and for obtaining names and contact details to follow up.

2.18. Interviewing Respondents'

All except two of the eighty-eight respondents agreed to be audio taped, and with the exception of two telephone interviews, all were face-to-face interviews. Post interview telephone contact was made with 16 respondents either to clarify issues or to 'test new emergent themes' with them in their capacity as critical scrutinisers.

Some of the venues selected by respondents for interview, for example the cafeteria in the employer organisation or foyer of a public building, can only be described as odd because they did not accord privacy or have any due regard for confidentiality. Rose (Barbadian) explained *'it is better we sit in an area in full view of everyone. It's the only way not to get quizzed about what I was being interviewed for'.* Bridget

(Sierra Leone) asked me to book into a particular bed and breakfast accommodation situated close to a busy trunk road to reduce the risk of being *'found out'* by nurse managers who were *'bullying, hounding and harassing'* her. Needless to say, the most demanding interviews were those conducted in public places where the acoustics were poor, there were constant distractions from a hub of conversation around us, interruptions by colleagues stopping by to greet us and constant scanning of the environment to check that it was safe to proceed with the dialogue. Data collection was problematic on other occasions too, especially when respondents had not negotiated total privacy with their colleagues. On six occasions the interview was abandoned and rescheduled for another day incurring further costs. The length of each interview varied from 2 to 4.5 hours. Ten respondents were interviewed more than once because of a substantial change in their career or personal experiences. A number of respondents, either by virtue of having completed their own PhD studies or their academic posts, adopted a 'critical examiner role' by questioning me about the conceptual and theoretical frameworks adopted for the research, findings to date, sampling mode, and so on.

Biographical data obtained by means of the specially designed proforma or curriculum vita supplied by respondents served to act as a cross check for the information and events cited in the interview. Other means of cross checking data were media information for example appointment of black nurses in leadership position - the classic ones being any appointments to professional organisations, Trust management boards, nursing boards; reportage of harassment and racism or the outcome of tribunals; and other pertinent literature.

2.19. Data Management

I transcribed each audiotape as soon after the interview as was possible. In the case of the two respondents who had refused permission for the interview to be audio taped, their interview notes were written up more fully, but care was taken to differentiate between the on-the-spot notes and the added detailed to avoid researcher bias especially in regard to recall. The reasons for undertaking transcribing myself lay in the sensitivity of the data collected, a wish to preserve respondent anonymity and the importance of listening to respondent stories to enhance the analysis.

Transcripts were read and re-read carefully and analytical notes made alongside. These extended to a range of notes pertaining to issues requiring clarification; similarities with or differences from findings in literature or other transcripts; questions being asked of the data; key words or concepts which were common to all scripts; and any exceptions in the data. The next stage of data management was searching for emergent patterns and concepts pointing to interpretations of experiences, for example racial experiences, personal agency, explanations and understanding of external and internal events which provided insights to the structures and processes the respondents were dealing with. The processes continued until all the transcripts had been analysed and then were revisited on three other occasions to ensure that important issues had not been missed out. On completion of the task, the emergent themes were formalised and returned for member checking to four randomly selected respondents who I refer to as scrutiners for checking.

Subsequently the themes formed the basis of this thesis.

2.20. Trustworthiness

Methods for assessing the rigor of research findings depend on the research paradigm adopted, for example positivist research paradigms apply four standard criteria of internal validity, external validity, reliability and objectivity to an inquiry (Denzin and Lincoln, 1994: 481). In contrast, the evaluation of qualitative research is more complex because (a) there are numerous approaches to select from, and (b) the belief that as qualitative research is concerned with describing, interpreting and understanding the meanings people attribute to their social world, it would be difficult to generalise or transfer to other contexts. Qualitative researchers accept that the social world is multi-faceted, and that its outcomes are based on the interaction of human agents (Cutliffe and McKenna, 1999) and that the essence of assessing the rigor of any qualitative research is to measure its truth-value.

The truth-value of this inquiry is embedded in gaining an understanding of actions, beliefs and values of the respondents frame of reference which is socially, historically, professionally and politically constructed. Throughout the conduct of this inquiry, I have endeavoured to examine the influences on data collection and the authenticity of findings by attending to questions such as the potential of introducing researcher bias, ensuring that member checks were made to assess representativeness of the data analysis and findings, and that the categories selected

for discussion grabbed the essence of the phenomenon under description. Hammersley (1992 in Cutliffe and McKenna, 1999) asserts that an account is valid or true if it represents accurately those features of the phenomena that it is intended to describe, explain or theorise.

Holloway and Wheeler (1996: 162) write that trustworthiness exists when findings of a qualitative inquiry represents reality, and its rigor can be demonstrated through the use of a design trail from the selection of the research design through to the analysis and presentation of the findings. Lincoln and Guba (1985) suggest that the criteria for establishing trustworthiness are: credibility, transferability, dependability and confirmability. The credibility of my research was improved through engaging with the research topic over a prolonged period to allow for the recruitment of suitable respondents as described in 2.13; peer debriefing with other researchers and supervisors through semi-formal presentations to generate debate and discussion; triangulation of data collection methods, data sources and theory; and member checks (Holloway and Wheeler, 1996: 164).

The credibility and trustworthiness of data and findings (Spradley, 1979; Brenner et al, 1995; Holstein and Gubrium, 1995; Lofland and Lofland, 1995) are dependent on the researcher remaining true to the data and presenting findings in a way that captures and reflects respondents' stories such that respondents can recognise their own biographies. Research conducted by a sole researcher is at risk of being interpreted from a narrow perspective, either because the researcher is not open to the breadth of data or is coming from a particular perspective. There is a possibility

that the earlier data sets were shaped by my line of questioning derived from the questionnaire data as issues that needed clarification. The reflective research log was a useful strategy for reflection-on-action, an activity that confirmed respondent feedback about the overlap between the information sought by the questionnaire and interview, steps were taken to minimise the degree of overlap. The process of checking and comparing interview data sets enabled me to assess if the respondent was playing to the gallery by emphasising the positive or negative aspects of their career or giving me information the individual perceived I wanted. Comparison of data sets revealed that the majority of information given was balanced, insightful, and detailed processes that were subsequently identified as bearing similarity to those described by other respondents.

As advocated by Lincoln and Guba (1985), a system of cross checking my interpretation of data and findings was built in by instituting member checks, that is allocating the task of critical reader to 4 respondents (referred to as scrutinisers). The scrutinisers were randomly selected from the pool of respondents, to check and analyse their own transcripts and another 2 anonymised scripts each, against my analytical and theoretical notes, findings and tentative conclusions. Member checking (Sandelowski, 1993: 4) is a technique that allows the individual to check that the evolving interpretations. Letting go of the data to others, especially in the raw stages made me feel extremely vulnerable on a personal level for fear of the data being assessed as too weak, irrelevant, not saying very much or saying what was already known. Feedback during Phase 2, enabled me to recognise that I avoided probing if the respondent was tearful or stated that it was too painful to dwell on the

issue leading to a review of the handling of the 'tears and anger spots' whereby the respondent was allowed time to regain control before returning to the topic. On completion of the thesis, I asked two respondents who had not previously acted as scrutinisers to read the thesis to check its authenticity and to see if they could recognise any respondents. Both indicated recognition of numerous interpretations as being their own or very similar to their own experiences. More importantly, neither individual matched the anonymised names to actual individuals. This feedback ameliorated anxiety associated with allowing respondents to read the whole thesis in relation to the authenticity of the findings and match of quotes with the theoretical discussion.

There were clear differences in the circumstances of data collection, for example experience of conducting biographical interviews strengthened the quality of the data (Miles and Huberman, 1994: 268). As stated earlier in this section, some data sets collected early in Phase 2 of the research were weaker because they lacked probing and I was over reliant on the questionnaire data. Opening the interview using the same trigger wording, audiotaping interviews and summarising key points of the interview with the respondent ensured consistency of the research processes. Data quality was also enhanced through triangulation: use of a reflective research diary to keep a check on researcher effects and biases; by getting feedback from respondents at the end of the interview and in respect of analysis undertaken; keeping a log of issues associated with my feelings and perceptions about the data I was being given; using multiple data sources; questioning if the stories were exaggerated or curtailed; revisiting the research questions and design to ensure that I

was not deviating from the original foci selected and by implementing coding checks. In addition, I recognise that the quotes presented in the text are segments of larger data sets (Sapsford and Jupp, 1996: 295-296) and that I had a responsibility to ensure that the material extrapolated reflected the story and was supported through theoretical triangulation. Care was taken to ensure that the quotes selected revealed accurate descriptions of respondent's experience/s and did not draw on the words of the articulate respondents alone. The wording of the quotes is unaltered, except on a few occasions where it has been necessary to add a word or two (always within parenthesis) to ensure syntactic accuracy.

The findings of this research are transferable to other contexts (Miles and Huberman, 1994: 279), principally to other black professional groups either on a population or case-to-case basis.

2.21. Ethical and Reflexive Considerations

Ethical issues are an integral component of the research process incorporating every phase, element included and decision/s taken throughout (Turner, 1997; Green-Powell, 1996; Mason, 1996; De Raeve, 1996; Stanley and Wise, 1993). As a Kenyan-Indian female in nurse education, researching the careers of black nurses raised ethical concerns for me that went beyond the standard issues of the individual's rights to dignity and privacy; informed consent, protection of human subjects from exploitation and harm and consequences included in a variety of

Codes of Conduct for Research by various professional groups (for example BSA, 1993; RCN, 1993; Beauchamp and Childress, 1989). While such codes are concerned with avoidances of certain actions and aspirations for a level of professional conduct to ensure that rights of others are respected, obligations fulfilled and augment benefits (Hammersley and Atkinson, 1995; Robson, 1993; Edwards and Talbot, 1994; Glesne and Peshkin, 1992); they do not protect the researcher from self-discovery. Additional ethical concerns relevant to my work were related to (a) how I, as Kenyan-Indian female in nurse-education would handle personal bias and research relationships, and (b) the epistemology that would be best suited to address the ethical issues of research focusing on 'race', ethnicity, class, oppression, women, men as a minority group in a female profession.

Obtaining topical life history, to a point constitutes an intrusion into private experiences (Ersser, 1996). For this research to proceed, I adopted the cardinal rule that the well-being of the respondent came before the interests of the research (Thomson et al, 1994:34), and yet I accepted that the emotionality of revisiting the career was likely to cause some respondents a degree of pain or they were likely to express frustrations and anger with themselves, peers or the employer organisation. Also, in the process of explaining what ones research is about and negotiating participation, I found myself alerting potential participants to some of the emotions experienced by previous respondents. In so doing, was I acting as an honest broker, or was I channelling the respondents to a certain way of thinking?

In the process of the research, I had to acknowledge that my lack of knowledge of

broader 'race' and gender issues in the labour market had affected the way I had perceived my own career and was now challenging me to review those experiences against the new knowledge. I felt there was a danger of seeing oppression or racial connotations when there were none. I was unable to shift my ethnic identity from that of 'Kenyan-Indian' to a 'black person', but I did acknowledge the intersection of social structures, ethnicity and gender in my life chances. Handling personal bias (Green-Powell, 1996), for example non-recognition of the racialisation of the everyday life experiences of black people was a discovery of my personal journey of this research. I felt traumatised by the degree of the daily racisms experienced by some respondents. There were other contradictions in term, for example not wishing to distress the respondent but wanting them to reveal their story; accepting that respondent identities would have to be concealed but also wishing to allow the reader of this thesis to access as much 'un-sanitised data' as possible. Thus when one of the scrutiners recognised one respondent from the narrative, I felt devastated, believing that I had let the individual down. In hindsight, I should have been prepared for this because the social world of black nurses is small and it was inevitable that some aspects of their lives would be in the public domain.

2.22. Reflexivity

The direct interface between the respondents and myself occurred at three points, that is as an initial telephone contact to discuss the research and negotiate participation, followed by mailed documentation, and finally a face-to-face

interview. In contrast, the indirect interface continued through the processes of data management and writing up when I was either analysing data from the questionnaires and transcripts or listening to the audio taped interviews. Interview data was accessed in three formats: as field notes written during or immediately after the interview, typed transcripts and as subsequent playback of the audiotapes to select quotes for inclusion in the thesis.

In 2.21. I acknowledged that I felt traumatised by the degree of racism experienced by some respondents. On reflection my emotional responses were not solely related to the level of discrimination experienced by the respondents but also due to the vivid detail and the visual display of their anger, pain, sorrow and bitterness towards the systems and / or individual perpetrators. On four occasions I was so concerned about the emotional state of the respondent that I stayed with the person until she / he was composed and then instinctively kept in telephone contact with the individual for the next few days. The content of these telephone conversations was excluded from research data.

I had anticipated that when I listened to the audiotapes post-interview, my research training would ensure that I would be objective and clinically detached about the data given to me. Instead, I found that the multiple exposures to hearing respondent voices, often raw with regret, anger and pain caused me to become very angry on their behalf. On more than one occasion I considered writing to the national broadsheets to expose the racism in nursing, an action that would have had disastrous affect on my integrity as a researcher. In fact the process of reflection on

this issue led directly to focussing on the strategies adopted by respondents to manage their personal situations.

During Phase 2 of the research I questioned whether my own colonial history, of being born and raised in Kenya, affected the way I which I interacted with black African respondents and / or impacted on data analysis. For example, was I more in tune with Kenyan-Asian respondents because of the ethnic match between us or was there a greater affinity between female respondents and I? In the event none of these concerns mattered probably because I identified with the respondents on a professional level, an aspect that was critical in understanding their career histories. Having said this, while I was immersed in the writing up of the thesis, I found that I became extremely sensitised to the needs of respondents who had either left the profession for ill-health reasons or had experienced long term sickness during their career, because I was recently diagnosed with a chronic health problem.

In addition to the discussion in 2.20, it is important that I clarify that the process of selecting quotes for inclusion in the thesis was guided by two principles. The first principle being that respondent identity was to be protected, therefore extreme cases were excluded as these were more likely to lead to identification, and the second principle being that the quote selected needed to speak for a cluster of respondents with similar experiences.

2.23. Conclusion

In the first half of this chapter, I showed that the definitions of terms such as "race" and ethnicity are complex, and normally apply to demonstrate difference between the dominant group and others, and the terms have developed as a measure of ability and competency. The stereotype of black people as lazy and mentally slow has served as a barrier to social mobility. Discussion demonstrated that the arrival of black people post Second World War was intrinsically linked to labour market shortages in Britain, especially those in the NHS, public sector and industry. The original location of the majority of black people in the unskilled and semi-skilled sectors of the British labour market helped to ensure that a cheap source of labour was available and manufacturing costs were kept down. Fifty years on, Modood et al (1997) argue that intra-ethnic and inter-ethnic group differences in the experience of social mobility are linked to the commonalities and differences between groups in relation to access to higher education, qualifications, racial discrimination in the work place and access to opportunities per se. In effect, the literature has shown that the structuralist theories of disadvantage have been partly modified by a more detailed examination of the intersection of structures and processes by Modood et al (1997).

In the second part of this chapter, I have explained my rationale for selecting biography as the research strategy to allow the capture of the personal experience against the social and political milieu of the period. I have provided detail of my research journey and decisions during it to demonstrate reflexivity and ethical

conduct. The remainder of the thesis will now focus on the findings of the research to provide an integral account by drawing on respondent data. Chapter 3 focuses on the social construction of British Nursing and the contribution of black people to the NHS, so as to understand respondents' experiences, the structures they were required to negotiate and individual processes used. Chapters 4 and 5 will address the ethnic influences on nursing as a career in relation to cultural receptivity to it, and influences on career decisions. Consideration will be given to cultural capital as abilities and assets to support career development and achievement. This leads into the debate about black nurses experiences (Chapter 6) from entry to the centralization of practice domain incorporating examination of standard and non-standard entry to nursing, the drivers for acquiring professional and academic qualifications, access to resources. In Chapter 7, the debate moves to examining the reasons why respondents became careerists and the agencies mobilized to assist them in that quest. Lastly, I shall examine (Chapter 8) the political, social and personal significance of being at the top.

CHAPTER 3

THE SOCIAL CONSTRUCTION OF BRITISH

NURSING – BARRIERS AND OPORTUNITIES FOR

BLACK PEOPLE

3.1. Introduction

Nursing is an integral part of the fabric of British society by virtue of its state

provision, organisation and regulation to ensure fitness for practice. People's

experiences in their chosen occupation or profession are a reflection of their lives

in the broader society, for example their position in'society, status, the resources

and opportunities available to them, their relationships with the majority culture

and the constraints on their lives. Therefore the career experiences of black nurses

need to be seen as an integral part of nursing and social structures. Before

focusing on respondent biographies, we need to know the social structures they

came into, worked in, and negotiated their career through by describing,

explaining and understanding the organisation and structures shaping nursing,

nursing careers and the social context in which British nurses working lives are

lived. Only then can we understand the processes and the ways the respondent's

personal agency was effected.

In the context of this research, agency equates with actions at an individual and or

collective level, 'to determine ones own destiny' (Wicks, 1998:16), through

resistance to negative power at specific levels, by challenging the status quo in that organisation, peer group, within client-nurse or doctor-nurse relationships, to assist release from oppression, victimisation, discrimination, restrictions and limitations imposed. In research terms employment of health service staff including that of minority staff has not featured as an important research topic, nevertheless there is literature on generic employment issues such as the opportunities and discrimination experienced by women employees in the NHS (Davies and Rosser, 1986; Chiplin and Greig, 1986), black people in the NHS (Doyal et al, 1981), overseas doctors (Smith, 1980; Coker, 2001), and nursing (Ball et al, 1995; Dixon et al, 1994; Caines and Hammond, 1996; Buchan et al, 1998). Nursing's invisibility in career research underlies its subordination to the medical profession and managerialism (Carpenter, 1993:95).

This chapter addresses four inter-related key themes considered to be pivotal themes for answering the fundamental research questions and underpinning discussion in subsequent chapters in relation to: the career choices in post-Second World War Britain and professionalisation of nursing; the structural changes to nursing over a 50 year period including the reasons why nursing is a dual labour market; and the social context of nursing, to examine their segmented position in nursing and their contribution to the NHS.

3.2. Career Choices

In this section I shall demonstrate that the structures, namely labour markets, gender, socio-economic status, and the individual agency of actions and decisions, shape career choices. Human beings have a strong need to feel secure, safe, accepted, and have their physiological needs met (Lauffer, 1985: 11-35) because self respect is tied in with personal esteem, desire and need for growth to achieve their potential (McClelland in Lauffer, 1985:25). Such desires, expectancy to achieve, or quest for power, are not innate but learnt behaviours, shaped by socialisation, social values associated with their class location, social capital (Fine, 2001), and observation of others. One western model of achievement in life is by 'doing better than ones parents' (Rosenberg, 1957; Super, 1957, 1963, 1994), normally through investment in further or professional education, as evidenced by inter-generational class mobility.

An individual's occupational decisions have important implications for their future life activity and satisfaction, and have their agency in social structures. For example, the intersection of education, social class and gender, influence access to resources, knowledge of and opportunities, such as knowledge of occupational alternatives (Holland, 1994). Career decisions taken prior to leaving school (ages 16-18) equate with a period when most individuals are unclear about their own talents (Rosenberg, 1957) and are guessing about the sort of skills an occupation needs or that society will need when they enter the labour market. It is contended that occupational alternatives are bounded by the structures of gender, ethnicity,

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religion and culture (Grossman and Northcrop, 1993:157); education level including subjects studied social status and social knowledge of the occupation, and personal reality factors centring on individual's physical and mental capacity. From a structural perspective, compulsory education qualifications have a huge impact on career opportunity in relation to accessing further education and training, for example inability to meet entry requirements may either bar entry or require the deficit to be remedied via other strategies such as specially designed entrance tests or access courses. Decisions about work, specifically which employer organisation one works for, or opportunities pursued for personal development through education and training can be either limiting or provide growth in ones career (Krumboltz, 1994). Social structures influence personal agency through cognitive processes that retain or reject occupations. For example, it is unlikely that Brahmin women would entertain nursing because it is socially inappropriate for high caste Hindus (Somjee, 1991); or the desire to pursue protracted professional studies (Rosenberg, 1957) may be modified in recognition of insufficient family capital to support such a quest.

The critical 'push' factors in career decisions are the self-values, self and parental aspirations, and the long-term extrinsic reward values associated with its status. Super (1994) suggests that career decisions may seek to relate some specific aspect of childhood experiences by combining fantasy with subsequent occupational choice. For example playing doctors and nurses, a period of hospitalisation or voluntary work are activities that may assist to conceive medicine or nursing as important areas of work. If that occupation is selected, the

period in formal education for accreditation serves as the foundation for the realistic period, allowing the individual scope to explore the fit of the earlier decision. Super (1957, 1963, 1994) introduced the notion of a five stage developmental theory taking into account the individuals environment throughout life, their characteristics and capacity to be guided by others, maintaining that each of the five stages (growth, exploration, establishment, maintenance and decline) if successfully completed would lead to growth and the next stage. Super (1994) visualised career choice as a process of adjustment to the structures individuals were negotiating and working within. His third and fourth stages (establishment and maintenance) spanning forty years no longer fit the current rapidly changing economic and labour markets that are witness to second careers in mid life or concurrent careers (Golzen, 1988).

Gender roles in pre Second World War Britain, segregated the majority of women into unpaid domestic work or part time low paid work in sectors deemed as womens' work, with a minority who proceeded into professions and careers (Rowbotham, 1999; Dex, 1987; Walby, 1988, 1991), but the same structures allowed men to enter the worlds of work, education or professions according to their personal aspirations and socio-economic profiles. Thus, individual career decisions were circumscribed by social-economic structures, gender and the division of labour (Dex, 1985, 1987) and then adhered to for one's lifetime, normally with the individual remaining with the same employer with the purpose of achieving linear upward career progression.

After the Second World War, career opportunities were affected by structural changes in British society, namely the creation of the secondary modern and grammar school tiers of education enabling access to higher education for youth who were not public school educated; and a significant increase in white-collar work in new service industries such as the NHS, administration, insurance and sales. The education opportunities, expansion of the labour market and according to Rowbotham (1999) slum clearance, contributed to alter individual aspirations for lifetime chances such that previous patterns of work were altered radically. For example, an employee did not have to remain loyal to a single employer to achieve career progression but could do so using geographical mobility. At the same time, women were moving into light industries undertaking tasks requiring nimble fingers and dexterity, while those who were educationally mobile were moving into careers and professions, such as medicine, finance and teaching, which had previously been perceived as male domains.

From the 1980s onwards, there is evidence pointing to people making career changes to alternative sectors in mid life (age 35-45) reflecting changes in the contraction and growth of specific sectors of the labour market. For example, contraction in engineering resulted in a male Kenyan-Asian respondent to enter nursing as a second career. Career decisions, vertical or lateral, regardless of whether they are in the same or different organisations; alternative employment opportunities or self employment; are influenced by the relationship of personal aspirations about 'wants, rewards, social and technical environment, job satisfaction' (Krumboltz, 1994:77) and structures. The debate about the need for

specific career theory to replace conventional male orientated career theories (Gutek and Larwood, 1987; Diamond, 1987; Alimo-Metcalfe, 1993) has gained momentum because conventional theories do not adequately describe or explain women's careers, the differentials between men and women's careers or the impact of changing labour markets on individual careers.

3.3. Nursing as a Career

This section begins with a brief historical overview of nursing and then focuses on 'nursing as a career' for both men and women by taking into account the opportunities not/available by tracking the entry gate into nursing from 1948 to the present; and examining the opportunities and constraints for career development and progression in nursing alongside a changing labour market in the profession, as well as by gender.

From a historical perspective, nursing was a component of church or monastic life (Milligan, 1993) and prior to the Crimean War, the women of the household, usually through their servants tended to the sick and frail. The elevation of nursing as a middle class occupation came about with the State's requirement for nurse training to be established, a process completed after the Second World War. Post Second World War, male-nursing orderlies from the military hospitals, collectively won the right to train as general nurses (Milligan, 1993; Mackintosh, 1997:233; Davies, 1980; Dingwall et al, 1988), thus expanding the opportunities for men in nursing.

Similarly, the war experience of female nursing assistants was recognised by admitting them to the State Enrolled Nurse Roll (EN) of the General Nursing Council (GNC). The NHS, almost from the point of its inception, has employed a substantial multi-ethnic workforce mainly because of the diverse needs of the primary and secondary labour market sectors of the NHS. Wicks (1998: 128-129) challenged the notion of nurses' 'identity being tied up with being a nurse' by demonstrating that people drifted into nursing and that the notion of a strong desire to nurse was not based on innate traits but was a component of making connections between home, work and wider society. Wicks maintains that women in nursing is not about 'naturalism' or 'biological determinism (Wicks, 1998: 16-17) but a division of labour, a social relation through its social and historical connections with male dominance, patriarchy and women's subordination. In order to meet the labour needs, especially in laundry, portering, ward cleaning, catering, and nursing, black men and women were recruited from the New Commonwealth countries to supply the labour at a cost that was lower than employing indigenous people (Doyal, et al, 1981; Graham, 1997). Similarly, acute doctor shortages in the 1960s in general practice; mental health and geriatrics were met by overseas-qualified doctors, mainly from India and Pakistan (Gill, 2001).

In any examination of nursing careers, it has to be acknowledged that the depiction of the conventional nursing career as a vocation dominated by single women who made it their life's work, has changed (Davies, 1990; Davies and Conn, 1993) being radically refashioned by a series of structural changes associated with work force needs, social legislation and the nature of work combining to affect the recruitment

and retention of nurses. Structural changes in social legislation such as maternity rights for women and Equal Opportunities Legislation (Doorne-Huiskes, 1995) have allowed nurses to return to employment after childbearing, and supposedly removed the barriers affecting their access to professional development. The nature of nursing work has changed either as a response to efficiency demands such as early discharge schemes to increase the level of bed occupancy, or an expansion of professional roles typified by nurse led initiatives such as NHS Direct, requiring more flexible and creative patterns of employment (Davies, 1990; Davies and Conn, 1993) to ensure that the labour market needs can be met by a workforce prepared to the desired level of competency through skill mix. Alongside these developments, the contract culture linking local workforce planning to the business case has contributed to a reduction in the number of nurses being trained.

Historically, nurse recruitment and retention was a problem long before the creation of the NHS due to its low status, poor pay and long-unsociable working hours (Baly, 1995). More recently, recruitment and retention of nurses has been further affected by demographic factors related to a decrease in the number of people entering the labour market, increased competition from other professions for the same pool of recruits and the fact that nursing pay remains poor in comparison with other professions requiring a similar level of preparation. Between 1948 and 1970, Britain relied on the New Commonwealth countries to bail it out of nursing shortages by targeting black women into nursing (Hugman, 1991:173) and in essence reproduced black slave labour (Carby in Hugman, 1991; Graham, 1997).

A two-tier second wave of international nurse recruitment began during the 1990s in response to nursing shortages and education consortia contracts for nurse training. The first tier refers to the recruitment of qualified nurses, often from Third World countries, to ensure that staffing can be maintained at safe levels (Buchan, 2000, 2001; Kenny, 2001:5). The profession has not welcomed recruitment of overseas-qualified nurses on three counts: (a) it depletes the source country of a valuable asset, (b) the requirement for overseas nurses to have an individualised adaptation programme has led to exploitation of many of these nurses by unscrupulous employers, and (c) union concerns (Nursing Times, 2001:6) about the risk 'that jobs were being given to overseas recruits and not English qualifiers'. The second tier of international recruitment is for pre-registration nurse training, a strategy that allows education providers to meet their contractual obligations to the local (nurse) Education Consortia in the knowledge that this pool would make little difference to the nursing labour market as Home Office rules bar the overseas nurse from remaining in the UK post qualification. Two recent changes will affect overseas-qualifiers further: First, new DoH regulations (applicable from November 2001) mandate that only home (nursing) students or those meeting the three years residency requirement are eligible for a DoH bursary, thus excluding overseas students unless they are fee-paying; and second, the relaxation of Home Office Rules allowing overseas-qualifiers to apply for a job in the UK without having to leave the UK (Labour Party Conference: October 2001, BBC News 24 on 4th Oct 2001). In real terms, the losses of the first action will actually worsen the situation in three years time.

Literature on the relationship of the labour market with ethnic minorities (Bhavnani, 1994; Smith, 1980; Modood et al, 1997; Skellington, 1996) provides a partial explanation apropos the opportunities open to women related to social class, gender and education affecting employment opportunities. Genderisation of certain sectors of employment, for example women dominating clerical work (Davies and Rosser, 1986) and gravitation of men towards 'action and high tech' areas of Accident and Emergency or ITU nursing (Williams, 1989), adds to the complexity of differential outcomes, that serve to concentrate black people in a subsidiary level of the labour market (Modood et al, 1997). It is likely that 'black – white' power relationships with roots in the colonial past, have an implicit contribution to institutional racism.

3.4. Professionalisation of nursing

The debate about the status of nursing as an occupation, vocation, semi-profession or profession remains unresolved to an extent because although nursing meets the three classical pre requisites of a profession, that is provision for education and training leading to a formal qualification for practice, self regulation and controlled entry through registration, it continues to allow unqualified personnel to call themselves nurses and deliver care. A major criticism of nursing is that the body of knowledge underpinning the 'professional know-how' is of an applied nature, with its primary theory borrowed from other disciplines. However, it is argued that the process of professionalisation has ensured that the art and science of nursing is

underpinned by theoretical knowledge that allows the individual to function at a sophisticated and advanced level (Benner, 1984) using analytical and diagnostic skills. Nursing until recently, with the exception of midwifery and health visiting, has been very much doctor led.

As a career, nursing does not compare favorably with teaching, social work, medicine or other professions, in terms of status or remuneration potential. The status of nursing in the UK is not too dissimilar from countries such as India or Pakistan where nursing, regardless of the level of qualification is rated alongside hotel housekeeping (Somjee, 1991; French et al, 1994). However, nursing has provided women the opportunity to progress within it, potentially to the level of chief nursing officer for England, Scotland, Wales or Northern Ireland. Of the professions favoring womens' entry, for example, teaching, social work, nursing, medicine and professions allied to medicine (PAMs), the status of nursing is the lowest of all professional groups, a situation that has its roots in poor pay, low prestige, lower level exit qualification in comparison to the other professions, lack of defined career ladder, subordination to other professions and lack of opportunities to practice independently. A survey of 7,000 children in England for the Cooperative Insurance Society (Nursing Standard News, 2001b:5) revealed that nursing was out-ranked as a career choice by teaching, football, police and veterinary science.

3.5. Nursing as a Dual Labour Market

Nursing is a dual labour market having two sectors of employment: a primary sector of qualified personnel and a secondary lower paid sector of the unqualified nursing auxiliary with limited opportunity for progression (Hugman, 1991). Unlike other labour markets, its primary sector is a hybrid one being segregated further by four structures: (a) the level of pre-registration education which influences subsequent professional qualifications (b) the credentials associated with specialist and higher-level practice, (c) gender segregation and (d) ethnicity. I shall discuss each of these now:

3.5.1. Level of Nurse Training

In 1948, nurse training and nursing qualifications were delineated along two very distinct pathways leading to the award of State Enrolled Nurse (EN) or State Registered Nurse (RN), with each pathway having the scope for qualifications in mental health, mental subnormality and general nursing. Other differences between the two pathways included those of entry gate requirements, period of training, assessment modes and level of qualification. The crux of the differentiation between the EN and RN qualifications was that the former was and remains subordinate to the RN (Davies, 1995:108) because it was designed as 'an assistant to the RN', a tier that was above the nursing auxiliary but not equal to the RN (Hugman, 1991:153; Doyal et al, 1981). Furthermore, imposing strict criteria for conversion from EN to

RN controlled movement between the two levels of the qualified nurse.

3.5.2. Specialist Nursing Practice

The primary sector of nursing shows segregation by credentials. For example the

Post Registration Education and Practice Project (PREPP) (UKCC, 1990), made it

mandatory for the exit point of specialist practice community nursing courses (for

example in health visiting, district nursing, practice nursing, community childrens'

nursing) to be at graduate level from 1992. PREPP recommendations did not apply

to specialist practice in the acute sector. More recently, the UKCC standards for

teacher preparation (ENB and DoH, 2001) have introduced a postgraduate

qualification for nurse teachers and practice educators. Credentialisation via

mandates about the level of preparation for nurses wishing to practice in certain

disciplines is a source of inequalities in relation to who is admitted or who gets

resources (Davies, 1995; Hugman, 1991:157) to pursue their goals and aspirations.

3.5.3. Gender Segregation

Gender segregation is evident in the primary sector of the nursing labour market

within practice specialisms according to the male or female dominance of the

practice specialisms (Evans, 1997:228) associated with the gender traits. For

example, male nurses opt for ITU or accident and emergency care because of their

association with male characteristics, technical power and cool headedness; psychiatric nursing for physical strength and anaesthesiology for its technical power and autonomy (Evans, 1997; Wicks, 1998). In contrast, health visiting and midwifery are dominated by women for two reasons: orientation towards maternal care and the exclusion of men from these practice specialisms until recently, whereas female domination of practice nursing may be linked to work patterns to fit with child care needs. Dex (1987, 1991) and Davies and Rosser (1986) showed that breaks in employment are often associated with downward mobility into lower grade jobs that serve to keep women in segregated positions.

3.5.4. Ethnicity

Ethnicity emerged as a fragment of segregation of both the primary and secondary sectors as a direct consequence of the discriminatory recruitment practices of the NHS nurse training schools and employers. Ethnic minority nurses were channeled inappropriately into the EN pathways (Baxter, 1988; Hugman, 1991; Doyal et al, 1981; Mayor, 1996) by recruitment officers either by withholding information about the different levels of qualifications, misuse of the entry gate test or ad hoc decisions by admissions tutors. On qualification, both the ENs and RNs were channeled into the 'difficult to recruit to' Cinderella services of learning disabilities, mental health and general nursing (Davies, 1995:108), and in addition black RNs faced inordinate barriers to break into high status disciplines such as children's nursing, specialist practice and nurse education (Nazroo, 1997; Culley

and Mayor, 2001; Beishon et al, 1995). Segregation of ENs continues because of lack of opportunity for professional development (Beishon et al, 1995) which in turn affects the ENs ability to undertake diploma level academic studies; barriers to accessing conversion programmes (Nazroo, 1997) either because NHS employers have not invested sufficient resources to enable large scale conversion to occur, or the near retirement age of ENs. According to Manning and Ohri (in Hugman 1991:157) professionalisation through credentialisation perpetuated inequalities because power remained with white professionals. Davies (1995:29) maintains that British nursing includes all the hallmarks of gender, class and ethnic differences.

Examination of the dual labour market in nursing has shown that segregation between the primary and secondary sectors was emphasised by differentials associated with gender, level of pre-registration preparation and initial qualification, credentialisation and ethnicity, all having an adverse effect on the opportunities for black nurses due to the incremental effect of these factors. The nursing labour market has been continually shaped by two intersecting structures: events specific to the profession and those embracing British society.

In the next section I proceed to examine the structural changes in British nursing by focusing on key developments between 1948 – 2001 so as to understand the structures within which respondents operated and their impact on career opportunities or constraints.

3.6. The NHS 1948 - 2001

The creation of the NHS in 1948, made the State the dominant health care provider and employer, and at the same time permitted a cross sector provision of nursing between the State, the independent sector, the work place and the voluntary sector. From its inception, the NHS became the largest employer in Britain, offering uniform conditions of employment and pay structures for each staff group, with pay differentials and conditions of employment varying between staff groups. Much of the work in the NHS at both professional and support levels, for example nursing, cleaning, laundry and catering, can be aligned to domestic labour normally undertaken by women. It is argued that the very nature of roles accepted by society as domestic labour type work has permitted genderisation of those jobs. The majority of staff employed in the NHS with the exception of doctors, researchers and career 'general' managers is female. In the NHS, genderisation of work is linked to higher levels of employment of women in those fields which are also associated with lower remuneration, lack of opportunity and progress, low levels of value placed on access to training and education, and higher turn over of staff. Research (Davies and Rosser, 1986; Chiplin and Greig, 1986; Caines and Hammond, 1996) points to lack of opportunity to progress and institutional processes of discrimination preventing progress for women in the NHS.

Nursing remains a predominantly female profession, with an approximate ratio of 90% female to 10% male nurses (Carpenter, 1977a, 1977b; Nuttal, 1983; Hunt, 1991a, 1991b; Ratcliffe, 1996:390) compared with 3.1% in Canada and the US

(Evans, 1997:226). However, it is evident that a disproportionate number of male nurses reach leadership positions, for example, Nuttal (1983) found that 43.8% of Divisional Nursing Officers and 50.5% of Directors of Nurse Education were male (Hunt, 1991a, 1991b). In contrast, a recent report on the government-commissioned survey of 135 nurse consultants describes them as 'married white female' (Mulholland, 2001:11). Managerialism in the post-Salmon (Salmon, 1966) and post-Griffith (Griffiths, 1983) NHS has worked in favour of men primarily because the NHS became tied into masculine traits for its managers. A series of DoH reports by Dixon et al (1994), Ball et al (1995), Disken et al (1995) and Dixon (1996) confirm that the top nursing jobs are occupied by white males and females. The NHSME (1996) report showed that 50% of women had no children compared with 7% of male counterparts.

It is evident that structural changes resulted from key NHS reports (including Salmon, Hospital Plan and Griffiths Reports) and nursing reports (Platt Report; Project 2000; PREPP) (detailed in Table 3.1). Structural changes affecting nursing occurred on three levels: (a) its organisation, (b) Clinical Grading and (c) nurse education. Alongside these structural changes were other social changes, specifically the Immigration Acts and Race Relations Act that served to compound the impact on the recruitment and retention of black nurses. I shall discuss each of these aspects now:

3.6.1. Structural Changes to the Organisation Of Nursing

Structural changes affecting the organisation of nursing were triggered by the Salmon Report of 1966 (implemented in 1968) bringing functional management tiers to a more local level of departments or units; the Hospitals Plan (1962) leading to large district general hospitals being built to replace smaller ones in order to improve the services to patients and the Griffiths Report (1983) which introduced market principles, the internal market and management to the NHS (Baly, 1995; CRE 1992; Baly and Clark,1995; Cowie, 1995; Clark, 1995). Each of these key reports or developments either constrained or expanded the opportunities for career progression.

Before the implementation of the Salmon recommendations, the nursing management of General Hospitals was structured such that the matron was accountable to the Chief Medical Officer, and in the case of the Mental Hospital, the male charge nurse was directly accountable to the matron of the female side and not the chief medical officer. The matron had total control of 'her hospital' from the hiring and firing of nursing and domestic staff to dealing with disciplinary matters on behalf of the chief medical officer. Nursing continued to be organised in a hierarchical way, replicating tiers in each specialism so that management remained with same discipline nurses, until the Salmon recommendations of 1966, gave male nurses the opportunity into nurse management because male traits in management were perceived as more desirable (Carpenter, 1977a, 1977b). These recommendations changed the accountability pattern from those of a bounded local

hospital base to a district level and emphasised the hierarchical accountability to the management tier above them. For example, the ward sister grade reported to the Nursing Officer (NO) who was accountable to the Senior Nursing Office (SNO), who in turn reported to the next tier up and so on. As the Salmon Report was about rational management of nursing and not for services extraneous to it, it altered the scope of what, who and how much the nursing officers managed.

Table 3.2 shows the accountability patterns at three different points of nursing history. Nurses' gains in managerial careers were wiped out by the implementation of the Griffiths Reforms (Lorentzon, 1990:55-56) for two reasons: One 'Griffiths' separated professional authority from managerial authority, an action that led to the diminution of nurses managerial power, with managers taking charge over professional workers; and second the desired managerial style was that of industry. The Hospitals Plan of 1962 was a growth era for the NHS, bringing increased opportunity for employment in the NHS. Nevertheless, it brought deployment through closure of the smaller hospitals or there was a contraction for specific grades, for example, a reduction in the number of ward sister / charge nurse in employment. Parallel to the employment opportunities created by the Salmon Report and Hospitals Plan, the Immigration Acts of 1965 and 1968 (Citizens Advise Notes Service Trust, 2001) severely and systematically curtailed the recruitment of black nurses from the New Commonwealth countries. While literature (e.g. Phillips and Phillips, 1999) connects deterioration in race relations to Enoch Powell's 'Rivers of Blood' speech, its actual impact on nurse recruitment from the New Commonwealth countries cannot be separated from the restrictions imposed by the

Immigration Acts.

Table 3.1: Key Nursing Reports: their impact on nursing

KEY EVENT AND IMPACT ON NURSING
1940-1949 **1943:** The Nurses Act whereby the enrolled assistant nurse became subject to discipline of GNC. **1946:** National Health Service Act. **1947:** Nursing shortages: Recruitment from Africa, Asia and West Indies **1948:** NHS created. **1949:** Nurses Act: (a) Students left legally as employees. (b) Separate registers for male nurses and fever nurses closed.
1960-1969 **1962:** Hospital Plan launched. Huge investment in hospital building to replace smaller hospitals. **1963:** Evaluation of nursing by Commission on Higher Education which did not accept nurse education as being higher education. **1964:** Platt Report which recommended: (a) Raising entry level requirements to 5 O' levels, (b) Clear distinction between Register and Roll of nursing, (c) Reducing number of schools of nursing from 987 to 200, and (d) Students to stop being employees and be given full student status. **1965:** Salmon Report on Structure of Senior Staff in hospitals which recommended structural management into nursing. **1968:** Report No 60 on pay of nurses and midwives recommended implementation of nursing management structure as per the Salmon Report
1970-1979 **1970:** Briggs 'Committee on Nursing' set up. **1974:** Briggs report accepted by government and its recommendations subsequently forms the basis of nursing curricula for Project 2000. **1974:** Halsbury Report re-evaluated nursing and midwifery, increasing nurses pay by 30%. **1979:** Nurses Midwives and Health Visitors Act. UKCC established
1980-1989 **1983:** Griffiths Report – NHS Management Report. New managerialism – introduced general management principles to all levels. of units. Power and influence of nursing management transferred to general managers in 1984. Senior nurses eased out with very few nurses appointed as general managers. Nursing groups no longer managed by same profession managers. **1986:** UKCC published treatise on reform of nurse education. Project 2000 (P2K) nurse education reforms to commence in 1988. **1988:** Clinical grading whereby nurses salary were restructured and introduced clinical grades **1989:** UKCC published Post Registration Education and Practice Project report (PREPP) – generic recommendations.
1990-1999 **1991-92:** UKCC PREPP report for community nursing education introduced degree level specialist practice community nursing education. **1992:** CRE investigation into Clinical Nurse Grading found evidence of direct and indirect racism.

Sources: Baly (1995); CRE (1992); Baly and Clark (1995); Cowie (1995); Clark (1995).

1948	1966	2001
Matron	Matron	Chief Nurse - policy making function at local level - accountable to the Board of Directors. Does not have functional management responsibility for staff or service provision
Deputy Matron / Senior charge nurse [for mental hospital]- accountable to the matron	Senior Nursing Officer/s – accountable to the matron	Director of Nursing – accountable to the directorate executive.
Night Superintendent – accountable to the matron	Night Nursing Officer – accountable to the Senior nursing officer	Assistant Director of Nursing – accountable to the director of nursing
Night sister accountable to Night Superintendent.	Nursing Officer -accountable to the Senior nursing officer	Directorate / Service managers – accountable to the directorate executive
Ward Sister – accountable to the matron	Ward Sister / charge nurse / community district nurses and health visitors accountable to the nursing officer	G, H or I grade clinical nurse specialists - accountable to the service manager
Senior Staff nurse accountable to the ward sister	Senior Staff nurse accountable to the ward sister / charge nurse	H grade Community Practice teachers – accountable to the service / locality manager for the education role only and to the team leader for care delivery
Staff nurse accountable to the Senior staff nurse	Staff nurse accountable to the Senior staff nurse	G grade Team Leader / Charge Nurse / Ward Manager / community based team leaders – responsible for budget and people management, accountable to the service or locality or department manager.
3rd, 2nd and 1st student nurses accountable to the staff nurse / Senior staff nurse and ultimately to the ward sister	3rd, 2nd and 1st student nurses accountable to the staff nurse / Senior staff nurse and ultimately to the ward sister.	F grade nurse – accountable to the G grade.
Nursing auxiliary – accountable to the staff nurse or Senior staff nurse or 3rd year student nurse who was in charge of the ward	Nursing auxiliary – accountable to the staff nurse or Senior staff nurse or 3rd year student nurse who was in charge of the ward	E grade nurse – normally accountable to the G grade
	Ward clerks	D grade nurse [newly qualified] normally accountable to the G grade
		A and B grade Health Care Assistants normally accountable via the E or F grade to the G grade
		Student nurses normally accountable to the G grade via the mentor.
		NB: Clinical grades D-F also include ENs.

3.6.2. Clinical Grading

The government intended the 1988 Clinical Grading exercise to evaluate nursing with the sole purpose of re-classifying nursing staff according to the scope, responsibilities and skills of the job they were doing and then pay them accordingly. As a nurse, my interpretation was that the sub text of the exercise was intended to reduce the power of the Whitley Council as a negotiating body and introduce skill mix to underpin the deficit created by the implementation of Project 2000. Clinical grading had a disastrous effect on many ethnic minority nurses (Commission for Racial Equality (CRE), 1992) who were often down graded and concentrated in grades D, E and F. A CRE investigation found that the clinical grading exercise was inversely linked with ethnic minority nurses (CRE, 1992), that is, the lower the grade, the more ethnic minority nurses were found in that grade. A decade later, the appeals procedures were still in the process of trying to remedy incorrect grading issues for some of the ethnic minority nurses.

3.6.3. Nurse Training and Education

Between 1948 and 1998 nursing students operated within two systems: one being that of a salaried employee having duties, responsibilities and obligations associated with that status and second as 'student', a label that made little difference to them because they provided 90% service to the employer organisation. Nursing students undertook tasks and functions that were not fundamentally different to that of a

qualified nurse, with certain exceptions, for example, not administering opiates. The minimum generic entry requirements for nursing set in 1948 by the General Nursing Council (GNC) remained unchanged for thirty-nine years. A non-standard applicant, one who was unable to meet the entry requirements, was given the option to take the GNC entrance test designed to test literacy and numeracy skills (Baly, 1995). Having set the minimum entry requirements, the GNC permitted Schools of Nursing (SsON) to determine their own entry requirements if they so wished (Baly, 1995). The more prestigious and sought after SsON exceeded the minimum entry requirements specified by the GNC without experiencing any apparent adverse effect on recruitment from home students. Other SsON specifically those situated in outer London or in the 'country' experienced difficulty in recruiting adequate numbers from within the UK, therefore relied on Ireland and the former British Colonies in Asia, West Indies and Africa, for their recruitment.

Using 1948 as a starting point, it became apparent that concerns about nursing recruitment and retention had led to a series of government commissioned reports detailed in Table 3.1, for example, the 1943 and 1949 Nurses Acts, Commission on Higher Education in 1963, Platt in 1964, Briggs in 1974, Project 2000 in 1986 and the PREPP Report in 1990 (Baly, 1995). The essence of each of these key reports was an attempt to redress the recruitment and retention issues by changing the entry gate and structure of nurse education to bring nursing to a level on par with other professions. Unfortunately, for the profession, it either failed to convince the government of the day to accept and implement the recommendations of each of the reports fully, or the government deliberately obstructed the restructuring of nursing

and nurse education in accordance with the recommendations. The reasons for government obstruction were probably related to the potential cost of providing nursing care by a fully qualified workforce, and resistance from other more powerful professional groups, namely medicine who did not see the necessity for a better qualified nursing workforce. Another consideration was that the recruitment and retention crisis in nursing militated against any actions that may impact further on workforce requirements. Therefore what we find is that on one hand the government acknowledged concerns about nursing and at a great cost set up numerous commissions or committees to find remedies, but then failed to act on the recommendations of its own processes for the reasons described here. The failure of the Commission on Higher Education (in 1963) to recognise nursing as higher education probably did more damage to its status than any other events or reports.

The first structural change impacting on nurse education occurred in 1982, thirty-three years after the GNC first defined the entry gate, when the entry requirements were 'upped to' 5 GCE subjects for the RN pathway. I was unable to identify any literature reporting on the impact of this change on nurse recruitment. Six years later in 1988, the recommendations of the Project 2000 report (UKCC, 1986) triggered structural changes in the delivery, management and structure of nurse education. These recommendations had major ramifications for both the EN and RN qualifications because: (a) it led to the demise of the EN pathway, (b) restructured the RN qualifying route into four branches of Adult, Children, Mental Health and Learning Disability Nursing, (c) changed the level of the pre-registration nursing qualification from certificate level to an undergraduate diploma, (d) removed nurse

education from the NHS control into Higher Education (HE), and (e) gave nursing students a full student status. However, P2000 was not without its fundamental flaws, for example, the entry requirements of 5 GCSEs for an award of undergraduate diploma do not equip nursing students to met the demands of HE. Although a very small number of P2000 students come through the undergraduate route, the two levels of study, diploma and degree, segment the student body through differences in entry requirements; differentials in bursary entitlement whereby degree students are not eligible for a non-means tested bursary; different assessment modes and different exit qualifications. The level of the exit qualification does not have any bearing on the starting salary or clinical grading of the new qualifier. While P2000 has served to alter the level of the exit qualification, it has exacerbated the recruitment and retention issues in respect of a high failure and attrition rate associated with the entry gate; not providing an adequate level of educational support to students who do not possess advanced level school leaving qualifications. The insistence of the National Nursing Boards that the prescribed class and clinical teaching hours must be adhered to means that nursing students do not have the same freedoms that other undergraduate students take for granted. Iganski et el (1998) found that P2000 failed to make the profession more attractive to British ethnic minorities. In reality, there are fewer home-ethnic minority students applying for entry into nursing (Nursing Times, 1999a:8).

Two further structural changes to nurse education resulted from the implementation of Post-Registration Education and Practice Project (PREPP) requirements (UKCC, 1990) by mandating that the level of preparation for

specialist nursing practice (SNP) was at undergraduate degree level and all qualified staff were to have periodic refreshment for the purposes of re-registration. Resource issues impact on specialist nursing practice (SNP) education even before the commencement of SNP courses if applicants lack credentials to meet SNP course entry gate requirements. Resourcing periodic mandatory refreshment is a thorny issue for employers and employees alike in respect of staffing levels to enable study leave and responsibility for financing study leave and actual study. Anecdotal data indicates that fewer black students are successful in securing employer-secondment and a place in HE for specialist practice education.

The final structural change to nurse education was the incorporation of Schools of Nursing into Higher Education (ISNHE), an issue discussed in Chapter 2 as a component of the focus on ethnic minorities in higher education. ISNHE was a two-stage event, managed by the DoH via the Regional Health Authorities (RHAs). Stage 1 took the Schools of Nursing (SsON) into mergers with other schools, reducing the number of nurse education centers to just over 100 in England. The rationale being that the amassed student numbers became more attractive to HE and reduced overhead costs by rationalizing management tiers. Initially, it tied education contracts to specific geographical boundaries. Stage 2, the process of incorporation into HE, saw a further reduction of nurse education centers. At each stage of restructuring, personnel were likely to experience relocation, dislocation, disengagement, redundancy or a change in the working practices. Once ISNHE was established, it brought opportunities through

expansion of the nurse education market into multi-disciplinary education, broadened the scope of business by identifying niche markets and new work streams.

3.6.4. Nursing Fields and Growth of Specialisms

During the last 50 years, nursing has developed in complexity with a massive expansion of specialisms and levels of qualifications. Tables 3.3 and 3.4 provide an illustration of the developments in nursing from the original six areas of general nursing, mental nursing, mental subnormality, midwifery, sick children's nursing and community nursing in 1948 to a plethora of specialisms and qualifications in 2001, each with its own specialist preparation. For example, General Nursing was replaced by 'Adult Nursing', an ill fitting term coined as part of the Project 2000, incorporating a vast number of specialist areas such as cardiac, renal, trauma, respiratory care, and tissue viability.

In the last two decades, nursing specialisms have expanded rapidly in response to professionalisation, the scope of professional practice and extended role of the nurse. Growth of nursing specialisms has led to the creation of elite groups within nursing, for example clinical nurse specialists, consultant nurses, nurse practitioners and other specialisms such as specialist practice nurses have evolved virtually as specialisms within specialisms.

As specialisms emerge, they give rise to elite groups that in turn are associated with prestige, kudos, status, and are seen as measures of individual ability, achievement, leadership and power. Routes of membership to elite groups are both unclear and nebulous. It is postulated that membership is subject to having the right credentials viz a viz qualifications, appointment to a post at a particular level, visibility either at conferences or in the nursing press by way of contributing to the literature and debate, membership of regional or national policy making committees and invitations to speak as 'the expert' on the subject. Membership of an elite group is rarely associated with a recognised status passage marking entry, yet others recognise that membership to exist by virtue of the opportunities open to the member. Credentialisation as an entry gate to an elite group also serves to exclude certain groups of practitioners from membership.

Prior to the creation of the consultant nurse grade, nurse education was perceived as the elite group as nurse teachers brought higher-level clinical skills to the job and were mandated to qualify as teachers. Within nurse education, there is an elite group possessing higher degrees and doctorates that may be less visible but are recognisable by those with insider knowledge of nurse education. The elite in nurse education are those academics who are invited to act as consultants for curriculum development, selected as panel members for the Quality Assurance Agency's subject review or as members of the Research Assessment Exercise panel or invited by nursing boards to act as experts for curriculum validation processes. Within the elite nursing ranks, for example clinical nurse specialists (CNS), black nurses are almost absent unless they have been appointed as CNS for black health issues such

as haemoglobinopathies, mental health, or forensics. To date I have not identified

any literature on the appointment of black nurses as consultant nurses, but I was able

to locate them in senior management posts in nursing practice, education

management, nursing policy and research.

Table 3.3: Nursing Specialisms in 1948

General Nursing
(General nursing included sub-disciplines such as medical and surgical nursing) Fever, TB nursing, Orthopaedic Nursing, Ophthalmic nursing were qualifications that were subject to the individual being a registered nurse.
Sick Children's Nursing
Mental subnormality nursing
Mental Health
Midwifery
Community Nursing Health Visiting, District Nursing, School Nursing
Nurse Teaching Senior Tutor and Sister Tutor
Nurse Management Matron, Deputy Matron, Ward Sister

Adult Nursing: includes Specialist Nursing Practice in:
Renal , Cardio – thoracic, ITU / HDU, Transplant, Diabetes, Tissue viability, Elder care, Continence, HIV and AIDS, Sexual and Reproductive Health, Haemoglobinopathies, Asthma, Tuberculosis, Respiratory Care, Orthopaedic nursing, Ophthalmic nursing, Theatre / peri-operative care nursing
Children's Nursing Ambulatory care, Paediatric High Dependency Unit, Hospital at home scheme, Respite care
Learning Disabilities Single qualified or dual qualified as social worker
Mental Health Forensic, Elderly mentally infirm, Mother and baby, General mental health, Community mental health, Rapid Response mental health
Midwifery (provision for direct entry or post RN qualification) neonatal　. fertility assistance
Specialist Practice Community Nursing Health Visiting, District nursing, School Nursing, Occupational Health Nursing, Community Mental Health Nursing, Nursing in General Practice
Nurse Education Dean, Heads and Associate Heads of Department, Principal / Senior lecturers, Lecturers / Visiting Lecturers, Lecturer-Practitioners, Practice Educators
Nurse Management Chief Nursing Officer, Director of Nursing / Assistant Director of Nursing, Locality / Service Managers, Team Leaders / Ward managers

3.7. Social Context of British Nursing

One of the key themes of this chapter is the 'Social Context of British Nursing', which examines the social structures into which black people came to live and work. In this section, I consider the political climate shaping legislation such as the Race Relations and Immigration legislature, social events such as the race riots (Notting Hill), and the location of black people in the social system, as a precursor to debating how these structures affected their agency.

The social structure of any country is a reflection of the structural positions particular occupational groups hold within that society (Giddens, 1993). As previously discussed (in Chapter 2), the social mobility patterns of post Second World War Britain changed rapidly due to expansion of white collar work, a contraction in the manufacturing industries, increased number of women in work, home ownership and access to further education. Theoretically, career choices open to ethnic minorities entering the labour market should be the same as for the indigenous population, except that there are differentials over and above those of gender, education and social class (Sokoloff, 1992; Mirza, 1992; Modood et al, 1997; Carter et al, 1999). These differentials include entry qualifications (Modood et al, 1997), application of ethnic penalty (Modood et al, 1997) and direct/indirect racial discrimination (Modood et al, 1997; Torkington, 1985, 1987; Culley and Mayor, 2001). Research evidence (Coker, 2001; Esmail, 2001; CRE, 1988) confirmed that discrimination occurs at application, appointment and at promotion. It would seem that the more elite and prestigious the employment sector or grade,

the greater the level of discrimination (Modood et al, 1997; Carter et al, 1999; Coker, 2001).

Earlier in this chapter, I established that acute staff shortages in the NHS (nursing, medicine and support staff) led to government sponsored overseas recruitment (Coxall and Robins, 1998; Phillips and Phillips, 1999; Doyal et al, 1981). It is argued that economic migration was facilitated by the intersection of personal motivations with labour market opportunities or barriers in the source countries and the UK as destination country. Economic migration was enabled at five levels: **First** and perhaps the most critical factor for its promotion was the fact that in the period immediately after the Second World War, Britain was very concerned for its economic stability in the face of acute labour market shortages in low and hourly paid jobs. Labour shortages resulted from a combination of factors such as the number of war dead and injured, and emigration from the UK. The British governments concerns to protect its investments in the colonies and desire to keep the colonies white, encouraged economic-emigration via government sponsored schemes to Australia, Canada, New Zealand, Kenya, South Africa and Southern Rhodesia (Humphreys, 1994). At one point, more people emigrated to the 'old-white' colonies than migrated into the UK. For the Welfare State to expand and deliver government promises, its huge labour market needs for professional and non-professional grades of staff had to be met, but there was little scope to do so from the pool available in the UK because British men and women who had become socially mobile through the post war housing programmes and service industry employment were not interested in doing dirty jobs (Phillips and Phillips, 1999).

The concerns for the economy were such that it pushed the British Government to recruit labour from the colonies / former colonies to meet the labour shortages.

Secondly, economic migration out of the Caribbean was facilitated by two factors: for some there was the desire to cash in on their war service and return to the UK to put those skills to use and for others the limitation of employment opportunities in the newly independent countries (Phillips and Phillips, 1999) provided the impetus to seek overseas work. Phillips and Phillips (1999) note that economic migration from the Caribbean was a necessity borne out of domestic circumstances. **Third,** the loyalty of the commonwealth citizens to the 'British Motherland' (Phillips and Phillips, 1999) was predicated on the belief that the colony was an extension of Britain, a belief borne out by the fact that commonwealth citizenship gave them the same rights as the indigenous British (Coxall and Robins, 1998; Phillips and Phillips, 1999). Thus movement to the 'motherland' was welcomed as a means of employment, education or travel. **Fourth,** the replication of British education systems in British colonies ensured that colonial and British pupils studied identical syllabuses for identical school leaving qualifications. In theory, colonial students were judged to have equivalent education status that is until they began to compete for jobs that white indigenous people coveted. **Fifth,** the custom and practice of colonial times was for affluent or scholarship students to come to Britain for either part or all of their professional or graduate studies. In addition, Britain established some higher education facilities in selected colonies, for example teacher training in the West Indies and Kenya (Holden, 1991); nursing schools in Kenya, Nigeria, West Indies, Mauritius, India and Uganda (Holden, 1991); and medical schools in India

and Uganda (Holden and Littlewood, 1991) such that the qualifications awarded by these august institutes were recognised by the British institutes.

These five push and pull factors were events occurring in different parts of the world, in circumstances that were independent of each other, yet their synergy was crucial for Britain to overcome staff shortages in the NHS transport, foundries and manufacturing by relaxing the immigration rules to allow large scale migration into the country, and for the economic migrants to follow their goals. However, while the British Government applied stringent criteria to select intellectually bright white British people to emigrate to the old white colonies (Humphreys, 1994), they did not show any probity about the social conditions to which black people were being recruited, and nor did they make any effort to match migrants' skills and qualifications to the types of jobs available here. On arrival in Britain, many migrants found that their previous educational qualifications, training or experience were discounted and they were channelled into jobs for which they were over qualified (Doyal et al, 1981; Skellington, 1996; Alexander, 1999). The majority of West Indian men and women were recruited into lower grade jobs in factories, public transport, hospitals, steel works and mills, and nursing (Phillips and Phillips, 1999; Skellington, 1996; Alexander, 1999; Doyal et al, 1981).

3.8. Nursing Contribution Of Black And Ethnic Minorities To The NHS

The final theme of this chapter follows on from the above by examining the nursing contribution of black people in underpinning labour needs of the NHS against the structures shaping career opportunities and barriers to them. Doyal et al (1981), Alexander (1999) and Williams (1989) showed that black staff in the NHS provided a critical source of cheap labour that helped to keep the labour costs down, and permitted the post war expansion of the welfare state, for example, in 1981, 84% domestic staff, 33% of doctors and 20% of student nurses were black (Thomas and William in Ward 1993:170). Furthermore, the process of channelling and employing black people into support services, as ENs or nursing axillaries, was a reproduction of imperial relationships that continued to promote racialised division of labour from there on.

Other literature (Baxter 1997, 1988; Bharj, 1994; Davies, 1995:11; Mayor, 1996, 1998a; Bandoo, 1997; Thomas and William 1972in Ward, 1993) indicates that black nursing recruits irrespective of the country of origin were manoeuvred into the state enrolled nurse (EN) category of nurse training. Post qualifications, one-third of all black ENs were located in Cinderella services such as mental health, learning disabilities and elder care (Pearson, 1977 in Ward, 1993:170). There is no published literature to explain or justify why black recruits were channelled towards enrolled nursing except that the labour shortages in nursing required sufficient numbers of qualified staff to deliver care at the bed side and the 2 year EN training offered a

faster route towards getting a qualified workforce. If this hypothesis were to have credence then one would also expect to see a higher number of 'white recruits' channelled to the EN route. Alternative explanations for channelling black nurses into EN arise from the use of critical realism (Porter, 1993, 1995, 1996) that indicates that the perceptions of white people about blacks were based on historical myths and individual consciousness. Historically, white people through the narratives of colonial rulers, held stereotypical images of black people as not being capable or as being slow in the head (Smaje, 2000) – notions that were reinforced by government sponsored surveys of British employers. Thus in any discourse with or about blacks reflect their personal and collective beliefs replicating colonial oppression (Porter, 1993, 1995, 1996). From a financial perspective, the investment and time to train an EN was shorter by a year, a consideration that together with the collective consciousness that black people were mentally slow but capable of managing domestic work may have subconsciously prompted 'admissions officers' to channel black people into a shorter and less arduous level of nurse training, without acknowledging or being honest about the ramifications of their actions.

Racism in the health sector is not new. Alexander and Dewjee (1984) provided an account of the rejection of Mary Seacole, (a Jamaican doctress), who was better qualified and more experienced than Florence Nightingale, by Nightingale herself; Doyal et al (1981) documented the systemic racism and oppression of ethnic minority support staff; and more recently, institutional racism has been added to the list (Hugman, 1991:148; Esmail et al 1996; Nursing Times, 1999b:9; Alexander, 1999; Parish, 2000; Sawley 2001). An example of institutional racism in nursing

could be the 'discussion exercise' many SsON use as a measure for verbal fluency in English. The process, discussion topics and time allowed for individuals to lead the discussion favour UK educated applicants. In nursing institutional racism occurs at two levels: one being that of recruitment and selection of students and qualified staff, and job opportunities black nurses access; and second, the curricula with regard to what is taught, how difference is managed, the quality of clinical experiences accessed by black nursing students and their racial experiences (Sawley, 2001:33-35). Racial experiences refer to any 'happenings or events perpetrated by peers, health professionals and patients or their carers' because the individual is not white. Media coverage over a number of years has acknowledged that ethnic minorities in the police and armed forces, in education, media, law (Taylor, 2001), business (Dhaliwal, 1998), civil service (Chiplin and Greig, 1986); medicine (Smith, 1980; Gill, 2001; Esmail et al, 1996; Esmail, 2001), and ethnic minority graduates in engineering and pharmacy, are subjected to direct and indirect, institutional and non-institutional racisms. An MSF survey (Carvel, 2000) of performance related pay (PRP) awards worth £1300 for community nurses demonstrated inter-ethnic group differences between black and white and black and Asian community nurses, whereby black nurses were less likely to get PRP than the other two groups (5% compared with 14%).

As mentioned earlier, current nursing shortages have brought international recruitment into focus (Nursing Times, 2001:6), with one significant difference - that source countries in Africa, Asia and European Commission are being targeted for their qualified nursing workforce. The UK investment in providing adaptation

programmes for these nurses will be negligible in comparison to educating and training nurses for initial registration. It seems that once more, international recruitment (Martell, 2000:12-13; O'Dowd, 2001:8; Gulland, 2001:12-13) has become the panacea to manage nursing shortages without giving consideration to their post-adaptation programme professional development, career development requirements or strategies to combat racism. The majority of overseas recruits are concentrated in the lower clinical grades (D and E), suggesting that their employment patterns mimic those of black nurses (Beishon et al, 1995; Pudney and Shields, 1998; Hugman, 1991; Torkington, 1985).

The nursing contribution of black nurses can be tracked in every domain and discipline of nursing, midwifery and health visiting, however, they are absent in higher grade posts and elite areas of nursing, for example as Chief Nursing Officer or her deputy or consultant nurses. One attempt to try and redress the balance was the DoHs annual Mary Seacole Leadership Award for each of the ten years of the award, a strategy modelled on the US government doctoral programme for black nurses in the 1960s and 1970s (Morris and Wykle, 1994:177). But, unlike the US programme the British awards are not intended for fast tracking the Seacole Scholars in their chosen career fields. As long as the inverse relationship between promotion and senior level employment, and black nurses exists (Beishon et al, 1995; Pudney and Shields, 1998; Hugman, 1991), it is unlikely that nursing gain in recruiting from groups currently under represented in nursing (Iganski et al, 1998; Gulland 2000:13).

In comparison with education and social work, nursing has been treated differently by not receiving special government funding to employ black staff specifically to service the black community. The single exception to this omission was the jointly funded DOH and Save the Children Fund initiative, the 'Asian Mother and Baby Campaign' that employed bilingual link workers for a period of three years. A second initiative, one embracing all health professions was the Ethnic Health Unit, was also time limited and subject to tight monetary controls, was set up specifically to support ethnic health research projects with the aim of the work being mainstreamed by the end of the research funding. There is no evidence to suggest that these two ad hoc initiatives enabled ethnic minority nurses to enhance their careers.

3.9. Conclusion

In this chapter I have discussed a number of complex issues to demonstrate the intersection of structures and processes shaping the careers of black nurses. I have shown that while historically, recruitment and retention has always been a problem for nursing, the creation and expansion of the welfare state placed huge demands for labour, which could not be fulfilled by British people. Thus overseas recruitment was a phenomenon borne out of duality of need of source and destination countries, that is, the British need for a labour force and the migrants need for employment, professional qualifications and economic security. The dual opportunities for migration and acquisition of employment and/or professional

studies enabled the UK to obtain cheap labour. The over-representation of black people in the support sector, for example cleaning, catering, portering, laundry (Bhavnani, 1994; Modood et al, 1997, Doyal et al 1981; Skellington, 1996), lower grades of nursing (Beishon et al, 1995; Iganski et al, 1998; Finlayson and Nazroo, 1998; Buchan et al, 1998) and concentration in 'Cinderella services' such as geriatrics, mental health, reflects society's values and perceptions about nursing as a career, the role of black people, and replication of models of servitude developed in Britain's colonial past. We have seen evidence of sexism in the recruitment into nursing from the New Commonwealth countries by targeting black women into nursing (Hugman, 1991; Doyal et al, 1981), and employing them in lower paid work to save on labour costs without due regard for the welfare of Black nurses (Carby in Hugman, 1991; Graham, 1997; Doyal et al, 1981, CRE, 2000). It is clear that racism operated both at an institutional level, for example at the entry gate, and obstructing and controlling movement between the primary and secondary sectors (Doeringer and Piore in Hugman, 1991:150-151), and for promotion. The opportunities created by the expansion of nursing disciplines were negated by the entry gate requirements, which often-black nurses had difficulty meeting for lack of opportunity for professional development. Also, increasing professionalisation together with the restructuring of nurse education has served to reinforce the segmentation of black nurses at the lower rungs of the profession. This chapter underpins the discussion for Chapters 4, 5 and 6 which seek to understand the reasons why respondents selected nursing as a career, the structures they negotiated at the entry gate and the opportunities or constraints throughout their nursing careers.

CHAPTER 4:

ETHNIC IDENTITY AND CULTURAL

RECEPTIVITY: INFLUENCES ON NURSING AS A

CAREER CHOICE

4.1. Introduction

This chapter examines how membership and identification with an ethnic group

may influence respondents selecting nursing as a career to understand (a) how

these influences shaped individual actions, and (b) the context in which those

decisions were taken. We know that individual career choices are dependant on

one's gender, people's family's social class and its association with parental

occupation, education qualifications, the labour market opportunities and the

resources an individual can draw upon (Roberts, 1981; Super, 1994). We do not

know whether the reasons informing career decisions for those entering classical

professions such as medicine also apply generally to nursing. The interaction of

the 'push factors' in the colonies and the 'pull factors' in the UK that served to

assist overseas nurse recruitment (discussed in chapter 3) provides an insight

about the constraints of the local labour market and opportunities migration

offered, but it does not explain the reasons why black men and women chose

nursing or how their social milieu influenced their decisions.

In this chapter, some empirical data is presented as a means of understanding the black nurses' experiences. Respondent data are discussed at three different levels: data pertaining to the 88 respondents as a cohort, by ethnic group, that is African, African-Caribbean and Asian groups, and at an individual level. I begin this chapter by elaborating on respondents' perceptions of their ethnicity in relation to descriptors adopted in this thesis. Then I focus on 'cultural receptivity to nursing as a career' to examine how cultural attitudes influenced respondents perceptions about nursing, and why they chose nursing in preference to other career options. I was particularly interested to discover if perceptions about nursing as a career were affected by ethnicity, gender, and socio-economic status.

4.2. Respondents' Perceptions of Ethnic Identity

Definitions of ethnicity are pluralistic and open to interpretation at a variety of levels (Modood, 1994a, 1994b, 1994c; Luthra, 1997; Papadopoulos, in Baxter, 2001:45-47), being determined by how the individual wishes to present themselves with reference to their country of origin or emphasis on the language, religion and or class / caste / African-tribal systems. As previously discussed (in Chapter 2), the term ethnicity has its location in the ancient Greek 'ethnos' (Jenkins and Solomos, 1989:9) which broadly translated refers to people living and acting together, engaging in cultural practices in the belief that they are of

common descent, for the purposes of cultural differentiation and demonstrating cultural identity (Jenkins and Solomos, 1989:10). The values and beliefs of ethnic groups resonate similarities and differences at the inter-and-intra-group levels. Definitions of ethnicity based on the skin colour are political in origin (Mirza, 1997; Jenkins and Solomos, 1989), being dependent on the social consciousness of individuals in relation to how they think about themselves or others in terms of their difference from the dominant group.

In this study, geographical origin emerged as a primary descriptor of ethnicity by respondents, thus I have adopted those labels in this thesis. Within the African group, respondents described themselves as being West or South African. African-Caribbeans either described themselves as West Indian or by their island of origin. In some ways the Asian group was the more complex due to their geographical dispersal as they originated from India, Pakistan, Bangladesh, Uganda, Kenya and Tanzania, Mauritius, China, Hong Kong and Malaysia. Individuals, who were of mixed parentage, for example having both black and white parents, were asked to indicate the ethnic group they wished to be recorded for them. This strategy was not intended for the respondents to deny their heritage but allow them the freedom to choose and reflect the ethnic identity they felt most comfortable with. Definitional problems associated with the inclusion of the Chinese respondents who were not of Indian descent were resolved by the

respondents agreeing to be included in the Asian cohort rather than having a separate sub-cohort created for them.

By using respondents' country of origin as the single field of variation to determine ethnicity, intra-group diversity was evident with respondents originating from 26 different countries including the United Kingdom (UK). Table 4.1 shows that with the exception of Mauritius, which was a French colony, the countries of origin show a bias towards, what were at the time the respondents entered Britain, current or former British colonies.

Migration patterns of the Asian group out of the Indian sub-continent can be traced to employment opportunities that colonial rule offered and patterns of colonial indentured labour to East Africa, the West Indies and Dutch colonies (Visram, 1986; Peach, 1991). The ethnic heterogeneity of each of the 'African, African-Caribbean and Asian' respondents was problematic in so far that by using the three labels, it created clusters which could be viewed as being meaningless because intra-cohort differences would be lost altogether or diluted to such an extent that they may become invisible. However, the alternative approach of recognising up to 27 different ethnic groups with very small numbers, for example one or two in some instances, was also problematic. Therefore a decision was taken to include the country of origin alongside the respondent pseudonym but refer to the three broad groups when making comparisons between them.

Table 4.1: Countries Of Origin For Each Of The Ethnic-Cohorts

Ethnic Group	Countries of Origin
African (19.32%) 7 males, 10 females (Includes 2 Anglo-Africans, 1 Black-African British)	Britain Ghana Nigeria Sierra Leone South Africa Zimbabwe
African-Caribbean (42.05%) 6 males 31 females (Includes 2 Anglo-Caribbean 1 Indo-Caribbean, 1 British-Caribbean)	Anguilla Barbados Britain British Guyana Curacao, Grenada Jamaica, St Kitts St Vincent Trinidad
Asian (38.63%) 15 males 19 females (Includes 1 Anglo-Asian)	Bangladesh British Guyana Denmark Hong Kong India Kenya Malaysia Mauritius. Pakistan, Sri Lanka Tanzania, Uganda

Cultural identities are transformed between and within generations, being subject

to political and historical influences (Hall, 1993), evolving from the lived

experiences into a cultural hybridity of multiple ethnic identities. My own ethnic

identity shifts according to the social group I am in. For example, my dual

membership of the Hindu and Punjabi ethnic groups is negotiated as a practicing

Hindu and speaking colloquial Punjabi in the home, but at the same time I can use

my Kenyan birthplace to describe myself as a Kenyan-Indian to emphasise my difference from sub-continent Indians or refer to myself as British-Indian when I display my birthright credentials of being British. Interview data showed that respondents related to the concept of their ethnic identity changing according to the audience and or the need to present certain credentials.

A number of West African respondents (Valerie, Bert, Nigel) saw their ethnic identities in terms of their birth countries and their tribes but not religion. For East African Asians (African Asians), their inter-group differences were determined by the replication of relationships of the various ethnic groups in the Indian sub-continent, based on caste, caste purity, skin tones, religion, geographical origin, and the inter-group differences between them and the White British. In East Africa, inter-group differences between the Asians and White British were extended to include the Africans and Arabs domiciled there. African Asian respondents recognised the inverse power relationships between these groups and the dominance of the Whites over Asians, Arabs and Africans, and that of Asians over the Arabs and Africans. Their experiences lend support to inter- and intra group differentiation relying on skin colour, social position and power. Babna (Kenyan) referred to 'a three tier, colour coded system of white Brits, brown Indians and black Africans. Indians wielded power through their business acumen or as professionals'. Prakash (Kenyan) concluded that African Asians were 'the buffer zone between whites and blacks'. Banu (Tanzanian Ismaili) pointed out that 'Asian Muslims except for Ismailis' had less power than Hindu and Sikh

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groups', an observation that is supported by Modood et al's (1997) findings about the position of British Muslims.

Rowena (Jamaican) maintained that Caribbeans' *'interpret ethnicity according to the island of origin'* suggesting that group identity is associated with their geographical origin, a concept that as far as I know has not been previously recognised by research into the social position of Caribbean people. Marcia (Trinidadian) linked her ethnic identity to *'family origins and the ancestral home'*. It was evident that respondents incorporated multiple concepts, including citizenship, geographical origin, economic power differentials, skin tone, tribal system and religion in determining their ethnicity and in essence their difference from the dominant group. Jo-Jo's (Jamaican) comment makes reference not just to the heterogeneity of social groups but also to the concept of otherness: *'the heterogeneity of the West Indies is relative to the level of genetic mix of British, Spanish, Indian, Chinese and Black African gene pools through inter-racial marriage and relationships. I think, in Britain my ethnicity is a misnomer for my 'otherness'.*

4.3. Cultural Receptivity to Nursing as a Career

Across the globe, the way in which each society is structured plays an important role in male-female differentials determining access to resources to pursue post

compulsory education and entry to employment. Literature (Barribal and While, 1996a, 1996b; Abel-Smith, 1960; Grossman and Northcrop, 1993) illuminates reasons why white men and women select nursing. We have some idea why black and Asians shun nursing (Bandoo, 1997; Bharj, 1994; Rudat et al, 1994, Nursing Times, 1999a:8) but we have no systematic knowledge as to why ethnic minorities select nursing as a career. I wanted to know about the status of nursing for each of the ethnic groups. For example, how did it compare with other career options? Also given that nursing is a feminised profession, I wished to learn more about cultural attitudes to men in nursing. In addition, I intend to demonstrate that cultural receptivity to nursing is contextual to the country of origin, the socio-economic structures and attitudes towards nursing.

Of the three ethnic groups, African respondents made up 20% of the whole sample with the Asian and African-Caribbean groups being approximately equal in size (38.63% compared with 42.06%). The one notable difference between Asian and African Caribbean groups was the ratio of male and female respondents in each of the groups. The ratio of African-Caribbean men to women was 1:5 compared with a ratio of 1:2 for Asian men and women and 1:1.4 for African men and women.

4.4. Asians' Receptivity to Nursing

Previous research findings (Rudat et al, 1994; Bharj, 1994; Iganski et al, 1998; Nursing Times, 1999a:8) pointed to the reluctance of Asians to enter nursing with particular reference to its lower status when compared with higher professions such as medicine, law or pharmacy, or in relation to its appropriateness for high caste Hindus (Somjee, 1991). Therefore the number of Asian respondents, especially the number of Asian men in nursing was contrary to expectations, but could be interpreted in relation to their heterogeneity in terms of the dispersed geographical origins as demonstrated by Table 4.1. One explanation for the large number of Asian men in nursing may be that it is a consequence of gender bias in promotion. It is possible that previous explanations about the reluctance of Asian females to enter nursing (Rudat et al, 1994; Bharj, 1994) or the employment sector (Brah, 1993; Bachu, 1992; Bhavnani, 1994; Modood et al, 1997) are less likely to apply to Asians domiciled outside the Indian sub-continent because their value systems have been modified to be more in tune with the society in which they live in rather than their country of origin. In independent India, there is evidence of women entering into segregated and gender appropriate occupations professions and semi-professions pre marriage (Somjee, 1989, 1991; Bachu, 1992).

Two African Asian respondents cited liberal parental attitudes for their entry into nursing. Banu (Tanzanian) came from a 'an affluent professional family', one

where her *'mother was professionally qualified but did not undertake paid work'*. Banu was schooled for higher education but chose nursing *'on a whim, even though I had no idea what it entailed'*. She recalled that her parents were *'very surprised but there was no opposition to the idea of nursing'*. Banu believed that parental support was forthcoming because her parents were socially aware of the opportunities in nursing from other Asian families with *'daughters who had trained in England and were working in 'Sister' positions in local private hospitals'*. Banu reflected *'I don't think I appreciated then just how important it was to know these families socially. The bottom line was that it paved the way for me to train abroad'*. In contrast with Banu's experience, Mala's parents (Kenyan) *'were vehemently opposed to nursing. They expected me to study law, pharmacy or medicine'*. According to Mala, her parents were so anti-nursing that they would not allow her to submit an application, however, she found an unexpected champion in her brother who *'was able to persuade them that nursing was not a bad thing. He enabled them to see its business potential'*. For a family with strong anti-nursing views, and one that favoured classical professions, nursing equated with downward social mobility. The most likely explanation for the family's acceptance of nursing lies in the political climate of Kenya that required them to make a careful assessment of resources they could access. At the time, seven years after Kenyan independence, the country had expelled several thousand Kenyan Indians, leaving others feeling very vulnerable and anxious about their future and concerned about the stability of the country.

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In 1972, four years after the Kenyan expulsion of Asians, the expulsion of Uganda Asians occurred. The settlement patterns of the majority of Kenyan and Ugandan Asians in England and Scotland reflect dispersal concentrations by ethnic group. For example Sikhs settled in West London, Southall and Yorkshire; Gujeratis in Wembley, Leicester and Preston areas; Hindu-Punjabis in Scotland, South London, Leicester and Surrey; and Muslims in Yorkshire and East London. Mamta (Ugandan) came to the UK as a 15 year old, completed her 'O' and 'A' levels at a state school and was aiming to study medicine. She explained, *'I blew my chances of studying medicine as I had met a [Sikh] boy and wanted to get married'*. Her wish to marry at 18 posed a threat to her father's values, especially his liberal stance on the education of women, and his social standing in the community trying to persuade Sikh parents *'to allow their daughters access to further and higher education and not to marry their daughters off at a young age'*. Mamta said that she had no intention to *'give up my plans for higher education'* but found that her *'in-laws opposed university studies because I would be living away from home in the week, a concept that was socially unacceptable to them. I was disappointed but I didn't abandon the idea of an alternative option. I knew I would not be satisfied to be a housewife, work in local industry or enjoy a clerical job. I considered nursing and was pleasantly surprised that they [the in-laws] agreed to it as long as I continued to live in the joint family set up'*.

Babna recognised that as a consequence of her family's resources being depleted by their refugee status in the UK, she had to look at alternative routes for a

professional qualification. Her family's personal knowledge of other Sikh women in nursing and their social visibility through appointment at Sister grade (mid 1970s) was useful *'when considering nursing as a career option. They were the silent role models for us as a family. No one tried to deter me, in fact they were proud I'd got accepted at a world renowned training school'*. Both Mamta and Babna demonstrate their personal agency via their willingness to adapt and compromise in order to negotiate structures. Hazel (South Indian) cited her reasons for becoming a nurse as *'I felt I had a vocation to become a teacher or nurse. I chose nursing simply because that offer came first.'* Hazel's strong Christian background influenced her thinking from an early age. Her family and community valued the concept of *'doing good'*, subscribing to the belief that there was a purpose for being on earth and for her it *'encapsulated in the two career choices I pursued. All I ever wanted to do was either to teach or nurse'*. A number of other respondents (male and female) from all three ethnic groups also shared their perceptions of *'karmic influences on their career to fulfil their destinies'*, personal philosophies which have seen them through their experiences in nursing.

We know that attitudes towards Asian women in employment (Brah, 1993; Bhavnani, 1994; Modood et al, 1997) are influenced by economic activity in the area of residence, access to higher education, career aspirations, family support for women to be employed in the outside world, ability to manage domestic responsibilities, gender ideologies and cultural identity. For example, Pakistani and Bangladeshi women are under represented in the work force not just in the

UK but also in other countries in the European Community (Bhavnani, 1994; Doorne-Huiskes et al, 1995; Powell, 1999). The reasons for their under-representation in the work force are related to traditional community attitudes and values that favour the woman remaining within the home. The majority of Pakistani and Bangladeshi women came to Britain as dependents rather than as workers (Modood et al, 1997) and as recent migrant communities, Pakistani and Bangladeshi women lag behind other Asian women in respect of educational, vocational and professional qualifications (Modood et al, 1997). While it is possible that Islamic dress and behaviour codes may be perceived as barriers for women seeking employment, it should be noted that nursing accommodates Islamic dress codes.

Inter and intra generational attitudes and influences on career options reflect the changes in the economic and labour market, social structures and education qualifications for entry to occupations. The case of Indian and East African Asian women demonstrates such changes (West and Pilgrim, 1995:358), as they are slightly more likely than others to be in professional careers (Modood et al, 1997). Bachu (1992) showed that professional and educational qualifications of Punjabi-Sikh women had become the extra ingredient in the dowry, a sort of intellectual one upmanship whereby the status of the woman was positively correlated with the level of the professional qualification she achieved. The role played by the Aga Khan, the spiritual leader of the Ismaili Muslims, in encouraging Ismaili men and women to become nurses (French et al, 1994) illustrates the social and

religious leadership influencing career decisions. The almost even split of Asian males to females in this research may be a reflection of the changing world view about its potential as a business venture or a recognition of the lack of career choices available in the country of origin.

4.4.1. Mauritians in Nursing

Mauritian respondents support the notion that nursing is a valued option for both men and women because of its entrepreneurial scope in a privately funded health care system in Mauritius. Nursing in Mauritius was organised around midwifery, mental health and general nursing as the main disciplines, with the majority of the nursing work force being female. According to Lal, Daniel, Christian and Amin career choices in Mauritius were dependent on family connections, family resources or individual luck. Lal, explained: *'Mauritian economy offers four options - to be in business for oneself or family; get a government job in civil service, teaching, police, banking; try and a scratch a living or be employed by others'.* Althea's description of career options open to women suggested that women in Mauritian society were positioned in a segregated labour market, as *'married women were more likely to be in unpaid work in the home and those who were in work did not get promoted ahead of men'.* Althea said that promotion in nursing was related to *'seniority through length of service and not merit. Nursing actually offered women an opportunity to be professionally qualified, own a*

business and be financially independent. Many married women opted for self-employment by running a small clinic from home or undertook maternities'.

The reasons for men in nursing revealed a strong match in the assessments offered by male and female Mauritian respondents. Liette, Althea and Claire indicated that men in nursing were a phenomenon related to easily attainable employment opportunities through emigration. Liette voiced that *'Mauritian men came into nursing because it suited them to use it as a stepping-stone. It wasn't because they had a vocation or a desire to nurse. It was a means to an end'.* If Mauritian society perceived nursing to be women's work, the number of Mauritian men in nursing exceeds expectations. According to Amin, *'Mauritian men in nursing happened par hasard* [by chance]. *A few came to Britain, who knows why they took up nursing, but they did. Voilà, it opened a career route for others like me'.* Accounts offered by Daniel and Amin suggested that the Mauritian Asian middle class *'aspires to do well in business. It is a virtue to be seen as self made. In Mauritius, nursing was not seen as men's work whereas it was considered to be a good business for women. Some ·of us were faced with stark choices, unemployment or nursing'.* It was acknowledged that career decisions involving higher education overseas required a huge *'long term financial commitment'* to sustain those decisions (Daniel) but at the same time alternative careers *'such as teaching assistantships were dependant on family connections'* (Lal). For Amin, the reality of the family's restricted resources was such that *'we actually needed another person in work. My chances of a job with long-term prospects were*

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negligible. Nursing offered a window of opportunity for employment and study'. Christian had failed to gain admission to teacher training, the police academy and the civil service *'for lack of sponsorship from influential others. As a family we did not have any connections to open doors. Some one pointed out that my bilingual skills [French and English] made nursing in the UK a viable option'.*

In contrast to the Mauritian men, Anthony, the only Malay-Asian man in this study indicated that he opted for nursing as a means of obtaining an entry visa to the UK with the intention to change his study to law. Anthony's initial career choices were informed by his personal motivations and aspirations, parental support and ability to meet the entry gate requirements for law. However, the modifications to Anthony's career choice were shaped by external structures, specifically the changes in British immigration regulations such that his application for a student visa to study law was rejected but granted for nursing in order for British nursing labour market needs to be met, as well as his willingness to circumvent the barriers he faced.

4.5. Africans' Receptivity to Nursing

In cultures with strong traditional values about gender roles, men and women are more likely to opt for gender-specific occupations, for example nursing would be viewed as women's work. However, these values hold true only as long as the

social structures remain unaltered or the local economy and labour market continue to sustain the status quo but would have to change to take account the changing economic world, as was the case for of newly independent countries in Africa. Valerie (Ghanaian) and Erin (Nigerian) explained that, *'nursing and midwifery were highly valued career options for women having scope for self employment and nursing home ownership'*, but *'men in nursing were an anathema. Nursing was definitely not for men'* (Erin). Bert (Ghanaian) said that, *'men were doctors, surgeons or pharmacists, not nurses. It was a taboo. It raised questions about one's personhood (sexuality)'*. Rob (Nigerian) reasoned that, *'the explanation for African men in nursing could be found in the post-colonial experiences of African countries. Coup d'etat were a common occurrence leaving many of us studying overseas in dire financial predicament. As money could not be transferred to us via the normal channels, we had to find other means, like nursing for survival. Others saw nursing as a way for escape and used it to escape hostile circumstances such as civil war'*. Roger's (Ghanaian) *'life goals were affected by a coup d'etat'* just as he was finishing foundation year of pharmacy. He *'couldn't return for fear of being drafted into the militia. I had no money to support me and the Home Office would not convert the student visa to a work permit. Without realising it, I suppose I capitalised on nursing shortages for my own security'*. In contrast with Roger's experience of an enforced entry into nursing, Nigel (Ghanaian) came into nursing as a second career, having decided that secondary school teaching was no longer a challenge. He *'was steered into*

nursing by an aunt who could see connections between my goal of working in Europe and desire to retrain, without being financially embarrassed or dependent on others'.

At a simplistic level, nursing was a means to an end for both Roger and Nigel who drifted into nursing for the security and opportunities it offered to either remain or work in Europe. It is generally accepted that male nurses have to overcome powerful gender bias of being in a female profession (Roberts, 1981; Cockburn, 1987). Both Nigel and Roger found that other African men, *'questioned their sexuality and could not understand what they were doing in nursing'*. Roger felt ostracised, *'excluded from social gatherings. They didn't know how to relate to us'*. Nigel recalled *'others made fun and frequently asked if I was a failed doctor'*. When these two men came into nursing in the mid-1960s, there was no history of African men in nursing, thus they were the vanguard. According to Roger, African attitudes to nursing embraced gender specific parameters, such that nursing was seen as *'women's work because they are born to it. In my culture the women nursed the sick, nurtured children and cared for the elders'*. Erin summarised the West African experiences of health care as, *'male doctors and female nurses and midwives. Nursing tasks were performed by women, never men'*.

4.6. African-Caribbeans' Receptivity to Nursing

African-Caribbean men's entry into nursing was explained by Rowena (Jamaica) as, *'boys with notions to travel, used the opportunities nursing provided'*, whereas for James (St Vincent) it was a means to an end of *' being in gainful employment rather than being unemployed and getting into mischief'*. Eric (Trinidad) had considered a career in the armed forces but did not pursue it, *'I wanted to realise my dream to travel. Someone said a nursing qualification would help me with that. Within six months I was in England on a general nursing course.'* Maurice (Jamaican) chose nursing specifically because it allowed him *'to be self-sufficient. I was disappointed that I could not study sociology but family circumstances would not allow that. I have used nursing to reach my original goal'*. Fred (Jamaican) was employed in the civil service but *'I wanted real qualifications. There was no way I could work and pursue higher education study in parallel. Nursing gave me the opportunity to do just that'*.

For African-Caribbean women, nursing and midwifery were valued, respected professions with potential for *'life time employment'* (Laurette: Trinidadian) and *'business opportunities'* (Nikki: West Indian). Several female respondents had a fairly clear idea of the opportunities in nursing through their social worlds in which their mothers, sisters, aunts or cousins were in nursing and midwifery or they had social knowledge of it through the role models in their community. Ruby

(Trinidadian) stated that there was personal and family pride in being accepted in nursing.

Inter and intra generational attitudes and influences on career options reflect the changes in the economic and labour market, social structures and education qualifications for entry to occupations. The above discussion points to the entry of men into nursing as 'opportunistic' rather than being a sought after career on par with medicine, law, engineering or pharmacy. Data indicates that cultural receptivity into nursing for both men and women was shaped by socio-political and labour market factors, family resources and an assessment of its projected value for eventual gains.

4.7. Making Career Choices

An aspect linked to cultural receptivity of nursing as a career was the actual process of making career choices. I now look at how respondents made their career choice, the factors they took into account and the relationship of those decisions with education, parental influence and family's social capital. Preparation for adulthood and eventually work is an ongoing process with antecedents in childhood. Socialisation processes guiding career choices are structured by exposure to genderised roles (Giddens, 1993; Dex, 1991), and structures imposed by ones position in the social class system affecting access to

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education, language codes, attitudes and aspirations, and resources (Giddens, 1993; Fine, 2001). Decisions about the career one is likely to pursue are arrived at over a period of time (Super, 1994; Savickas and Lent 1994; Bevan, 2000). Career development theories, for example 'Social Learning' (Krumboltz, 1994), 'Life Span, Life Space (Super, 1994), 'Occupational Aspirations' (Gottfredson in Savickas and Lent 1994), acknowledge the interdependence of social structures, personal agency and individual personality traits. Other literature (Gregory, 1999; Higginbottom and Romero, 1997; Osler, 1997; Evetts, 1994; White et al, 1992; Davidson, 1997; Bevan, 2000) identified three inter-related key factors of parental guidance, pre-career education and individual aspirations as being the main influences for individual decisions. Two other dimensions, those of family circumstances and availability of opportunity should be added to this list.

An individual's career interests and aspirations are a product of witnessing the progress and achievements of ones parents, siblings, relatives, and social peer group, as well as the encouragement received from parents and teachers for the ideas espoused. Ultimately, career decisions are based on one or more of the following:

(a) A combination of individual and collective (family, friends and teachers) knowledge of the range of career choices available in ones geographical location or beyond, and the eventual rewards of the goal,

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(b) Projection of the labour market needs at the point of qualification,

(c) Access to the selected career route, for example one's ability to meet the entry gate requirements,

(d) An assessment of the fit of the career choice with the individual's personal interests, aspirations and goals, and

(e) The family's ability to support the career choice financially.

There are very few occasions when specialist assessment of the applicant's aptitude or personality traits is undertaken to test their fit with the career goal. Normally, assessment of the fit of the career choice is subjective, often being based on the family recalling incidents which support career choice, teachers pointing to particular personal traits of the pupil to support career advise and the individual expressing a pull towards the selected discipline (Wicks, 1998). Generally, the notion of specialist testing is associated with selection for middle and higher management jobs (Alimo-Metcalfe, 1993), pilot selection, certain types of armed personnel, for example, the SAS, and jobs associated with above average stress levels, for example air traffic control.

4.7.1. Parental Role In Influencing Career Decisions

Parental role, if any, in providing guidance at the point of making career decisions is a micro event compared to decisions taken in selecting schools at nursery, primary and secondary levels; the social contacts promoted or access to extra curricular activities. Parental role varies according to their socio-economic status, cultural norms and resources they can invest (Gregory 1999; Bevan, 2000). Bevan's (2000) premise that parents are there to provide guidance in relation to subjects selected for 'school leaving certificate', help and support them access guidance from outside the family circle if necessary and in material terms have the ability to support the education plans, implies a universality which may not be evident in all cultures and does not take into account family units where family elders rather than biological parents have the power to influence career decisions.

The teacher's role on one hand can be one of encouraging and nurturing the student to make the most of their capabilities and on the other hand may be dismissive of the individual's aspirations for their future (Smith and Tomlinson, 1989; Mirza, 1992; Mac An Ghaill, 1991). Under achievement of black and other ethnic minority students in language attainment, reading ability, examination results such as 'GCE', 'GCSE' and 'A' level, is well documented (Smith and Tomlinson, 1989; Mirza, 1992; Mac An Ghaill, 1991). Modood et al (1997) noted a reversal in trend of the improvements in achievement of black and other ethnic

minority students who in some cases exceed the attainment of the indigenous population.

Rowena's, (Jamaican) father, as the pastor promoted self-help for his community whereby ' *the community helped and supported each other'*. Rowena recalled that *'from an early age, I would help to look after people. Long before I became a Sunday school teacher, I helped looked after the younger children. I was raised to believe I was doing god's work'*. Her recollections revealed that family members visualised her as a nurse, based on her childhood desire to be a nurse *'apparently I insisted that when I grew up, I'd make people better'*. She recalled *'aunts and cousins telling me stories about how I would strut around in a nurses dress my aunt had sewn for me. I suppose over time the idea of nursing was reinforced. On leaving school, I went into nursing.'* Rowena, having grown up in a household and community focused on caring and 'doing god's work' did not have any difficulty accepting the subjective judgements about her personality being assessed as ' *born to be a nurse'*.

Hilda (Guyanese) grew up knowing that her parents expected her *'to get a professional education'*. She said *'there was no history of anyone in the family in nursing. I did not want to be a teacher, work in a shop or become a secretary, but I did want a professional qualification. The headmistress suggested I tried nursing, an idea which was well received by us, that is the parents and myself'*. Hilda did not recall any consideration being given to her personality traits or

qualities desirable of a nurse because at the time, *'the goal was to have a professional qualification, it didn't really matter in which field'*. The head teacher's role in this case was one of a guide, enabling her pupil to explore and consider other alternatives. Ruby's (Trinidadian) entry into nursing was, ' *along a well trodden path'* as she came from a family with a strong nursing and midwifery background, *'mother was a midwife, two aunts owned nursing homes, both elder sisters were training in England'*. Ruby's family links with nursing provided her with more in-depth insights about the profession than would be accessible to other women going into nursing, giving her a clear idea of the rewards it could bring and the long term goals she could aspire to.

Marcia's (Trinidadian) intention to *'get a degree'* was modified because her family could not *'support several years of education'*. She said that the *'alternative employment options from office jobs to being a teacher's assistant were simply not attractive'*. Marcia accepted her parent's guidance that *'nursing in England was a good option specifically because it offered the opportunity to get a qualification and made me financial independent of them'*. Marcia offers an example of career choice being driven by a combination of the lack of opportunity in the local labour market and a lack of family resources, but one that required her co-operation to modify her own aspirations to exploit the window of opportunity offered by the nursing labour market shortages in the 'mother country'.

Kiran's (Indo-Malay) story demonstrated cultural transformations of a Sikh father who insisted on freeing his daughter from cultural oppression by supporting her decision to commence nursing abroad amidst extended family opposition and at the same time modified his own aspirations for her. Kiran said, *'my father did not want his daughters destiny to be that of being married off at 17+ like other Sikh girls. He wanted us to access further education. The relatives objected to this because they didn't see educating girls as being important. With his backing I sat entrance exams to go to University in the US and then couldn't because I was unsuccessful in getting a scholarship. I then explored television and media work but this time my father opposed the idea because he didn't think it was secure and was experiential rather than study based. By chance, family friends told me about their daughter training to be an RMN. It sounded like challenging and worthwhile work, therefore I decided to apply for RMN training. The relatives objected to the discipline, the move overseas, and the lack of family in England. My father told me to ignore them and make the necessary arrangements to come to England'.* In Sikhism, men and women have equal rights but the degree to which these rights are exercised to access education and employment outside the home vary according to the education level of the parents, their social status and values. For a Sikh man to resist family pressures and allow his daughter to study overseas epitomised the intra-generational cultural hybridity.

Frank's (Hong Kong Chinese) entry into nursing was orchestrated by his mother, a nurse, who urged him to *'plan for long term by having a career to provide for*

long term security'. Frank did not welcome the idea of nursing and would have preferred to train as a music teacher or study pharmacy, but *'neither option was open to me because I lacked the educational entry qualifications'.* He said that *'once I had assessed my options, critically and without sentiment, nursing became a possibility through the GNC test'.* As previously discussed (Chapter 3), the General Nursing Council (GNC) entry test was designed for applicants who did not have the standard pre-entry educational qualifications (Baly, 1995).

Discussion shows that respondents decisions about nursing as a career were influenced by social structures outside their control, for example labour market needs of their country of origin; opportunities provided by nursing shortages in Britain; the level of school leaving education qualifications and access to family resources to pursue education which had to be paid for. Among those surveyed, support for career choices seemed to be gender neutral with respondents experiencing a good level of support for their choices. According to respondents', career choices were made in the knowledge of constraints and assets they needed to operationalise their decisions; the opportunities available locally; and the resources required to support the career choice. Career destinations, for example, nursing, teaching, lower clerical jobs in civil service / local government, secretarial and bank work, normally favoured by females (Williams, 1993), over time have transitioned to be viewed as women's work (Williams, 1993), such that

entry is in their favour and females are encouraged to consider them as 'end destinations' on leaving school (Mirza, 1992; Williams, 1993).

Five respondents, Lulu (Chinese-Malay), Claire (Mauritian), Erica (Nigerian), Roger (Ghanaian) and Samuel (S. Rhodesian) discounted medicine as a career option when they discovered the magnitude of financial resources their family would have to find to fund the seven years of training. For a number of respondents, nursing was attractive particularly because of the stipend it provided for the training period. Amongst the male respondents in the study, none had qualified as nurses or applied to train as one in their country of origin, probably because the opportunity was not provided in their countries of origin. There are examples of individuals systematically exploring their career choices, and rejecting initial choices primarily for financial reasons or for lack of entrance requirements, suggesting that the rank order of nursing as a career choice was influenced by external events.

Intersection of gender bias and cultural norms was evident in Jamuna's case whose access to secondary school education was initially denied in favour of her only brother's education. When she eventually chose to study nursing, neither the occupation nor the place of training were acceptable to her parents, family or community, a decision which estranged Jamuna from them until *'they saw that I have succeeded in my chosen career'*.

4.8. Rank Order of Nursing as a Career Choice

The above discussion revealed that respondents based their career decisions on an assessment of factors in or against their favour, were aware of opportunities or a lack of them, and most importantly made decisions to avoid compromising the family unit financially. Their accounts point to nursing as a career choice being influenced by multiple inter-connected personal, family and structural factors.

Respondents rank order of their preference for nursing as a career choice showed that 35 respondents (39.77%) ranked it as first choice, 28 respondents (32.95%) ranked it second, 11 respondents (12.5%) ranked it third choice and 7 (7.9%) ranked it fourth. Virtually all the respondents who ranked nursing as a third or fourth option said that their entry to nursing came about because the preferred options were not viable from a financial perspective, lack of entry qualification, or made the decision after having worked in other fields. These respondents indicated that while nursing may have been a weak choice to begin with, it moved up the rank order as other choices were discarded, or aborted in the knowledge that there was little chance to break into the preferred option.

Two respondents cited serendipity as the reason for their entry into nursing. Both Faisal (Pakistani) and Maxi (Jamaican) had 'selected it on a whim'. Faisal admitted that he enquired after 'seeing advertisements on a bus', whereas Maxi

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was prompted into action by an advertisement in a *'magazine. It looked interesting'*. Both respondents believed that nursing had *'been a good choice'*.

4.9. Conclusion

This chapter adds new knowledge to our understanding about the reasons why black people select nursing as a career. The findings of this research show considerable inter-ethnic group diversity to explain why men came into nursing. I have also shown that respondents' ethnic identity was related to geographical origin indicating that the descriptors were a way of locating origins rather than as a way of establishing social groupings. It is clear that.there were differences in the cultural receptivity to nursing as a career, differences that have their roots in the social value placed on nursing and the roles ascribed to men and women. It was apparent that perceptions about nursing as a career were subject to inter and intra-generational shift and its potential to meet ones life goals.

Career decisions were influenced by the inter-section of social structures, principally the labour market, education attainment and access to family resources with cultural, political and economic constraints. For many respondents, the process of discarding other choices or having to alter a previous career trajectory, to 'end up in nursing' demonstrated personal agency in dealing with structures. The synergy of the lack of employment opportunities in former colonies, and the

acute nursing shortages in Britain, offered an opportunity to black people for employment and acquiring professional qualifications. For some nursing was the means of escaping civil war, a means for remaining in Britain or a strategy for travel. I have also shown that while many female respondents chose nursing either because of karmic influences, family history, and personal desire or as a good alternative choice, men in nursing came into the profession opportunistically, but primarily because other occupations or professions were closed to them, or they wished to travel.

In the next chapter, I shall elaborate on the role of cultural capital on peoples' careers by examining how respondents drew on in their adult life to shape their career, cope with life and deal with adversity.

CHAPTER 5

CULTURAL CAPITAL – ASSETS OR CONSTRAINTS

TO CAREER PROGRESSION?

5.1. Introduction

In this chapter I explore the cultural capital the respondents draw on in their adult

life to shape careers, cope with life and deal with adversity. Early childhood

socialisation, primarily within the family and early schooling, has received much

attention to understand their impact on a child's personality, linguistic skills,

social development, and moral development. In comparison, the 'structured'

contributions of cultural capital (Bourdieu and Passerson, 1990) and social capital

(Fine, 2001) on life events have received less attention. I intend to show that in

adulthood, decision making processes are in part shaped at a tacit or sub

conscious level, by a combination of intersecting social and cultural values

immersed in childhood socialisation processes, family values, personal

expectations, and learnt behaviours. Furthermore, some of these cultural values

have the capacity to be regarded as assets or constraints on people in their career

quest. Two issues that interested me were: (a) the capacity for transferring capital

between different social milieu in relation to the nature and extent of adaptation

required for people to function in dual cultures; and (b) to discover the degree of

similarity and difference in inter-ethnic group cultural capital.

I begin this chapter by focusing on the concept of cultural capital and then proceed to explore four key concepts: (i) the role of collectivism in accessing secondary and further education. The notion of individualism is presented as a feature of cultural adaptation required of respondents; (ii) the influence of family values and expectations on respondents' ability to deal with adversity; (iii) the role of other agencies, for example, religion and the church in meeting social needs and nurturing skills; and (iv) the educational structures respondents' had to negotiate. This discussion leads me to question whether cultural capital was an asset or a constraint on some people in shaping their professional careers. Finally, I discuss the notion of bi-culturalism, that is the dual cultural worlds of respondents requiring them to negotiate between a 'black' culture at social and domestic levels and the dominant 'white' culture in the work place.

5.2. Cultural Capital

Culture is a human experience (Kelley and Fitzsimmons, 2000) allowing expression of personhood (Sitelman and Sitelman, 2000). The value systems of a culture that help to define the individual in terms of a particular group are biased towards themselves in order to embrace a common history, shared sense of destiny, distinct system of tradition and values. As a concept, culture is dialectic: being difficult to define because it is a shifting social construct that is shaped by events in the community, yet defining the individual in terms of a particular group (Hall, 1993). The three key features of belonging to a particular culture include shared meanings and understandings between individuals within groups; shared

practices; and the effect of everyday practices on social and political regulation for them at individual and group level. Given that individuals have multiple identities, depending on the social context, gender and social class, cultural processes are also affected by ethnicity and 'race' (Bell and Nkomo, 2000).

Cultural capital helps one to make sense of life and at the same time positions individuals in life in terms of the social, linguistic and political forces tied in with ethnicity, gender and social class. These forces are dialectic in that on one hand they offer valued assets linked to opportunities for accessing resources and allowing culture to underpin abilities, while on the other hand, the same forces can operate as constraints or discriminatory barriers. Amott and Matthaei (1996 in Bell and Nkomo, 2000: 221) maintain that the processes reflect a 'struggle of subordinate groups and control by powerful elites', a concept matching Marxist ideology (Giddens, 1993).

Becker (1995 in Fine, 2001:41-48) argues that what motivates individuals 'to maximise their own utility (benefit) or welfare within externally given constraints' is choice, exercised through personal underlying preferences depending on gender differences (Fine, 2001: 42), external constraints, social class, and influences and norms exerted by others, for example peers (Fine, 2001: 48). The notion of capital embraces the economic, symbolic and cultural (Bourdieu, 1986 in Fine, 2001:65-69). For example, students accumulate cultural capital via self-improvement through education. Symbolic capital is associated with ones connections or volume of assets that may be mobilized through connections to reflect ones personal capital whereas social capital equates with the status of individuals in that society (Fine, 2001:72), in terms of relationships

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between various types of capital or goods to gain employment, consolidate ones socio-economic position, gain entry to higher education and school performance (Coleman, 1990). Social capital is defined as the 'source of human capital over and above the resources invested by the individual, employer or the state' and has the potential for transference to other societies (Fine, 2001:72-75). Coleman (1990) linked individual social capital or investment to educational attainment; while Putnam (1993 in Fine, 2001) maintains that superior levels of social capital are associated with civil society having vertical and horizontal relationships with government and economy.

According to Bourdieu and Passerson (1990) and Bourdieu (1993) cultural capital is the vehicle for producing and reproducing social circumstances in which individuals' live. Bourdieu (1993) views cultural capital as the culture of the dominant classes that permeates education, linguistic skills, behaviours and mannerisms, confidence and know-how in a way that bestows advantages. Possession of the desired cultural capital enables one to engage with the high culture, for example for the purposes of formal, technical education. Both Bourdieu (1993) and Giddens (1993:148) contend that schools and other institutions perpetuate social and economic inequalities across generations through the hidden curriculum influence on values, attitudes and habits, in such a way that the system limits opportunities of some by eliminating them through failure or self-selection, and translates it into wealth and power for others. Success in the education system is dependent on prior skills and knowledge that children of dominant classes have internalised in the pre-school years and are reinforced

by the school years. The inverse relationship of social class and linguistic skills is one such example (Bernstein, 1975).

Bourdieu's work raised a number of fundamental questions for me in relation to the social milieu from which some respondents had come from. It led me to question if the cultural capital was culture specific or if it was transferable to allow people to function competently in a new social world. The second issue concerned linguistic skills. For the majority of respondents', including those from the Caribbean, the 'Queen's English' was not the primary language spoken in the home, but it was taught as the primary language in the former colonies. Here we have a situation where regardless of the social class of the respondents' family, they were potentially disadvantaged by not having the desired language skills in English at the beginning of the formal education. Furthermore, the fact that compulsory education was not a universally established concept meant that the level of education that the majority of colonial children accessed was dependent on parental ability to afford education (Giddens, 1993:444). Thus the education structures presented a dialectic: on one hand respondents were disadvantaged by not having the appropriate level of language skills on entry to school, yet they were privileged by virtue of their access to secondary school education, and acquired the means for entry to a profession. What remains unclear is the knowledge of factors that redressed the balance in the respondents favour. It may be that the value systems of respondents' families were middle class in relation to their motivation towards high academic performance, career goals and aspirations and seeing qualifications as relevant for getting on in life (Giddens, 1993:438).

5.3. Collectivism Assisting Access to Secondary and Further Education

Interview data for this research indicated that in every case respondents' early socialisation was in the tradition of 'collectivism' emphasising co-dependency between family members from early childhood by placing importance on family members pooling and sharing resources, as an investment to benefit the family (Bourdieu, 1996 in Fine, 2001:55). According to a number of respondents, there was an unwritten rule that sacrifices such as finding money for private tuition to prepare for examinations, or supporting the education of younger members of the family, may be required for the long term good of the family, a concept which Bell and Nkomo (2000) suggest is a reflection of African-American cultures long term resistance against the dominance of white colonialists. The social backgrounds of the respondents in this research were diverse, with a mix of moderate economic deprivation to privileged, affluent and influential households. Respondents' accounts did not identify overt racial or gender oppression.

Interview data showed that the tradition of collectivism enabled some respondents to either access secondary school education or find the fare to come to England. Margerita (Sierra Leonie), Rose (Barbadian) and Julie (Guyanese) provided examples of collectivism in assisting their access to secondary or further education. Margerita owed her high school education *'to a distant cousin who boarded me for the duration. Later I discovered that this sort of help was a family tradition'.* Julie said she could not have travelled to England to commence nursing without *'some of the aunts, uncles and cousins helping with the fare. They weren't asked for help, but were aware of our financial situation and gave the*

money, didn't loan it, there were no strings attached to it'. Rose provided an example of deep family friendship reaching out to her when she came to England to commence training: *'These Barbadian friends hadn't seen me since I was knee high ...They met me at the port, then took on a loco-parentis role even though I was not a blood relative, just the daughter of friends they had not seen in ages.... They treated me like one of their own. It cultivated a desire to help others in the same way I had been helped'*.

5.4. Family values and Expectations

Family values and expectations emerged as a theme early in the interviews through discussions focussing on respondents' family lives, their school days and the people who had played a significant part in their childhood or early adulthood. A number of respondents described the home as the core of being, steeped in the notions of respectability where social skills were learnt with the parents acting as role models. The need for 'regard', such as caring for each other, considering the needs of others and respect for parents, aunts, uncles, older cousins, grand parents was instilled in family members from an early age. Family membership demanded unconditional loyalties and support. Personal problems of any kind were for sharing within the family, usually with the mother or grandmother and only with their approval would the matter be discussed elsewhere, with the family confidante determining the person with whom the matter was to be discussed. As Cynthia (Jamaican) explained *'As children, a certain standard of behaviour was expected [of us]. In company if one was spoken to we awaited a cue from the*

parent/s to confirm it was okay to speak.... An induction into society by observing how people behaved in company.. It was a very polite society modelled on a white way of being in the world.' In adult professional lives, these family values became constraints for some respondents, for example when it required the individual to challenge a decision or take a lead in the presence of more senior colleagues. Erin (Nigerian) recalled that in the early phase of her nursing career she was *'very passive in the presence of the ward manager and would accept criticism even if it was unwarranted because I'd been raised to accept that elders and seniors knew best'.* Claudia (Jamaican) could recall being perplexed when she observed that white students did not wait to be cued in to answer in class *'I saw it as being disrespectful to the teacher, and later discovered that they thought I was slow on the uptake'.* A number of the respondents indicated that having been socialised into keeping confidence and counsel within the family, they found it difficult to share their problems with others who were rated as acquaintances. Laurette (Trinidadian) confirmed that she found it hard to *'go against the grain. I felt I was being disloyal to the family by asking others for advice'.*

In Bourdieu's terms, acquisition of social skills would equate with symbolic capital (Bourdieu, 1993). The notion of the 'white way of being in the world' appears to be related to forms of social behaviours of polite society and formal dress for weekly church attendance or when visiting kith and kin. Inequalities in social class, and lack of occupational and professional parity meant that at a social level, black and white people rarely mixed. For most black people contacts with white people were at a distance being contacts of servitude or as a subordinate group of that community. Thus, black peoples' knowledge of white culture was

determined either through education, the media, from a distance or second hand, through others.

Participation in family gatherings taught younger members the skills of social conversation, the art of working at knowing others and how to behave in company. Celia (West Indian) recalled that *'being of good reputation enhanced the social standing of the parents'*, showed they had *'made a good job of raising their children'*. Social regulation from within the home was a reflection of that community's values on public behaviours and expectations generated by the family. Banu (Tanzanian) suggested that where the parents' social standing in the community was high *'more was expected of the children in all spheres, especially examination results and career achievement'*.

At a simplistic level, there was often an implicit expectation that respondents' would succeed in their chosen field by passing examinations at first attempt and getting a good job thereafter. According to Lulu (Chinese Malay), Lucy (Guyanese), Thom (Southern Rhodesian), Pierce (Ghanaian), Christian (Mauritian) and Rita (Barbadian), there was a personal expectation to be top or near the top of their class in examination, and to excel at in their chosen field. Virtually all the respondents recognised that they had grown up believing that opportunities and success in education, profession and life were based on personal investment along the lines of 'you reap what you sow', that is through hard work and merit, therefore they expected their progress in nursing to be on personal merit. Given the nature of racialised imperial relationships (Phillips and Phillips, 1999), it was surprising that respondents believed that Britain was a fair society where promotions and career progression were determined on the basis of

meritocracy, linked to one's performance, ability, effort, skills and effectiveness in the job.

Kiran (Indo-Malay), Prakash (Kenyan), Deirdre (Jamaican) and Maurice (Jamaican) observed that social standing was important for the privileges it brought. Prakash, recalled that his family's considerable influence in Nairobi's Gujerati community *'brought lots of invitations to social gatherings. Without realising it I was rubbing shoulders with the elite of the construction world in Kenya. Our connections were very useful when I first came to the UK to study'.* With hindsight, Prakash recognised the networking opportunities associated with socialising, its value for information exchange and social visibility. Similarly, Rowena's childhood in a manse provided her with a tacit knowledge about the utility of professional and personal influence in *'getting things moving. I think I always knew that leaders motivate others and through their leadership get work done'.*

Social standing was of clear importance in gaining admission to 'white' sports clubs. Segregation on ethnic lines, in education, housing tenure, membership of social and sports clubs and employment was a feature of colonial rule, but one that could be circumvented by wealth and social standing. Nigel (Nigerian) recognised that his father's government connections had been crucial in gaining membership of the Nigerian tennis club, and being coached by a white club member. In the next section, I shall be demonstrating that family influence can help to negotiate the structures of the education system.

5.5. The Facility of Educational Structures in Accumulating Capital

It is likely that the second most influential agency, after the family, in nurturing or diminishing individual aspirations for further education and / or career, was the educational system. In the former British colonies, the majority of government funded and private schools were not affiliated to any particular faith or religious philosophy, but the school infrastructure reinforced the social values about obligations to the school community and broader community. Teachers were often held in extremely high esteem and some would suggest were revered for their wisdom, their teaching skills and their guidance. Others would suggest that the education system was a negative structure with power to exclude people from school, causing low self-esteem and failure.

Betty (Trinidadian) recalled that her first heroine was *'Miss Margaret Morgan, she taught me black history [out of school]. Throughout my schooling this woman encouraged me. She told me I'd do well in whatever career I chose'.* Rob (Nigerian) realised that he would have missed his opportunity to finish high school if a particular teacher had *'not intervened to make me see that it would be a disastrous move long term...He mediated between my father and the school for me to remain at school. The man was like god to me'.* Erin's (Nigerian) entry into nursing was conceived through financial need, following her father's death. Her head mistress *'was so appalled to learn that I'd be removed from school to take up shop work. She intervened with the family and used her influence to get me into nursing school in Lagos'.* The headmistress's intervention as mediator, sponsor and patron to her pupil, helped to secure immediate employment, and in

the long term a professional qualifications. Jamuna's (Indian) fight for her right to education *'was teacher-assisted. If the teachers had not begged my father to let me continue in school I would not have completed senior school. They [teachers] helped me get a government sponsored training place [in south India]'.*

Cynthia (Jamaican) was one of the respondents with ambivalent feelings towards her senior schoolteachers, in particular the headmistress. She was angry that the school had not seen fit to ensure that the subjects she had chosen for 'GCE's' were incompatible with teacher training, my chosen destination. But she was grateful to one teacher for guiding her *'into nursing. She made me see that I had an alternative option, a profession I had not considered until she pointed it out'.*

Shabana (Bangladeshi) initially received little support or encouragement from her teachers, and had her family not moved house, it is possible that her education would have left her ill prepared for a professional career. Shabana explained *'they [teachers] had a low expectation of me. Looking back on those years, I question the way in which the teachers treated black and white pupils. I believe that the Bangladeshi pupils [and I was one of them] received less attention from them.. Often I did not have access to my own textbook. My parents could not understand why my academic profile was so weak. They got me private tuition for maths and English. The tutor confirmed I was behind but could not fault the work I did for him. Fortunately we moved house. At the new school, we were advised that I commenced in the year below to catch up'.* Here we see an example of the dual capacity of the education system: disadvantaging the student for reasons of gender or racial stereotyping, and assisting the same student to 'make good the deficits' but on its own terms, that is by keeping her down a year.

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In contrast with Erin's experiences of patronage from the educational system, Brenda's story revealed that not all teacher-pupil relations could be assessed as positive, reverential or harmonious. She said '*science became my worst nightmare when a new teacher came on the scene. For some reason she had a poor opinion of me. She told me I would fail my O' levels, that I was wasting my parents money, and she knew they were very disappointed in me. She constantly bullied me. I lost all confidence and failed my exams for the very first time. I was kept down a year. Fortunately, I had a different science teacher; she helped me regain my equilibrium and I did well. The experience has stayed with me as it made me realise that the relationship between teacher and pupil was important.. It's something I remind myself of when I am faced with a difficult student.*' Eric's (Trinidadian) '*antisocial behaviour in and out of school*' led to his expulsion from school. His parents used their '*social influence and their church connections*' to negotiate entry into another school. Eric volunteered '*I knew I had to tow the line...There were to be no second chances if I messed up. I was two years older than the rest of my class, people knew of my reputation, yet the school gave me the chance to redeem myself*'.

At individual levels, the educational system can be a powerful and oppressive structure to negotiate, but equally as was demonstrated by Erin and Jamuna's accounts, the educational system or its personnel can be an asset in opening doors through sponsorship and patronage. The direct and indirect influence exerted by teachers in colonial communities permeated all levels of colonial society. A teacher's positive assessment of a pupil's academic ability was essential for their family to consider plans for their future. The scope of career advice a teacher

could provide varied according to the wider world experiences of the teacher or head of school, their knowledge of the individual's academic ability and family resources, and the local labour market. During 'A' level studies, Shobna (Kenyan) was directed towards higher education *'because the teachers were aware that the family could support me'.* A small number of other respondents recalled that teachers did not have any expectations of them or were surprised to learn of their aspirations or had such poor opinion of their academic ability and /or motivation, that the teachers' views were psychological barriers. Terrie (West Indian) described herself as *'slow to mature. While I didn't really push myself at school, I managed to pass the exams. Coming up to the school leaving exams, I indicated I was going to go on to further study. The form teachers were so dismissive of my attitude towards learning, my lack of effort and motivation, that they cast doubts of my ability to see things through. Each time I went for interview, I carried their hostility with me'.*

5.6. Religion and Church

African, Caribbean and Asian communities have a strong tradition of religion with the church as an integral part of the community (Davis, 1999; Bell and Nkomo, 2000). More than 90% of respondents surveyed described themselves as Christian. In these communities, the church was an integral part of the community for devotional activities, community work and as a resource for receiving emotional, social and spiritual support. The role of the church in childhood encompassed the religious elements, becoming involved in the community,

developing social networks and in one case the agency of the church was activated to procure re-entry to secondary school.

Childhood involvement in the church gave some individuals the opportunity to develop skills, for example team working, organisational skills, leadership and communication. Celia (Jamaican) believed that her *'people skills were developed in the senior church choir'*. Rowena linked her time as a Sunday school teacher with *'taking responsibility, relating to others on a humanistic level and fitting in with others'*.

In England, the growth of the black church may be in direct comparison with the support received and desired in order that people of like mind and similar backgrounds could meet. A number of respondents had active roles in the church, for example, committee membership, as lay preachers or readers, 'social work type duties' or as treasurer. Individuals appreciated the skills developed in these roles as a means of broadening the repertoire of those acquired through paid work, while at the same time it fulfilling an innate desire to meet one's social obligation to their community. Also it was one sphere in which they are not judged against white people. However, these respondents also indicated that the employer organisations appeared not to value their external, unpaid activities. Terri (West Indian) pointed out the lack of recognition given to church work was a fundamental omission. For example, *'job applications ask for details of hobbies or interests but do not seem to take account of church work'*. Pierce (Ghana) too noted that although his curriculum vita made reference to, *'the transferability of my financial skills as church treasurer and fund raiser, these skills were ignored by interview panels'*.

Gloria (Jamaica) talked about the black congregations attempts to replicate the collectivism of the black community by providing a percentage of income to their church for social causes in third world countries. She believed that the church was one institution where the moral values reflected the *'values one grew up with.... I receive respect for who I am.... It's where my achievements are celebrated regardless of my ethnicity ....I feel valued as a community member'*.

5.7. Cultural Capital As Assets and Constraints

The works of Bourdieu (1990, 1993), Coleman (1990), and Fine (2001) support the notion that social capital accumulated through one's origins underpins self-esteem, confidence and ability to negotiate with the wider world. It could be argued that collectivism continued to play a part in the lives of the respondents in three ways: subscribing to its principles by supporting other family members to acquire professional or graduate qualifications, their willingness to share their experiences with newer members into the profession by setting up professional networks (discussed in Chapter · 8) and suppressing the emergence of individualism - a trait I suggest is necessary to pursue career goals and aspirations. Putting ones own interests before the interests of others was a concept which many respondents felt was an anathema and had to be learnt. Having been socialised heavily into believing that pooling and sharing was for the good of the family or others, respondent accounts suggest that their agency was constrained by those beliefs.

Veronica (Indo-Malay) recalled that she had not pursued her application for a ward sister post having been informed by the incumbent that her white colleague was more experienced *'but she wasn't ...We were on par ... The sister told me that if I applied I would not be appointed, a fact that would reflect on me and other coloured nurses for getting promoted .. I believed her. After all she was a senior member of staff and someone who was in the know about things. But when I heard that a staff nurse, far more junior to me had been asked to apply, I realised that I had been sold a pup, been lied to ... I too applied'.* Nevertheless, Veronica said she had agonised over the decision *'I worried myself sick, just in case my actions really did make things worse for the others'.* Veronica's concerns for others can be related to her childhood socialisation that put her individual needs behind those of the family or community. Her mind set was that her actions, that is perusal of her application for ward sister post would be detrimental to others,

Another area where cultural capital affected power relationships was in relation to the trust placed on senior staff, especially the matron or senior tutor, the regard in which they were held and expectations of them. It was almost as if the matron or senior tutor were being cast into a parental relationship, through the implicit expectation that they would take a paternalistic interest in the respondents' welfare, and provide direction based on individual aspirations or ability (Barribal and While, 1996a). Some respondents found that the trust placed in the matron and senior-tutor did not materialise or was inane. For example, Indira was directed to *'fever or TB nursing both difficult to recruit to disciplines. This woman could not see why I was so upset. She could not see that I had higher aspirations.*

I felt she had not seen me as an individual but as a black person to be exploited'.

Brenda (Jamaican) offered an insight into her transition to individualism through being misrouted into EN training. Having discovered that she *'was on the wrong course'*, she approached the course tutor to find out why. *'At first she [the tutor] said it was because all the places were taken and rather then keep me waiting had allowed me to get started on the EN training...I was given a vague promise of swapping to the SRN course, but it didn't happen. I had been raised to believe in natural justice but I found people were treating me unjustly, even though they knew they were in the wrong. I was furious. I felt mistreated and bruised. I wrote to the High Commissioner's office about the differential treatment...I really am not sure what transpired but within about a month of the letter, I was called to matron's office and told of my transfer to the SRN group.... That incident set the scene for me; from there on I vowed to look after myself. I no longer had a blind faith in people'.*

Rob (Nigerian) replicated the trust and reverence given to community elders back home by *'trusting the Head of School to provide me with a strong reference.... I was utterly disappointed and angry when I discovered that this person had been economic with the details.... Not getting the post was one issue, more important was the fact, that it destroyed my belief system'.* Prakash (Kenyan), Valerie (Ghanaian) Hazel (Indian) and Faisal's (Pakistani) experiences contrasted with the above, in that they selected the people to provide references, having made sure that these people were in a position to do justice to them. Valerie confirmed that *'if I approach someone to provide me with a reference, I talk with them about the*

job and why I think they are the best person as referee. I consider it important that I provide them with an up-to-date CV'.

Living in Britain, required adjustment not just climatically but also for every day practices. The establishment of black and Asian communities in the urban areas had little impact on the black and Asian Nurses living in nurses homes often within the confines of the training hospital grounds, and often at some distance from these settlements (Phillips and Phillips, 1999). Thus these nurses found that they were neither part of the emerging black / Asian communities, nor a part of the white community. Instead their 'being' was bounded by their own cultural identity, values and beliefs. Gradually, perhaps without even acknowledging that subtle changes were taking place, respondents learnt through observing their white peer group, the rules of engaging with and operating in a western community.

Britain is essentially an individualistic society, one that allows individuals' to consider their own needs ahead of others needs without feeling responsible for the impact of those decisions on others. Black and Asian respondents said that they found it unacceptable to push themselves forward or promote 'self', whereas in individualistic society if one does not adopt this approach, there is a danger of being overlooked or being perceived as unmotivated. Paradoxically, self-promotion challenged personal values, with respondents having to learn how to be assertive. Before black nurses could become assertive and challenge organisational structures, they had to deconstruct the layers of culturally bound structures guiding behaviours and engagement with the world and reconstruct

their personal boundaries to accept that challenging authority or structures was acceptable and necessary for survival.

Julie (Guyanese) confessed that *'learning to be assertive for personal gain was uncomfortable.. I considered it bad manners and pushy. I had to learn to that it was perfectly acceptable to argue with or challenge senior staff member, that it was okay to challenge attitudes and their treatment of me as a black person'*. Erica (Nigerian), Lulu (Chinese-Malay) and Lucy (Guyanese) focused on non-verbal communication as an area they had to re-learn. Lulu acknowledged that *'learning to eyeball senior people and those in authority was hard... In my country it was considered disrespectful. But here people thought I had something to hide or was being thick'*. Another area that caused confusion for Lucy was interpreting facial expression. She recalled observing someone being *'chastised for making a mistake in bandaging, the voice was cross but the face did not show anger. I could not understand this.... In time I guess I adjusted to these differences without even realising'*. Ellie's (Barbadian) assertiveness skills were developed *'during year 2. I felt so strongly about the specialist rotation allocation that I challenged the tutor to explain why I had not been allocated my first or second choice. I was re-allocated to a elderly mentally infirm ward - the Cinderella of mental health. Strangely, it was brilliant, that stint inspired me to train as an RMN at the same hospital. I learnt from that incident. I learnt that I did not have to be passive and take what was doled out to me without question, just because the decision maker said so'*.

Perhaps the single aspect where collectivism has had the most impact has been the reluctance of black nurses in seeking remedy through the courts and employment

tribunals for racial discrimination, mistreatment and abuse. Inspite of the Race Relations Acts of 1964 and 1968, respondents' experience of racism remained a private experience simply because it was rarely discussed with others. In hindsight, there were vivid recollections of the racisms experienced or witnessed. While the Race Relations Acts provided black people with the terminology to express racial experiences, created a legal framework to combat racial discrimination and put the onus on employers to be considerate of equal opportunities, there were clear breaches of the spirit of the law that went unchallenged. In nursing, the case law pertaining to racial discrimination and racial harassment remained weak. The reasons for this were multi-factorial, firstly and perhaps the most important reason was that black nurses were reluctant to share their racial experiences within or outside the group for fear of not being believed. In effect their silence isolated them, causing them to internalise their anger. Patience (S. African) pointed out that she knew when people treated her differently to her white peers *'having been raised in South Africa, I knew it was to do with my colour. If I said anything, I was told I'd imagined the slight/s I was referring to. Apparently others did not see what I saw nor did they believe me'.* Maurice (Jamaican) realised that *'people didn't interpret incidents in the way I did or they pretended not to understand my racial experiences and put downs...I wasn't imagining them, they were there - subtle but deliberate'.* Secondly, they were reticent about seeking legal redress for fear of the repercussions their actions would have on their own career and that of other black and Asian nurses. In addition there was a belief that legal challenges would do little to alter the status quo. Selena (Black British) could have claimed unfair dismissal for purportedly revealing an examination paper to her cohort of nursing students. She said *'I*

didn't seek redress of any kind. It equated with kissing goodbye to my own career...I voted with my feet when the opportunity arose'. When Roger was investigated following a minor incident at work, he *'was convinced that it was deliberately orchestrated ...There had been a palpable degree of hostility towards me over a period of time'*. He obtained a legal opinion on the matter, concluding that he had the grounds to serve a writ on the employer organisation *'for harassment and racism. The matter was resolved with legal support but the perpetrators were not disciplined in any way'*. Thirdly, the nursing unions such as the RCN were perceived as being reluctant to address issues on behalf of the black nurses. From 1990 onwards, nursing boards, nursing unions, education providers and employer organisations, saw the emergence of race equality as a major agenda that led to initiatives affecting employees, service development and delivery, education and training of staff about ethnicity, changes in curricula and equality training of appointment panels.

5.8. Cultural Duality

Bell and Nkomo (1989) and Bell (1990) define cultural duality as the movement of individuals between two cultures, in the case of respondents surveyed this would be African, African-Caribbean or Asian cultures in the home and a white culture at work, education and other spheres of life. The movement between the two cultures is an imagery or metaphor used to explain the dual worlds of the respondents', while acknowledging the dominance of either culture as being context specific. Babna (Kenyan) proposed that cultural duality should be

perceived in the same way as multiple ethnic identities because the *'changes in one's persona come about from everyday discourses...one's blackness cannot be altered but there are adaptations in thinking. Language too changes - English words — I find I use or switch between English and Punjabi.., dress style is modified according to occasion...I am influenced by my work, education, the society I live in. Without realising it I negotiate the two cultures fluidly — I cannot put a finger on where my Indianess stops and my Englishness begins'*. Valerie said she, *'was an African woman in England....I live like everyone else...Essentially I have the same needs as everyone else'*. Thom (S. Rhodesia) presented cultural duality as a *'tacit negotiated phenomena...at a sub-conscious level...not aware of negotiating it - at work or at home ...It may be somewhat easier for me as I have already adapted by being in an Anglo-African marriage...I'm not denying my cultural heritage or roots'*.

It seems that living and working in England involves processes of adaptation that are individually determined but nevertheless acknowledged as having occurred. Respondents' discussions about their career management suggest that cultural duality impacts on conceptual thinking, shifts the individual away from collectivism and towards individualism, and enables them to operate at different cultural spheres of that society.

5.9. Conclusion

I have shown that cultural capital continues to influence adult life; particularly in the way individuals choose to respond to and deal with adversity, and deal with

challenges or barriers. Cultural capital is regarded as the indispensable glue necessary for the stability of communities through social regulation, over time. It has the capacity to maintain cohesion in the community through value systems reinforced by the family and education systems. Respondents' accounts confirm that black cultures often facilitated later ambitions through the value placed on self improvement, good character, stamina to pursue goals, hard work, success in education, sports and occupational goals, doing good deeds and, having a deep sense of responsibility to ones family and community.

For some respondents, collectivism was instrumental in securing resources for the purposes of completing secondary education or to come to the UK to commence nursing studies. I have suggested that collectivism was a constraint to respondents for the purposes of seeking legal redress for racism, harassment or discrimination, in relation to the level of concern they had for others. The shift from collectivism to individualism was not spontaneous but related to critical incidents in the career journey. Cultural capital was transformed either through personal experience or as a component of adapting to a different social world. Transfer of cultural capital between different social worlds has contributed in retaining respondents' ethnic identity and cultural integrity.

The structures of the education system in assisting or diminishing career opportunities were evident for all three ethnic groups, in relation to the patronage or sponsorship of the system to either retain someone in the school system or to promote entry to a profession. Surprisingly, the role of the school in matching academic ability with career goals was virtually absent.

In the next chapter, the significance of cultural capital will be further developed through examination of the processes related to the entry gate, the respondents' ability to deal with discrimination at entry, their pursuit of professional and academic studies, their agency in securing resources for professional development and determining the focus of their career.

CHAPTER 6

RESPONDENTS' CAREER JOURNEYS: FROM

ENTRY GATE TO THE CENTRALISATION OF

PRACTICE DOMAIN

6.1. Introduction

This chapter follows on from Chapters 3, 4 and 5 which focused on 'The Social

Construction of British Nursing', 'Ethnic and Cultural Influences on Nursing' and

'Cultural Capital – Assets or Constraints to Career Progression', to examine

respondents' experiences at entry into nursing, up to the point of centralisation of

practice domain. Marsland et al (1993:323) described nursing careers as a series

of transitions between student and qualified status that may be voluntary or non-

voluntary in nature that allowed individuals to accrue professional qualifications

with the purpose of enhancing their employability. I visualised the pattern of

accruing professional qualifications as certificate gathering by **'going in and out

of a revolving door'**, characterised by a cyclical pattern represented as a series of

steps once the individual had acquired the initial registered qualification. For

example, **Step 1** entailed undertaking a short certificated course of 3 to 6 months

duration; **Step 2** required the respondent to spend a short time, normally 3-6

months, in that field (optional); and **Step 3** where the respondent proceeded to

another course. This three-step pattern was likely to be repeated until such a time

as the individual made a decision to specialise and remain in that practice domain

for the duration of their nursing career, a concept referred to as **centralisation.**
The key difference between practice in the centralised domain and the certificate
gathering phase was that from the point of centralisation, clinical practice in the
chosen field would serve as a foundation or launch pad for progressing on to the
next rung of the career ladder. Thus the career trajectory following centralisation
of practice domain was likely to be represented as: 'training period for specialism
selected' **followed by** a period as 'Staff Nurse' **followed by** 'a Senior Staff Nurse
post' **followed by** 'a Junior Sister / Charge Nurse post' **and finally be appointed
as** 'Sister / Charge Nurse Ward Manager (Ward Manager)' grade. The Ward
Manager grade was the career grade at which the individuals decided the next
stage of their career development in relation to nurse management, education,
clinical governance or practice. In essence the 'real nursing career' did not begin
until centralisation of practice had been achieved.

I was interested to know how these respondents shaped their careers by examining
the opportunities they had or lacked, occupational choices mobilised and the
preparation they undertook to support their occupational choices. The purpose of
this chapter is to ascertain how the respondents' personal agency was mobilised to
manage and deal with structures and opportunities at critical points of their early
career to arrive at the point of 'centralisation of practice domain', in order to show
the interconnectedness of the structures and the personal agency in their career
journeys. I shall begin this chapter with a focus on respondents' entry gate
experiences to explicate how the differentials in entry gate were embedded in
discriminatory processes and how individuals transformed them.

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6.2. Entry Gate Experiences

Until the late 1990s, applications for entry into nursing were normally managed by direct correspondence between the applicant and the Matron of the training hospital. Overseas applicants had the option of either applying directly to a training hospital in the UK, or via the appointed agent in their own country. Nurse education, with the exception of health visiting and district nursing was organised under the auspices of the NHS (see discussion in chapter 3). Also, before the introduction of Project 2000, the majority of pre-registration nursing qualifications were at certificate level, with few undergraduate courses available prior to 1970.

6.3. Standard and Non-Standard Entry to Nursing

As discussed in Chapter 3, the minimum criteria for entry to nursing for registered qualifications, that is State Registered Nurse (SRN), Registered Mental Nurse (RMN), Registered Nurse Mental Handicap (RNMH) or Registered Sick Children Nurse (RSCN), remained unchanged until 1987 when the minimum requirements were increased from 2 O' levels to 5 O' levels to include English and mathematics (Baly, 1995). The General Nursing Council (GNC) test was designed to test the literacy and numeracy skills of non-standard applicants for the registered nurse (RN) pathways only, but there is substantial evidence to suggest that many Schools of Nursing (SsON) applied it to the State Enrolled Nurse (EN) pathways. In theory, the EN could convert to RN by undertaking a two-year conversion course to make good the elements omitted from the EN course but in practice this

was virtually impossible as the biggest hurdle to conversion was the shortage of training places.

Interview data from respondents illustrated the anomalies in the entry gate system and the inequity in decisions governing the selection of candidates to sit the GNC entry test. Three entry gate patterns were identified: (i) a standard route where the applicant who met the entry requirement was selected for the appropriate course; (ii) the non-standard route where entry was gained either via the GNC entrance test or other schemes such as the cadet nursing scheme, and (iii) discrimination in entry route whereby the applicant was racially discriminated against by being required to take the GNC test even when they met the entry requirements, and / or was required to work as a nursing auxiliary prior to commencing nurse training. Table 6.1 demonstrates the permutations of these three entry gate patterns identified from respondents' data.

The majority of respondents surveyed (n=67), excluding the six who had qualified overseas, met the GNC entry criteria of a minimum of 2 GCE O' Levels and in most cases had passed in seven subjects at this level. Ten respondents had A' Level qualifications, two were graduates with science and engineering degree respectively, and three had UK recognised teacher qualifications. The graduates and teachers came into nursing as a second career. The six respondents who were 'overseas qualified', had completed their initial nursing qualifications in the Caribbean, India, Kenya or West Africa. Table 6.2 shows that 33 respondents, including the 9 who lacked the specified entry requirements sat the GNC test. Data indicates that selectors discriminated against 24 respondents by subjecting them to sit an entrance test unnecessarily.

Table 6.1: Examples of Entry Gate Route Applying to Respondents

Entry Gate Credentials	Outcome
Nursing auxiliary – without entry qualifications. Took GNC test → Passed test but routed to EN training.	*Direct discrimination and a racialised entry gate.*
Nursing auxiliary – without entry qualifications GNC test → Passed test → RN training.	*Non-standard entry route.*
Applicant does not meet entry requirements, Asked to take GNC test → Passed test → RN training.	*Non-standard entry route.*
Applicant had entry requirements of GCE or CSE qualifications. Required to take GNC test → Passed test → RN training.	*Direct discrimination and a racialised entry gate.*
Applicant had entry requirements of GCE or CSE qualifications. Required to take GNC test → Passed test → EN training.	*Direct discrimination and a racialised entry gate.*
Applicant had entry requirements of GCE or CSE qualifications → RN training.	*Standard entry route.*
Applicant had entry requirements of GCE or CSE qualifications → Required to work as nursing auxiliary → RN training.	*Direct discrimination for standard entry route.*
Applicant came via the Cadet nursing scheme → GCE or CSE Qualifications → RN training.	*Standard entry route.*
Applicant had A level qualifications → RN training.	*Standard entry route. Not informed of opportunity for undergraduate or dual qualification studies.*
Applicant had A level qualifications → dual qualification route of RN with undergraduate Degree.	*Standard entry route to Higher Education.*

Total number of respondents taking and passing the GNC test	33
Number who **met entry criteria** but were required to take the GNC test.	24 (72.7%)

6.4. Misuse of the GNC Test and Its Results

It is not clear why SsON required candidates who met the entry requirements to

take the GNC test. There is strong evidence that the GNC test was misused in

racist ways to target overseas nurses into EN pathways. Each of the 24

respondents, who had sat the GNC even though they had met the minimum

requirements, vividly recalled their feelings at the time. Nigel (Nigerian) who

came into nursing as a second career said '*the anger on discovering I needn't*

have sat the test made me impotent with rage '. Patricia (West Indian) '*felt cheated*

and was gutted that people could be so very devious', whereas Pierce (Ghana)

recognised '*the unfairness of it all*' and '*was overwhelmed by the*

discrimination…. At the time I didn't offer any resistance.. How could I'? The

pattern here was one of the respondent knowing that their treatment was different

but being 'unable to challenge' it at the time through their inability to articulate

their experiences and feeling disempowered. For example, respondents did not

share their experiences with anyone, let alone appeal to the right authority.

Five respondents, Jack (Chinese), Ruby (Trinidadian), Brenda (Jamaican), Fred

(Jamaican) and Nikki (West Indian) who had trained at the same hospital within

two years of each other, were asked to sit the GNC test on two occasions: once prior to the course starting and again four weeks later. Table 6.3 shows that while the 33 respondents' passed the GNC test, their success was not reflected in the training pathway allocated to them. Thirteen respondents were misrouted to EN training when they should have commenced training for the RN pathways.

A number of respondents from this sub-group were particularly incensed at the injustice, unfairness and discrimination they experienced. Nigel speculated that if black nurses who had been misrouted into EN training were given legal, financial and union backing, they would be in a position to *'mount a legal challenge.... Seek financial redress in a court of law.... [It] would not make up for the hurt or the lost opportunities...[but] it would be a public recognition of the deviousness and discrimination exercised'.* Samuel (S. Rhodesia) articulated a racial motive in the misuse of GNC tests *'where I trained it was unknown for a white student to sit the test ... I know for a fact that some of the Irish and English nurses did not have possess a single 'O' level between them, yet they weren't asked to take the GNC test'.* Fred (Jamaican) said he *'knew [now] that it was direct racism... How many others did this happen to? Does anyone care?'*

My contention is that there was an inherent racialisation in the treatment of black nurses. The experiences of the black nursing recruits fitted with British society's perceptions about black people at the time, being embedded in the master-servant power relationships of the British Empire (Phillips and Phillips, 1999) whereby black people were cast in role of servitude (Graham, 1997:128; Doyal et al, 1981; Smaje, 2000) and perceived as being less capable educationally (Mirza, 1992). Channelling black recruits into EN pathways excluded them from accessing

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career opportunities and any post qualification courses predicated on the RN qualification as a pre-requisite, for example midwifery, and denied chances of promotion for the same reason. Although the EN pathways were discontinued from 1990 onwards, the long-term sequelae of that qualification (Beishon et al, 1995) continue to reverberate in 2001 because the opportunity to convert to RN remains minimal.

Table 6.3: Entry Pathways For The 88 Respondents

Entry Pathways	Number
Number commencing registered nurse training For general nursing, mental nursing, sick children's nursing or mental sub-normality	**62** **(70.45%)**
Total Number routed into EN training	**18** **(20.45%)**
Number routed into EN training correctly	*5*
Number misrouted into SEN training even though the respondents met the criteria for the RN route and had passed the GNC test.	*13*
Number who transferred to RN pathways during EN training	*3 of 13*
Undergraduate route [1st degree + SRN]	**2** **(2.3%)**
Overseas qualified nurses (all for the register)	**6** **(6.8%)**

Margarita (Jamaican) who lacked the pre-requisite entry qualifications 'was delighted to get a place by taking the test' but then received another letter stating that she had 'failed the GNC test but could commence pupil nurse training to

qualify as an EN. My sister immediately said no. I didn't know why until later'.
Margarita said she was bewildered: 'it didn't make sense – one minute I had
passed, the next I hadn't... My sister who had already qualified as a midwife (in
the UK) insisted we went to see the matron– we turned up and eventually met with
her ...At first she (the matron) denied that contradictory letters had been sent out
– I suppose she had to concede that because we actually had proof...Then she
said I had failed the (GNC) test ..My sister did not believe her... The matron
asked me to retake the test ..I did because I wanted to become a nurse'. Although
'insider knowledge' of the system was used to challenge the decision, the balance
of power remained with the matron.

Of the 18 respondents routed into EN pathway, only three managed to change
their pathway during training. The principal reason for this was related to the
'authority structures' they had to negotiate as the two key people, the matron and
senior tutor, who had the power and authority to either grant or block applications
for transfer were the same people who had routed them to the EN pathway.
Brenda's (Jamaican) case, previously discussed in chapter 5, used the agency of
the High Commission's office *'to .effect transfer'.* Anil (Mauritian) said he
challenged the decision *'but each time I met with the senior tutor or the matron I*
got a different story......[both] played games with me...[and] moved the goal post
to make things difficult. I suppose they thought I would back off. The transfer
came through more than a year after I started as a pupil nurse'.

The other 15 respondents gave a range of reasons to explain why they were
unable to switch to the RN pathways during the training period – the key one
being not finding out in time the difference between the two pathways. Amin

(Mauritian) *'did not find out until 18 months into the pupil nurse training - with only 6 months left to qualification there was little point making a fuss – I would not have gained anything'.* Samuel was ' *delighted to be allowed to switch pathway but couldn't because there was no accommodation for me in the male nurses home'.* At the time he *'didn't twig that accommodation was not the problem as I was living in the male nurses home...It was a ruse – one that worked because of my ignorance of the system'.* Bridget (Sierra Leonie) said that she was *'asked to opt out and wait for a place on the RN course. The matron could not tell me when this would be'.* Deirdre (Jamaican) was also given the option of waiting for a place on the RN course but her financial vulnerability prevented her *'from opting out until I could re-start on the SRN training...[I] did not have this luxury... They knew this'.* As neither Deirdre nor Bridget were offered firm dates for commencing RN training or given the option to work as nursing auxiliaries in the interim, the conclusion drawn was that these actions were deliberate barriers, constructed in the knowledge that the applicant would not be able to meet the conditions.

Betty (Trinidadian) on discovering she had been misrouted *'took matters in my own hands and applied elsewhere. I honestly didn't know that GNC records were central and other training hospitals would discover I was training elsewhere. Within a couple of weeks, I was called to matron's office.... She accused me of duplicity, deviousness and causing them embarrassment, but failed to acknowledge why I took the action'.* Betty was not allowed to swap pathways *'it enraged me to the point that I used the knowledge as a form of civil disobedience...I would seek out each new black pupil nurse out and tell them*

about the dual level of training. I suppose I was trying to make sure that history did not repeat itself....My actions made me extremely unpopular with the matron, but she could not stop me'.

Respondents' understanding of being assigned to EN pathways included explanations about 'not meeting entry criteria', 'their command of English being weak', 'the EN pathway allowed them to qualify as nurses in 2 years compared with 3 years for the other nurses'. Scot (Mauritian) recalled being *'asked if I was interested in nursing people or ward management- I didn't know why I was asked that question so I said nursing - [as] that is what I had applied for'*. Scot was allocated the EN pathway on the basis of his response. Interview data identified two different patterns in routing overseas applicants to the EN pathway: by exploiting the recruits' lack of knowledge about nursing qualifications and those not meeting the entry requirements. I was unable to identify any respondent who made an 'informed choice' to qualify as an EN.

In the process of conducting interviews, I became intrigued by a number of stories that referred to the 'passport being confiscated by the matron'. The unique feature of this phenomenon was that it was specific to 11 respondents who had been misrouted into EN training. Sarah (Sierra Leonie) told me that her passport was *'confiscated by the matron on the pretext that it was to check the details with the work permit...It wasn't returned until I finished training'*. Claudia (Jamaican) intimated that the reasons for retaining the passport *'was to prevent us from changing to a different training hospital.'* Jacqui (West Indian) claimed that *'the matron's refusal to release my passport'* prevented her from changing training hospital. Surprisingly, none of these eleven respondents reported the matter of

their passport being confiscated to anyone, nor did they check out the legitimacy of the action with the Home Office. Such behaviours can only be described as intimidation, bullying, harassment and treating overseas employees as indentured labour.

6.5. Direct and Agent Managed Applications

Applications for nursing were managed either as direct applications to named training schools or via British government appointed agents in the source country. Respondent accounts show that for many of those surveyed, the process of direct application was marred by the misuse of the GNC test and its results, SsON not informing candidates about the branch or level of training they would be commencing and some black applicants being required to work as nursing auxiliaries.

During the 1950-70 period, agents in the source country often managed overseas recruitment by processing applications and executing English language tests, but it was the Matron of the training hospital who corresponded with the candidate to confirm the place offered and the date the 'nurse' was to report to her office. Four African-Caribbean respondents (Brenda, Emma, Rose and Jolene) showed me documents pertaining to offer of place, the date for commencing training and their allocation to general or mental nursing. These documents did not make reference to the level of training. All four were categorical that they *'had never been informed about the different pathways... [and] assumed that training would lead to qualifying as registered nurses – the only grade known back home'*. Lal and

Scot (both Mauritian) also denied any reference being made to the training route

or discipline. Lal admitted that he had *'agreed to take a place on any course*

going – [I] ended up in mental nursing'. Similarly, Scot was allocated to RNMH,

a field he had *'never heard of before ... [I] stayed because there were other*

Mauritian men in training'.

6.6. Black Nurses as a Source of Cheap Labour

Doyal et al (1981) and Graham (1997) have argued that black people were used to

keep the costs of the welfare state down by employing them at lower grades.

Without doubt, training and employing ENs was cheaper than training RNs. I

have already shown that more respondents than expected commenced EN

training. Interview data revealed that a number of training hospitals required the

respondents to work as nursing auxiliaries for periods of three months or more,

under the guise of providing them with 'time to acclimatise', 'accommodate their

late arrival' or 'help with English skills'. Cheri (Barbadian) appreciated the

opportunity offered to adjust to separation from family and become familiar with

the nursing tasks. She said it *'gave me some insight about nursing'*. Similarly,

Patricia (West Indian) welcomed the opportunity *'to get a feel for things in*

England'. Other respondents were critical, of such 'paternalistic and patronising

actions', interpreting them as more examples of racialised treatment of people

whose vulnerability was directly linked to being 'unsupported in a foreign

country'. Deirdre (Jamaican) signalled that *'it was pure exploitation.... An action*

perpetrated under the guise of doing me good ..Who could argue with that'? She

said *'I missed the start of the PTS by 4 days – therefore I was made to work as an auxiliary until the next intake - [The tutors] didn't apply the rule to the English girl who had also arrived late'*. Bad weather had delayed Maria's (West Indian) ship by two days. On arrival at the SON, she was *'informed that her place had been reallocated because I hadn't arrived in time.... At the time I thought it was grossly unjust, but in hindsight I think it benefited me'*. Nikki's training was deferred to give me *'time to get used to English ways – how patronising can one get'!* Respondents' accounts displayed both direct and indirect racisms and showed that senior members of nursing staff in certain training institutions held stereotypical views about the black peoples abilities. These accounts indicated that there was little or no effort made to put the interests of the overseas recruits first.

6.7. Professional And Academic Qualifications

The 'licence to practice as a registered nurse' awarded following the successful completion of that course was considered to be a 'starter package' that was pivotal to the nursing career. Three primary categories of nursing qualifications were identified as: registered, recordable and other qualifications. I shall define each of these and then examine how respondents have used them to develop their academic and professional profiles. My intention is to demonstrate that respondents' held a wide range of qualifications that were obtained in two different phases. The first was a certificate gathering phase when the individual was not clear about the direction of their career, and the time spent acquiring the

certificates was synonymous with 'testing one's fit with the practice field'. Normally these courses were of a short duration varying from 3 to 6 months in length, and as the training and employment was linked, course funding was not an issue. The second phase of qualifications were those aligned to the centralised practice domain, having a clearer link with career development, and were pertinent to their aspirations, job and interests. Some American research (Morris and Wykle, 1994:184) recognised that black nurses careers were 'barrier laden' and were opting for higher degrees as a strategy for promotion.

Registered qualifications were those required as a licence to practice, for example, General Nursing (SRN, RGN, RN), Mental Nursing (RMN), Learning Disabilities (RNMH, RLDN), Sick Children's (RSCN), midwifery (SCM, RM) or health visitor (HV, RHV), with a smaller range of qualifications for enrolled nurses in general nursing (EN-G) and mental nursing (EN-M). Recordable qualifications were those qualifications deemed as desirable for the practitioner to hold as a specialist but were not required as licence to practice for employment purposes, however these qualifications were entered on the nursing board and UKCC databases. Qualifications in this category include community nursing (except for health visiting which remains a registered qualification), teaching, and Nursing Board numbered courses such as the ENB 998. The status of teaching qualifications was reclassified from registered to recordable in 1987. The nursing boards or the UKCC do not normally record other professional development or academic courses, for example degrees, management qualifications, or other short courses unless they are a component of the recordable or registered nursing qualification. Respondent data displayed in Table 6.4, shows that 84 of the 88

respondents held more than one registered nursing qualification, with only four respondents having a single registered qualification evenly split between general nursing and mental nursing. Further analysis of professional qualifications showed that 78 respondents (88.6%) were qualified as General Nurse, 37 women had both Part I and Part II midwifery qualifications (42%), and 31 were qualified mental nurses (35.2%). Colin's (Mauritian) profile was unique in that having commenced as an enrolled nurse he spent the first decade of his nursing career *'lurching from course to course'* to accrue 6 nursing qualifications including EN(G), EN(M), RMN, SRN, RMSN, and RNT, and then went on to obtain a first degree *in nursing education and an MBA.*

Table 6.4. Range of registered professional qualifications held by respondents

Registered qualifications	African	African-Caribbean	Asian	Total Cohort
One	1	1	2	4
Two	4	8	8	20
Three	11	15	18	44
Four	0	10	3	13
Five	1	3	2	6
Six	0	0	1	1

NB: Registered qualifications are inclusive of any EN qualifications held by the respondent.

6.8. Academic Qualifications Held By Respondents

All respondents held or were in the process of acquiring a wide range of academic qualifications spanning from undergraduate certificate to doctorate. Forty-four respondents (50%) held a teaching qualification, ranging from 'Further Education Teaching Certificate' (FETC) to 'Post Graduate Diploma in Nurse Education' (PgD). Six teacher-qualified respondents had not sought UKCC recognition for their qualification because they did not intend to seek a career in nurse education, whereas 16 others had opted out of teaching to pursue other interests. Table 6.5 illustrates the range of academic qualifications acquired by the 88 respondents, excluding the teaching qualifications.

A number of respondents had proceeded to master's level courses on the basis of advanced standing through their work-based learning. The data showed that with the exception of two respondents who were in the process of career changes into law and business administration, respondents' academic qualifications were strategically linked to their future aspirations or current jobs. Analysis of the data related to academic studies completed or underway, infers that respondents had recognised the importance of credentials to their career and that like their American counterparts, these individuals were using higher degrees as a strategy for career enhancement.

Table 6.5. Academic qualifications and aspirations of respondents

Graduates

• **59 respondents are graduates** (67.04% of cohort)
 	
 - 14 have a first degree
 - 29 have a 1st degree and a masters degree
 - 1 has a 1st degree and Post Graduate diploma
 - 6 have a masters degree (without a 1st degree)
 - 9 have a PhD (other degrees excluded)
 	
 Of this group:
     - 12 are registered for their PhDs,
     - 2 are registered for masters degree.

Non-graduates: 29 of the respondents (32.95% of cohort) are non-graduates   • 5 Africans, 13 African-Caribbean and 11 Asians.   • 12 have a certificate level qualification   • 15 have a diploma level qualification   • 2 have a post graduate diploma qualification (non-standard entry gate)   *Of this group:*   • *6 are in the process of completing their 1st degrees,*   • *3 are doing their masters degrees*   • *2 are on a post graduate diploma course.*

6.9. Drivers For Professional and Academic Study

One of the goals of this research was to discover the motivations that prompted respondents to pursue academic and professional study. I shall demonstrate that the personal agency (of respondents) was a critical driver for undertaking academic study. Three 'driver' patterns, closely affiliated with individual motivations, were identified as: **'job related'**, **'personal development'** and **'insurance policy for enhancing promotion prospects'**. Dex (1985) and Walby (1988) point out that education qualifications and credentials do not guarantee

occupational mobility, but are an integral component of one's social capital (Fine, 2001). Valerie (Ghanaian) eloquently summed up her motivation for academic study as *'stroking ones career prospects'*. Selena (Black-Caribbean British) who was in the process of completing her third master's degree concluded that her aim was to have *'demonstrable job specific credentials'*. Individual motivations were expressed as, 'interest in the subject', 'intention to specialise in that discipline', 'broadening horizons', 'wanted to do the job better' and 'necessary to the job or the next step up'. A few respondents drifted into the professional or academic courses by emulating their friends or a specific happening in the work place stimulated their interest. For example, two community nurse managers elected to study a module on law following an in-service workshop on child protection, a realisation on their part that as managers they needed to have a more in-depth knowledge of the legal aspects governing child protection.

6.10. Resources To Undertake Academic Study

In Chapter 5, I discussed the importance of the social capital an individual could call upon to access resources symbolically and in reality. In this section I intend to show that respondents' access to resources, specifically paid study leave, course fees and adjustment to work load to facilitate study, was affected by poor management, reluctance of managers to grant support and racial discrimination. Interview data showed that resources to undertake academic study were secured from a variety of sources including the ENB, DoH, employers, local education authority, Kings Fund, scholarships, fellowships or awards (for example, the

Harkness Fellowship, Florence Nightingale Fellowship, HSA Awards), own savings or bank loans.

A total of 324 study episodes of academic study were identified and classified into three groups, those that were: **'fully employer funded', 'fully self funded by the respondent' or a 'mixed mode'.** 126 study episodes (38.8%) were fully supported by the employers who met respondents' fees, study time and travel costs in full. Mandatory courses such as teacher training or HV qualification were normally funded via the ENB, subject to the employer organisation and education centre selecting the individual for that studentship. It was evident that people were more likely to receive full or partial employer support if they demonstrated links between the study and employer-organisation goals. 89 study episodes (27.5%) were wholly self funded by respondents to the point that respondents negotiated the duty roster to ensure that the days off in the week permitted them to attend college or they took annual leave for that purpose, without any adjustment being made to the workload. The most common reason given for not receiving employer support was *'managerial perception that the study pursued was not job related but of personal interest to the employee'* (Ruby: Trinidadian). Frank (Hong Kong Chinese) concluded that *'shortsighted managers had difficulty acknowledging that management studies, counselling or health education, were relevant to our jobs. They refused to see the relevance of that knowledge to everyday practice when a black nurse applied for resources but had little hesitation in supporting white applicants'.*

Forty-eight respondents (15%) received partial support, for example help with fees only or were given a specified amount of paid time off for study, by the

employer organisation. In most of these cases, respondent contribution was the major component as employer support was often received for the final year study on the basis that *'commitment to the studies had been demonstrated'* (Anthony: Indo-Malay). Some employers allocated funds for study through competition, a process open to abuse and criticism because the *'criteria was covert'* (Maurice: Jamaican), or vague. For example Tim (Jamaican) was asked to write an essay on why he wished to study *'without knowing how the essay was to be judged and who by'*. Kiran said she was reluctant to *'put much effort into the application if it was for a fraction of the fees... I did not see that as time well spent. I know of white nurses getting full support for the entire course and black nurses having to apply each year with no guarantee of the level of support'*. Julie's (Guyanese) employers assessed the worthiness of requests for support on an annual basis *'using non-standard applications... There was no uniformity. What were they looking for? The committee were faceless and nameless.. Needless to say awards always went to white applicants'*. In contrast to these experiences other respondents, (Ruby, Hazel, Valerie and Faisal) felt they had been fairly treated when they applied for resources for their higher degrees. Barribal and While (1996b) found that continuing professional education was affected by lack of resources, for example funding and time for study; personal circumstances and domestic responsibilities of practitioners. Beishon et al (1995: 78-93) and Ellis (1990) concluded that ethnic minority nurses experienced more barriers than white nurses to access education and training opportunities.

Thirty-six respondents were seconded for specialist preparation for health visiting, district nursing or community psychiatric nursing, and 31 received Nursing Board / EAG support to undertake nurse teacher preparation (ITT). Secondment to mandatory courses was normally associated with a generous standard package covering: full study leave, a full salary on their clinical grade, reimbursement of travel costs and a sum of money as book allowance. It is possible that some respondents' received full ENB funding for more than one mandatory course, such as teacher training and health visiting. Thirteen respondents' self-funded ITT courses either because the study was pursued whilst being employed as a practitioner, they were not made aware of the potential for support via the school of nursing or were ineligible by reason of not undertaking a nursing board approved.

Twenty-eight respondents received support from the local education authority, SERC, DoH or the King's Fund Education Fund, to support their academic study. Another 26 respondents who were part way through studies displayed a resourcing pattern almost identical to the one described above. Seven respondents who received either full or partial employer funding indicated that they had been unsuccessful in securing employer support on at least one previous occasion allegedly because their applications were weak on articulating benefits to the organisation.

6.11. Patterns of Career Breaks

A career break is defined as time away from paid employment to pursue other activities, and may be voluntary in nature, for example for the purposes of personal development, maternity and child-rearing or involuntary through organisational restructuring. Literature (Davies and Rosser, 1986; Robinson, 1993; Joshi 1989 in Robinson, 1993) points to the negative aspects of career breaks in terms of delayed promotion (Ratcliffe, 1996) or difficulties in securing employment tenure (Gregory, 1999). Davies and Rosser (1986) having demonstrated that there was a gender bias in promotion to nursing officer grade (men reached it in 8.4 years, compared with 17.9 years for women), went on to show that career breaks for maternity reasons delayed female nurses promotion to nursing office grade by approximately 5 years. Respondent data demonstrate that career breaks were not utilised by respondents unless they were strategically linked to employment.

My analysis of career breaks revealed that 48 respondents, 10 male and 38 female, had taken at least one career break during their career while 3 female respondents displayed a pattern of multiple career breaks to include maternity leave, study leave and overseas work. One male used a career break on two occasions for personal development that is for his doctoral studies and working overseas; and then experienced an enforced career break for health reasons. The pattern of career breaks (detailed in Table 6.6) show that women dominate each category. Forty respondents did not take a career break of any description, managing further or higher education on a part time basis or as student of the

Open University. Given that nurse academics have been in HE since 1992, I did

not identify any episodes of paid sabbatical leave.

Table 6.6: Career breaks

Type of career break	Commentary
Maternity leave	60 maternity leave episodes between thirty two women 1 - 5 maternity's for African women 1 - 4 maternity's for African-Caribbean and Asian women
Academic study	68 episodes (12 male and 56 female) 37 of these were for full time teacher training and 24 for HV or DN courses 7 to pursue graduate or post graduate (including doctoral) studies
Personal Development	One episode of a secondment to another department (within the employer organisation) for a period of one year
Overseas work	Nine individuals (2 male and 7 female) worked overseas for periods of 1- 4 years (a total of 12 episodes).
Health problems	Two respondents . 1 African-Caribbean female and 1 African male.
Unemployment	Two Asian females and one Asian male experienced unemployment.

6.12. Centralisation Of Practice Domain

In Chapter 3, I referred to the complexities of nursing regarding its many branches

and growth in specialisms. Although respondents acquired a number of

professional qualifications during the certificate-gathering phase, the range of

those qualifications did not reflect the eventual field of practice respondents had

chosen to centralise in. I was interested to discover the processes respondents'

adopted to shape individual career trajectories up to the point of centralisation by

examining their initial training pathway, career guidance received, personal interest, and employment and training opportunities.

EN qualified respondents had to convert to RN before they could get on the first rung of the career ladder. Most respondents were not aware of the importance of the link between their initial qualification and subsequent access to post-registration nursing courses. For example admission to midwifery training and health visiting required the individual to be a registered general nurse, thus individuals who did not possess these pre-requisites were barred from entry. Kiran (Indo-Malay) and Prakash's (Kenyan) initial qualification as RMN was perceived as a barrier to promotion by senior nurse managers who informed them that dual qualification as RMN / RN was imperative to their career progress. Both respondents resisted pressure to train as RN on the basis that any promotion they would seek would be in mental health and considered the RN qualification as superfluous to requirement. Kiran found herself defending her reasons *'for not having an RN the very first time I applied for promotion as ward manager'*. The single qualification did not present any difficulties for Prakash as he was *'trading on previous managerial experience to make headway'*. Other respondents, including Maurice (Jamaican), Bridget (Sierra Leonie) and Roger (Ghanaian), *'accepted the general wisdom of the day'* and added the RN qualification to their portfolio. Maurice's assessment was that having been told that the *'custom and practice required me to be dual qualified, I felt it prudent to go with the flow'*. Bridget realised that while there were no guarantees that a dual qualification would secure promotion, she nevertheless felt behoved *'not to ignore the advice'*.

Access to further training opportunities immediately after initial qualification as EN or RN was controlled by the training hospital acting as a gatekeeper either through career guidance, providing references or preventing immediate exit following qualification by the training hospital imposing a rule requiring newly qualified nurses to 'staff' for a minimum period varying from 6 months to one year, allegedly to consolidate their training but in reality to meet nursing labour requirements. The majority of respondents surveyed for this research received little or no career advice even when they asked for it, and when it was given, it was limited to the custom and practice of the time. It is inevitable that without knowledge of opportunities, respondents lacked facility to formulate and realise their goals (Marsland et al, 1993, 1996). Respondents' commented that 'career guidance was a relatively rare event' (Nigel: Nigerian)) and according to Babna 'opportunistic in nature' rather than being 'person specific career advice'.

In nursing career counselling and guidance has been lacking for white and black nurses probably because it was not judged to be important or because the choices were fairly restrictive to begin with. Also custom and practice rules, which had served generations of other nurses, continued to be applied without anyone recognising that the principles were outdated. Valerie's (Ghanaian) recollection was that up until the mid-1970s, the 'standard advice for women was to go into midwifery, so as to be all rounded and for men to be qualified as general and mental nurses'. None of the HV, DN or teacher-qualified respondents' recalled being specifically advised to consider those fields; nevertheless their personal agency took them there. A point of note here is that career counselling or guidance in general has not been available in nursing, often by default. Marsland

et al (1993, 1996) identified 3 pivotal stages for career guidance: pre-entry to nursing; during initial training and post initial qualification. I suggest that personalised career guidance should be available at different levels throughout one's career to identify opportunities and must be relational to the individual's goals, aptitude and skills. Career development is not an innate skill but one that needs to be developed to ensure that individuals operationalise career choices strategically. For career guidance to be meaningful, it should bring about individual change, and concurrently meet organisational, professional and individual needs.

The concept of friends helping to shape a career trajectory emerged as an unexpected but strong influence in that informal discussions between peers often led to identical career moves being initiated. Respondents who fashioned their career journey on that of friends 'wanted to remain together as a group', almost as if they were recreating a family-group. In hindsight, Amin could see that '*what seemed like a good idea at the time was in fact lack of strategic thinking about the career'*. Rose (Barbadian) surmised that '*having discussed our ideas about 'where to next' ...the fact that we ended up doing the same courses or even applying to the same places was not unusual.... The reality was we relied on each other to access information, the level of guidance from tutors and others was poor'*.

Post initial qualification destinations revealed three main patterns: Pattern A was unique to the EN who either went directly to a conversion course or worked until a place was offered to them; Pattern B applied to the respondents who proceeded to a second registrable qualification, for example SCM, RMN or RN, and Pattern

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C referred to those who like Kiran and Prakash chose to 'stick with the single qualification' or elected to do a short course, for example theatre nursing or special care baby course. Table 6.7 shows that the pattern of professional qualifications, reflected a gender bias in favour of women for midwifery, health visiting, sick children's nursing and district nursing, and in favour of men for mental nursing and mental handicap nursing.

Table 6.7. Gendered bias in professional qualifications acquired

Professional Certificates	Male Cohort	Female Cohort	Comment
Mental nursing	22	9	89.28% of the male respondents were RMN qualified.
General nursing	23	55	Two women and 5 men were not RN qualified.
Mental handicap	4	0	2 Mauritian-Asian, 1 Pakistani and 1 African-Caribbean
Midwifery	0	37	61.66% of female respondents were SCM / RM qualified. Includes: 8 African, 20 African-Caribbean and 9 Asian
Children's Nursing	1	7	• One Mauritian - Asian male • Viewed as female role
District Nursing	1	5	• One Hong Kong Chinese male • Viewed as female role
Health Visiting	0	18	• 3 African, 11 African-Caribbean and 4 Asian • Males excluded until 1970s
Practice Nursing	0	1	• 1 African-Caribbean • Viewed as female role
Community Practice Teacher	0	7	• 1 African, 4 African-Caribbean, 2 Asian
Community Psychiatric Nursing	2	2	• All Asian

Men were barred from health visiting as a result of the pre-requisite of a midwifery qualification until 1970 when The Council for Education and Training of Health Visitors (CETHV) relaxed the entry gate by substituting midwifery with a 12 week approved programme in obstetric nursing. Thus it was not until the change in entry requirement that the first male was admitted into health visiting. The absence of male respondents' in midwifery was connected to the absence of men from the discipline per se when their admission was facilitated under the Equal Opportunities Act of 1976.

Unpacking the reasons why individuals elected to centralise their practice domain in one particular discipline or field of nursing was complex. Centralisation was patterned as: 'always wanted to be...'; 'attraction to the field through exposure to it'; 'recognition of opportunities for promotion in a given field, for example in nursing those with challenging behaviours, forensic mental health or elderly care; and 'serendipity'. The patterns suggest that the process of centralisation was a not guided or determined by external guidance; conceptual deliberation or assessment of aptitude, skills or knowledge requirements of the discipline; but was a process guided by a set of personal perceptions that did not include notions about some fields being easier for upward mobility or more receptive to promoting black people.

Many of the respondents' only learnt about the potential opportunities in service management, service development, policy development, research and education, when they reached the ward sister / charge nurse grade. Respondents' who elected to access these opportunities underwent a process of re-centralisation. Re-centralisation continues to include a number of contradictions: first it removes the

expert practitioner from clinical practice. Second it simultaneously takes the respondent into a new field, for example management, research or education where their previous experience is not of primary significance as the individual is required to learn new skills and ways of working. Furthermore, in some fields the respondent would be required to obtain the necessary academic credentials, for example, a teaching qualification. Third it places the respondent at the bottom of the career ladder in the new field but normally accords them a higher salary grade than the one occupied previously. Although re-centralisation normally occurred after respondents were appointed to the ward manager post, 6 respondents circumvented that career grade to re-centralise earlier. Harry (Hong Kong Chinese) and Erin (Nigerian) used secondment to district nursing to 'leapfrog' from staff nurse grade. Shabana traded on her bilingual skills and overseas public health experience to fast track on to a specialist practice community-nursing course. Tim (Jamaican) was certain that his year long *'stint in a world famous US oncology unit'* enabled him to make a vertical career move *'some three years earlier than normal'*. Babna's post as 'clinical teaching co-ordinator' was considered as equivalent to the ward manager grade, whereas Prakash's prior experience as a manager in industry was the key to his early re-centralisation. In Chapter 7, I shall discuss the factors that prompted respondents' to re-centralise.

6.13. Social Profile Of Respondents

Studies (Buchan, 2001; Davies and Rosser, 1986; Davidson, 1997:27; Gregory, 1999) indicated that women careerists tend not to be married, marry late and elect

not to have children. Gregory (1999) found that black women in US academia married later in life than their white counterparts and non-academic black sisters, or not at all. A series of DoH studies (Disken et al, 1995; Dixon, 1996; Dixon et al, 1994) confirm Hardy's findings (1983, 1986a, 1986b) of the profile of the men in leadership positions in nursing as one of being married and with children. Often the senior woman in nursing leadership is described traditionally as single and childless. The reality of the single woman making nursing her lifetime work has changed in the last two decades, for example Mrs Sarah Mullally, Chief Nursing Officer for England, the new General Secretary of the RCN and the General Secretary of the RCM are women with children.

Respondent data showed that 60 of the 88 respondents (26 male and 34 female) were married or in stable relationships, with 32 respondents having white spouses or partners. Fifteen respondents, (one male and 14 female) were single, widowed or divorced. The marital status of the remaining eight respondents (1 male and 7 female) was not known. 12 female respondents came into nursing after their marriage or after completing their families. The majority of respondents commenced nursing as single persons, although six of the men got married during their initial training.

6.14. Parenthood and Child Care

Given that some respondents came into nursing after marriage and child bearing, and others married either during or after nurse training, the issue of simultaneous career and family, that is, combining parenthood with professional careers (Lee,

1992:14) was an important one in terms of managing child care. Sixty-two respondents (70.5%) were parents, a number that was far higher than expected. At the time of data collection, the age range (of 142 children) spanned from 6 months of age to adult children with their own families. The largest family size was six children. Child-care patterns revealed that while women did not see any conflict in combining career with family responsibilities, they were concerned about the quality of childcare available (Davidson, 1997: 28, 32; Gregory, 1999).

Arrangements for managing childcare were often left to the female parent. Almost 50% of the parents believed that racial factors adversely affected their access to good quality childcare and may have contributed to the instability of those arrangements. Those who relied on their older children to help with childcare or had close friends registered as child minders (12 and 11 respectively) did so because they wanted to ensure that childcare was provided by a 'constant figure'. They believed that family and friends were more reliable and sustaining social influences, and perhaps the most important was the desire for same culture influence on their childrens' socialisation. Indira (Kenyan-Hindu) *'worried in case the children were fed beef... I didn't want the children to be treated differently at nursery but at the same time I worried about the culture and values they were exposed to'.* Champa said she persuaded her *'widowed mother to come to the UK so that childcare was culture specific and stable in the hands of the extended family'.* Other strategies for managing childcare included the employment of a 'day or resident nanny', private or public day nursery provision or social services recommended child minders. Only one respondent, without relatives in the UK used a long-term fostering arrangement for her child. Contrary

to expectation, night work did not feature as a primary strategy for managing childcare. The strategies to provide stable childcare reflected those of black women in academia in the USA (Gregory, 1999) and Davidson's study (1997) of black and ethnic women managers.

6.15. Conclusion

In this chapter, I have shown that the relationship between structures, namely entry gate, access to resources for personal professional development and agency, was underpinned by personal motivations and goals. Respondents' entry gate experiences for standard and non-standard entry, regardless of whether they made direct or agent managed application, were subjected to oppressive and discriminatory processes, namely the misuse of the GNC test and its results by misrouting respondents into the EN pathways, preventing them from changing pathways and using them as cheap labour. Often respondents were either not aware of the discrimination at the time of the incidents, but in retrospect could identify the inequalities experienced in entry gate and allocation to the EN pathway. For some respondents, participation in this research gave them the first opportunity to voice those racialised experiences. There was evidence of a few respondents' resisting structural barriers and processes, for example by informing the High Commission's office about the discrimination experienced or actively informing new black recruits about the potential for abuse. Respondents who did not possess the pre-requisite entry requirements considered themselves lucky to

have had the chance for a professional education and career via a non-standard entry gate.

The range of academic and professional qualifications acquired by respondents' demonstrate two phases: a certificate gathering phase that allowed them to test out fields of practice for short periods and a second phase of acquiring qualifications that were strategically linked to their fit with their career goals and centralised domain of practice. The supposed importance of centralisation of practice domain as the specialism of the nursing career was negated by the effacement of the processes adopted to arrive at those decisions. Lack of career advice and peer influence on shaping career was a recurrent theme. Respondents' experiences in securing resources and lack of career breaks were indicative of the barriers faced to secure resources to pursue academic and continuing professional studies. Respondents secured varying degree of resources from a variety of agencies, with the employer organisation and self-funding being the two primary sources. I have shown that in addition to the personal motivations, three drivers were essential for undertaking professional and academic study. These were perceived in relation to being either 'job related', for 'personal development' or as an 'insurance policy for enhancing promotion prospects'. The majority of career breaks were associated with maternity leave or with full time secondment for mandatory courses such as teacher training or specialist practice community courses. Although respondents did not perceive any conflicts in combining parenthood with professional careers, many believed that racial/ethnic disadvantage had impacted on the quality and stability of childcare arrangements.

In Chapter 7, the focus is on the reasons why respondents became careerists, the strategies they adopted to deal with the structures and processes resultant from earlier decisions and actions taken.

CHAPTER 7:

BECOMING CAREERISTS AND GROWING

SUPPORT NETWORKS: STRUCTURES AND

PROCESSES[1]

7.1. Introduction

This chapter follows on from Chapter 6 to elaborate the reasons why the black

nurses became careerists and the processes used to mobilize social and

professional structures, drawing on resources of social capital to access

employment opportunities, dealing with racism, and changes affecting the culture

and organisation of nursing. I aim to demonstrate that respondents' decisions

were influenced by factors such as their decision to remain in the UK, the

recognition of the higher-level opportunities available as they reached a particular

stage of the career ladder; and the development of black support networks in their

journeys to the top. The effect of organisational barriers on career opportunities is

well documented (Alimo-Metcalfe, 1993:71-72; Lee, 1992:8). Anleu (1992:651)

found that occupational mobility, that is the relationship between an individual's

achievements and the labour market structure is linked to the organisation of

work, normally through hiring and firing of staff, pay decisions and gender

segregation. I shall also show that in the process of becoming careerist, respondents' moved through a series of career phases that were extended beyond those identified by developmental and person-environment theorists and that these variations were linked to the organisation of nursing.

A nursing career is a multiple career consisting of employment as a nurse; participation in professional development that allows certificate gathering and shapes centralisation of practice domain; and the individual balancing other parallel-unpaid careers. Analysis of the career trajectories (spanning 10 to 40 years) of respondents' surveyed here identified a cyclical pattern of 7 phases (detailed in Table 7.1) through which the career evolved. All 88 respondents displayed sequential career patterns, (Stroh and Reilly, 1999) to include vertical and or lateral career moves either in the same or different employment organisations; professional and or academic studies (Barribal and While, 1996a, 1996b); and often had simultaneous careers as parents (Lee, 1992). Respondents' career trajectories showed diversity in the pattern of career breaks (discussed in Chapter 6), use of geographical mobility and permanent night work. Table 7.1, shows that phases 1, 3 and 5 had a fit with elements of career theories espoused by Super (1994), Holland (1994) and/or Krumboltz (1994). Super's (1994) developmental theory across the 'life span, life space theory' is linked to the career developing, transitioning and maturing over time. Holland's (1994) 'person-environment' theory relates to the selection and preference to work in organisations that had a fit with personal values and at the same time had the

potential for a return on the investment. Krumboltz (1994)*social-learning'* theory explains the relationship between social capital and organisational needs. Phases 2, 4, 6 and 7 were unique to the respondents surveyed in respect of the transitions and adaptations required for a nursing career.

Table 7.1: Phases in Career

Phase	Descriptor	Fit With Career Theory
1	Tentative phase from entry to qualification.	Super (1994)
2	Testing out career choice. Learning more about opportunities. Certificate gathering.	*Research finding*
3	Getting started in chosen field. Occupational choice is confirmed.	Super (1994).
4	Centralization of practice domain. Find position of security. Learn more about higher opportunities in field.	*Research finding.*
5	Assess if personal traits, attributes, aspirations and rewards, skills and abilities match requirements for higher opportunities identified in previous phase. Make career move. Maintenance and stability.	Krumboltz (1994) Holland (1994)
6	Recentralise practice domain. Develop the career to ensure progress.	*Research finding.*
7	Being at the top - Continue to achieve - Remain employable	*Research finding.*

The convergence between the different career theories indicated that descriptors could be interpreted from multiple perspectives with the caveat that career theories (Super, 1994, Krumboltz, 1994; Holland, 1994) were developed from the experiences of western, white, middle class, men in professions; with little or no attention being paid to ethnicity, gender or non-professional occupations or second careers in middle age. Also, stage theories, for example Super (1994), allude to a systematic progression through the stages without taking account of structural changes, for example in the labour market, the reasons why career choices were exercised or the personal agency mobilised to shape a career. Lee (1992:15) questioned the validity of career stage theories because of the effect of unpredictability of unexpected change creating conditions of uncertainty in the environment.

7.2. Becoming Careerist

The frequent transitions in nursing career make the task of identifying the exact point at which people become careerist impossible. Respondents' accounts enabled me to define 'becoming careerist' as the point at which there was an acknowledgement at a tacit or explicit level that their life's work was in the domain of practice of choice and that there was a firm intention to get to the top of the career ladder in that field. Two classical sentiments expressed by respondents related to the notions of: (a) time and resources invested in nurse training was

going to be made to work for them in a positive way, that is, as career gains, and (b) going with the flow of things whereby goals were reset at each stage of progression, followed by a recognition that the career was well advanced but could be improved upon with strategic investment of resources. King (1993:5) confirms that personal agency in determining individual choices is dependent on opportunities, societal constraints and conditions.

Respondents identified their reasons for becoming careerist as: family security; a decision to be permanently domiciled in the UK; and personal ambitions which often evolved in parallel with career opportunities. In Chapter 6, I indicated that when respondents' got to the career grade of ward manager, they had to exercise their personal agency to determine if they wished to recentralise their practice domain or remain in the practice. These decisions were based on their knowledge of opportunities in the local and broader nursing labour market; their exposure to activities that enabled them to assess their aptitude, interest and desire for alternative careers in education, research, service management, service development or clinical governance; and career advice.

Hardy et al (1997) noted that the factors influencing career decisions included organisational changes, individual skills and credentials linked to employability, career counselling, new challenges, chance and mentor guidance. Gender segregation cannot be explained by human capital theories in relation to emphasis on personal characteristics, career decisions and individual achievements (Anleu, 1992:652). Instead gender segregation is perceived in terms of labour market

constraints on womens' access to a range of occupational opportunities and structures that determine their decisions and achievements (Anleu, 1992: 652). Since the implementation of the Salmon Report in 1968, top jobs in nursing favour men through emphasis on leadership skills, technical competence, unconditional dedication to work; qualities associated with male sex roles (Evans, 1997:229). Greenberg and Levine (1971 in Evans, 1997) found that male nurses chose disciplines that did not require traditional nursing dress, thus allowing them to escape identification as nurses.

There were gender differences in the perceptions of 41% of respondents, about why the move into education or management was initiated. Several men commented that the move into education or management was negotiated because both were culturally and socially more acceptable career choices for men. Roger (Ghanaian) believed that the teacher label brought him, *'status... [and] respect'*, his *'sexuality wasn't questioned'*, and restored him to the *'West African social circle'*. Jack (Chinese-Malay) found the title of *'lecturer in communication studies was far more acceptable than owning up to being a nurse – [I] stopped getting the strange looks'*. Anthony (Indo-Malay) said his self-esteem improved when he *'qualified as a teacher...[I] stopped being embarrassed about the nursing qualifications...[I] didn't refer to them really'*. None of the women denied their nursing qualifications; instead they used them to demonstrate the higher credentialisation of nursing.

I identified five inter related reasons for becoming careerist. These were personal drivers; labour market needs; expertise and niche markets; business potential and serendipity; however all had an element of opportunism and a desire to reach one's aspired goal. I shall discuss each of these:

7.3. Personal Drivers

Individual goals and aspirations were perceived to be the most significant for the purposes of grasping opportunities particularly those reflecting their personal interest field. Banu's (Tanzanian) plans to take a career break until the children were at school were altered by her *'serendipitous appointment as night nursing officer'*, because she *' found her forte'* in management, *'it made me very career conscious – prompted me to enrol on part time management studies'*. Prakash (Kenyan) brought his managerial skills to nursing that aided, *'clarity in determining my goal. When I qualified as an RMN, I knew I wanted to move into management'*, thus when he saw an opportunity he set out to negotiate the structures using the networks he had developed as a student. Night duty enabled Maurice (Jamaican) to achieve his *'life-long ambition to graduate in sociology: a qualification that facilitated study of a higher degree by research. Both degrees were the lynchpin for manoeuvring my career into higher education and gaining promotion'*. Personal factors combined with a desire for self-development, develop practice, improve education and practice standards or wanting to give

something back to nursing were instrumental in decision making. A number of respondents (Nigel, Maurice, Anil, Faisal, Banu, Mala, Kiran, Hilda, Ellie, Frank, James and Valerie), from all three ethnic groups, were of the opinion that becoming careerist was intrinsically linked to reaching the career grade of Ward Manager when awareness of other higher opportunities was heightened. At a personal level each of the respondents' had taken it for granted that they would get to the top.

Peer recognition of one's flair for management, education, practice development or readiness for promotion often served as external evaluation / measure of one's capabilities. Babna's (Kenyan) move into nurse education, initially as *'hospital wide clinical teaching coordinator'* resulted from a colleague's assessment of the quality of the ward-learning programme she had devised for student midwives and nursing students. Respondents' accounts suggested that the majority of peer feedback opportunities were informal and normally unsolicited, compared with focused discussions solicited from trusted peers for the purpose of seeking feedback on specifics. For example, Rita (Barbadian) used focussed discussion with a trusted peer to *'check out my readiness for promotion to course director and professional lead in community nursing'.*

Experience of direct or indirect racism was intimated by Roger (Ghanaian) *'as the spur to stay on and prove them wrong...[I] had to surmount the barriers – I was driven to succeed...Why should negative energies stop me from achieving my goals?'* whereas, Emma (Jamaican) was so traumatised by her racist experiences

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in nurse management, she was *'treated for depression and anxiety'* and referred for *'stress counselling'.* Frank's (Hong Kong-Chinese) racist experience was located in higher education (HE). He felt singled out for criticism by the white female head of department, leaving him feeling belittled and harassed *'She'd trivialize anything I said ... [She] told people I had not met deadlines, [she] changed my position papers.. [and] was always checking up on me .[She] wouldn't let me get on with the job'.* He said he *'tried very hard to defuse the situation. [I] questioned if I was misinterpreting the situation or was a threat to her.. She was ultra polite and complimentary about the other two white male teachers.. I knew then that my experience wasn't gender related but racism'.* Frank sought resolution *'but the manager denied there was a problem',* therefore he felt behoved to *'look for job elsewhere...I used the HE experience as a leverage to move to another HE as course director'.* Frank offered an example of using a negative experience to create a positive opportunity. His perceptions were that HE was much fairer in its selection processes than the hospital side.

7.4. Labour Market Needs and Policy Changes

Robinson et al (1997:604) confirmed that occupational developments, for example nurse consultants, organisational change and changes in nursing structures, have major impact on career pathways, opportunities and structures. Labour market needs was the second of five drivers identified. In this section I

shall explain how new, unexpected growth or retraction in the nursing labour market shaped respondents' careers. Respondents' related factors such as the introduction of skill mix teams in community nursing; implementation of Project 2000 nurse education (UKCC, 1988); implementation of community care; development of nurse led services, and the emergence of new fields such as adolescent psychiatry and forensic psychiatry; as having major impacts on the nursing labour market. For example, closure of long term care institutions in learning disabilities (LD) and the transfer of LD clients led to the deployment of LD nurses into housing associations; community nursing; and the independent sector. Two Mauritian respondents exploited the business potential of the Community Care Act by diversifying into residential and respite care for LD clients and their families. The reorganisation of nurse education leading to its subsequent incorporation into HE, (between 1988 and 1998), destabilised nurse education by down sizing through natural wastage, early retirement and redundancy; altered the status and grade of some nurse teachers, and or loss of education contracts. It is also true to say that alongside this destabilisation, the move to HE brought new employment opportunities in nurse education through the creation of part time lecturer posts and expansion into multi-disciplinary education. The impact of NHS restructuring on the nursing labour market will be addressed later in this chapter.

7.5. Niche Markets and Expertise

The notion of niche markets was associated with respondents taking risks, investing their own resources to develop expertise, and developing careers in fields which were either just emerging, under exploited or considered to be risky. Respondents identified forensic psychiatry, black cancer care, organisational development, haemoglobinopathies, ethnic health, race equality, consultancy in nurse education, management, and clinical governance (quality) as niche markets. According to Meg (Black-African British) recognising niche markets was *'not easy. It is not something one can research, produce a business plan for and take a calculated risk in…it's a synergy of political astuteness, business acumen and risk taking without any guarantees of outcome'.* Selena (Black-Caribbean British) *'sussed out that race equality had an untapped potential'* providing she, *'packaged the product at an organisational level to demonstrate the gains to the organisation'.* The service and education development in haemoglobinopathies evolved as a niche market for black health professions in response to client and professional needs, removed it from being a subsidiary of haematology to be recognised as a new field. The public history of haemoglobinopathies shows that Professor Anionwu, a black health visitor, nurse educationist and researcher, spearheaded the development of a model of healthcare provision for haemoglobinopathies in the 1980s. She was also a key person in pushing for the extension of regional neonatal screening to include haemoglobinopathies, helped establish clinical nurse specialist (haemoglobinopathies), and led the field in the

education and training of pre and post registration nursing students across the country. Working in niche markets did not imply self-employment in the field; instead it referred to utilising a window of opportunity the field offered, entering the field and establishing credibility and building expertise in a way that assisted progression within that field.

7.6. Business Potential Of Nursing Skills

The business potential of nursing skills and qualification was exemplified earlier in relation to the Community Care Act and LD clients. Four other respondents had parallel careers as partner in nursing or residential homes for the elderly or LD clients. Others (Selena, Brenda, Patience, Veronica and Claire) used their academic and professional qualification in education, to develop consultancy and or independent business ventures. Both Veronica (Indo-Malay) and Brenda (Jamaican) turned to full time self-employment in response to work place racism.

7.7. Serendipity

Alimo-Metcalfe (1993:71) found that often, female managers careers emerged almost by chance. 'Serendipity', 'sheer chance' or 'being in the right place at the right time' were terms used by respondents to explain personal decisions to mobilise their careers. Typical explanations pointed to chance comments or

actions identifying opportunity. Babna believed that she was in the *'right place at the right time to act on the feedback about my teaching prowess and the clinical co-ordinator job coming up....If that job hadn't come up at the time or I hadn't applied, who knows which direction my career would have gone in'?* Salim's (Mauritian) friend brought to his notice that the *' new Nursing Officer's was less experienced than myself. This chance comment made me to look at my career and ask why I wasn't one? That review spurred me to begin seeking out opportunities.'* Maxi (Jamaican) insisted that she owed her career in community nursing management to *'serendipity'* because she was *'happy in the job, [and] had no intention to job hunt'* when an advertisement *'caught my eye...I obtained the application pack...[and] was pleasantly surprised that (a) I met the essential criteria and (b) I was interested in trying my luck... I applied and got the job first attempt. Make no mistake, I was well prepared for that interview'.* Fred (Jamaican) described his move into adolescent psychiatry as *'chance'* because had he not had a conversation with the nursing officer, he would not have heard *'about a new adolescent unit being commissioned .... Apparently they were planning to go to external advert as no one internally had expressed an interest. It was the first I knew of it. Anyway I was interested regardless of the fact that at the time I didn't know what the job would entail.... I spent a lot of time writing off to similar units to get a feel for what worked in these units and made sure that the nursing officer was aware of the groundwork I was doing. In the process of*

contacting other adolescent units I came to see the relevance of the diploma in counselling to the job'.

Regardless of the drivers to which respondents attributed their decision to become careerist, it was evident that none of the five driver patterns were sufficient to mobilise the career, without the individual social capital of commitment, personal investment, and access to resources. The intersection of personal motivations, aspirations and goal with organisational structures and labour market needs, together with personal circumstances, shaped respondent careers.

7.8. Glass Ceilings

The pace of individual career trajectories was respondent specific in relation to qualifications; the length of time spent in various employment grades; career breaks; opportunities accessed and barriers negotiated. Davidson (1997) writes that glass ceilings are the salient barriers that prevent individuals from getting to the top. Davidson (1997), Cooper and Lewis (1999) and Stroh and Reilly (1999) define glass ceilings as organisational and personal structures of ageism, sexism, sexuality, racisms and religio-cultural factors that act as barriers to negotiating progression in the career ladder. Glass ceilings (Davidson, 1997) allow the people below that level to see through to the next level, covet entry to it but face barriers to reach that level. The nature of the glass ceiling varies according to the

profession, its status, potential rewards, the richness of the recruitment pool, organisational location and reputation (Davidson, 1997).

Deirdre (Jamaican) said that one of her friends (a network of black colleagues straddling academia and practice focus) had commented that each of them had *'negotiated the glass ceiling'*. Deirdre indicated that she and others *'knew of at least one place we would never apply for a job to again because they did not want a black person in senior management'*. Other respondents also shared similar perceptions based on their personal experiences. Brenda (Jamaican) *'had experienced rejections based on racial stereotypes couched as the organisation not being ready to appoint a black person... They implied I had communication problems or I didn't have enough experience .... One post I went for asked for a higher degree, yet I was told that I didn't have the right qualifications'*. Daniel (Mauritian) was astounded to be informed that the organisation, one that had invited him to apply for a director post, had *'to think of the team being built and get the balance right ...Meaning what? Why did they not do so before approaching me to apply'?* Maurice's (Jamaican) drew on his experiences as an applicant and having served on numerous selection panels to comment that *'when an organisation doesn't wish to appoint a black person, there was a tendency to blame the applicant...[They] couldn't admit to being racist could they?'* Trevelyan (1990:45) found that post interview feedback to ethnic minority applicants to explain non-appointment often included reference to them being 'less qualified', 'less experienced' and criticised the nursing unions for not

advising, supporting or challenging racial discrimination. The reasons why employers should choose to short list candidates who do not meet critical selection criteria such as specific qualifications or experience, has not been addressed by research.

Experience of racism in the work place made respondents' cautious about selecting future employers or pursuing career opportunities within the same organisation. Bridget crafted her own glass ceiling, by *'choosing not to apply for the service manager post'*. Her reasoning being *'why bother. These managers were hostile to me at a personal level... [They] criticised my accent, did not give me credit for the developments. One even had my mileage claim scrutinised by an auditor because in her opinion it was excessive compared with other health visitors'*. Valerie (Ghanaian) with 3 decades of experience in the NHS and HE said that if her *'personal goals and organisational goals were out of sync [synchrony]'* she would not pursue her application or accept the job. King (1993:14) advocates the need to find congruence between organisational politics and personal values. Pierce (Ghanaian) a survivor of several restructuring episodes said he knew he could not *'function in a hostile environment. It prevents me from delivering...It is very stressful on a personal and professional level, and detracts from my goals ...This is learned wisdom, believe me it is not on'*, supporting Krumboltz's person-environment theory (1994). Pierce was not a lone voice expressing support for the person-environment theory as two other respondents (Thom and Len) moved jobs when their personal and work place

values became divergent *'through dissatisfaction related to not being promoted when I was the better candidate'* (Thom: S. Rhodesian), or *'not being given credit for the work I was leading / developing'* (Len: St Kitts).

Although Davidson (1997), Iles and Auluck, (1997), Powell (1999) and Coker (2001) confirm the under representation of ethnic minority men and women at middle and higher management grades by pointing to the glass ceiling as one of the principal barriers, literature (Davidson, 1997; Powell, 1999) provides inadequate insight to explain how the ethnic penalty (Modood et al, 1997) was operated. Kiran (Indo-Malay) summarised her own experience as *'I got to the Senior Tutor grade without problems ...I was the only black face at that level...Somehow, I never got the opportunity to act up for the section head... It felt deliberate - as if people didn't want me to progress beyond that level by not letting me act up.... It stopped me finding out what it entailed'.* In the run up to incorporation, at a point when job descriptions were being finalised and 'ring-fencing' arrangements put in place, Kiran was subjected to a witch hunt about the quality of her MSc thesis. She believes that *'the witch-hunt was racially motivated. My white competitors were not subjected to the type of innuendos I experienced'.* Black women in senior management may be in a double bind as symbols of ethnicity and gender, and have to cope with double negatives of sexism and racism (Davidson, 1995:27).

Kiran voiced that upward career mobility of black nurses triggered envy, jealousy and resentment of white peers and in some cases of other ethnic minority

colleagues too, and may lead to individuals to be disloyal, sabotage initiatives or undermine the appointee's leadership in the workplace. She commented *'there is always someone who is resentful or envious whoever is appointed ...When whites [nurses] feel they've been disadvantaged or passed over for a post, they involve the union to investigate...The blacks are noisy about it but rarely go further than being vociferous about their feelings'.* Nigel (Nigerian) noted that *'an Asian or a black person does not compete for a higher post unless they're ultra-sure they have the necessary credentials.. [We] dare not risk making any mistakes'.* His insights supported Kiran's claim about resentment and envy associated with a black appointment: *'as deputy director of education, I was aware of the trial by whispers in the SON...[I] didn't think it would apply to me as people knew me personally ...[I] heard stories about myself... I was autocratic, a demigod...People said I wouldn't last in the job, that I hadn't been short listed until I threatened to bring in the unions and the CRE...All this even before I had got past the first hurdle'.* Nigel's experience suggested that even though black applicants had ensured that they possess the essential pre-requisites for a given post; there were other structures to negotiate (Davidson, 1997). Hilda (Guyanese) concluded that not knowing the nature or substance of these exact structures were or how they would operate was *'very painful. I was short listed for a job where an undergraduate degree was essential. The interview went well or so I thought. The job went to a non-graduate even though I had a higher degree and was clearly more experienced than the other candidate. The whole process stank of double*

standards.... It was racist but I can't prove it'. She reflected *'racism is created by people it feeds on stereotypes – the barriers will have to be challenged'.*

Nigel introduced the concept of an unequal playing field that was not being levelled out even though black people were addressing educational and professional factors. He said *'I know I compete from a position of strength for qualifications, skills and ability... I can demonstrate achievement in previous posts but it does not stop the glass ceiling operating. I am at the stage where I feel confident to bite the bullet and ask why I wasn't appointed...If necessary I shall challenge the system, but I'm not sure if I would wish to work for that organisation given such a negative start'.* Davies (1995:10-11) confirmed that black nurses often experience discriminatory lines of questioning at interview, and were more at risk of having their promotion blocked. Glass ceilings normally operate through the implicit and covert structural barriers that serve to render the playing field unequal bring complexity to the processes mobilised or personal agency (Giddens, 1993; Modood et al, 1997).

Using Carter et al's, (1999) findings as the basis for comparison, survey respondents in HE compared well with their white nurse teacher colleagues for academic studies and qualifications, but fared less well in their quest to be appointed at the level of senior lecturer / principal lecturer or above, or in research. African-Caribbeans academics dominated nursing in HE, a finding that differed from Carter et al's (1999) who had found that Asian academics dominated the ethnic minority group in HE. The number of black nursing

professors has slowly increased since Justus Akinsanya (now Emeritus Professor at Anglia Polytechnic University), a Nigerian, was appointed in the mid 1980's. The single difference between white and black nurse professors was that the former often had a professorial title bestowed upon them even when they did not possess a doctoral qualification or the publication record associated with such awards, whereas the black professors had normally achieved their professorial title through the traditional university appointment system. March 2001 saw the appointment of an ethnic minority professor who was not a PhD, and in June 2001, Karlene Davis, General Secretary of the RCM, became the first black nurse to receive an honorary doctorate in science for her contribution to midwifery (www.RCM.org.uk June 2001. News).

7.9. Geographical Mobility and Night Work To Assist Career Progression

The role of geographical mobility to facilitate career progression was reviewed in relation to its extent and the reasons underpinning it. I also wished to determine if geographical mobility was a genderised agency as it is assumed that married men are more mobile (Carpenter, 1977a, 1977b). Definition of geographical mobility excluded consideration of employment changes within the same employer organisation, while accounting for changes to other employer organisations that were within and outside of a 40 mile radius of the home base or overseas. Thirty-

two respondents remained within a bounded geographical area for employment, a strategy that allowed a degree of flexibility in the employer organisations they could work for without affecting place of residence or the stability of social support systems. Fifty-six respondents (33 female and 23 male), including the 9 who re-located overseas, identified that geographical mobility served multiple functions that included an agency for facilitating career progression; a strategy for managing hostile work environs or as a component of remaining 'employable'.

Respondents' managed geographical mobility in one of three ways: relocating home and family closer to the new employment (n=23), working and living away from home (n=4) or commuting (n=31). Decisions about how geographical mobility was managed were guided by the affordability of housing in the new area; stage of children/s education; employment prospects of the spouse / partner; and or the nature of employment contract. The majority of the 56 respondents utilised geographical mobility as a strategy to make good career opportunities that would be otherwise unavailable to them. Jane (Ghanaian) indicated that she had limited the geographical boundary for employment while the children were in the 'dependent phase', in the knowledge that she would become more flexible once they completed compulsory education. Ruby (Jamaican) said that she 'accepted the necessity to be geographically mobile within a ring fenced area', explaining that she guarded against career moves that would necessitate major social changes in her domestic life. Emma (Jamaican), Jack (Chinese-Malay) and James (St Vincent), admitted that their decision to become geographical mobility was not

taken lightly as the ramifications included *'housing costs, mortgage differentials, disruption to social support networks... The list is endless'*. Nigel was clear that geographical mobility was *'not about immediate gains but about long term career gains ...At the end of the day it comes down to whether one wishes to utilise or discard the opportunity'*.

As previously discussed, Thom and Len used geographical mobility to manage a negative and hostile work place that was not conducive to their career trajectory. Len's perception was that geographical mobility was *'a necessary evil. A way of managing a stagnant career'*, whereas Thom's decision to seek a job elsewhere was to escape a stressful and competitive work place: *'it was dog eat dog... There was no trust... It affected me at a personal level'*. In managing one set of barriers through geographical mobility, such actions often generated other stressors. For example Len's new post, 100 miles away, made the logistics of daily commuting expensive and would have added five hours to the working day. As living away from home during the week was unpalatable to Len's family, they lived in rented accommodation for approximately one year before moving into their own home. Thom and a colleague shared commuting but abandoned it due to difficulties *'We tried synchronising our diaries. We lost the flexibility of start and finish times'*.

Eight of the 9 respondents who relocated overseas for periods of one to three years did so with their families. The ninth respondent faced a dilemma because the unique opportunity to establish a statutory nursing organisation came just as his spouse had recentralised her career into nurse education and the children were

coming up to critical stages of their education. The family took a decision that allowed the respondent to relocate without the other members.

It was noted that the commentary about remaining employable was not unique to nurse academic respondents who had experienced down sizing, relocations, changes in contract from permanent to fixed term contracts or down grading as a consequence of mergers between SsON and their incorporation into HE. Incorporation into HE resulted in nurse academics working for multi-site organisations, requiring them to commute between sites and also to ensure that they remained clinically credible so as to remain employable. None of the respondents believed their jobs were secure beyond 1 to 2 years because of the recent structural changes in the NHS under 'New Labour'.

Anecdotal evidence suggested that black nurses used night duty as a strategy for career progression and was the preferred choice for managing childcare. Respondent data did not support the second of these myths. Nineteen respondents (8 males and 11 females) used the enhanced opportunities night work offered them. The two main drivers for the men to work permanent night duty were to increase their income and use the *'window of opportunity of night work and study for an Open University degree'* (Maurice: Jamaican). Maurice found it easier to be appointed to a night charge nurse post than to a day post because *'People do not like night work as it is very anti-social and disruptive to family life .. My reasons for taking a night charge nurse post were three-fold: the kudos of having been appointed at that grade in a world renowned hospital – I saw that as an important*

plus to my profile; the additional income and I wanted time to get on with my OU

studies '. Like Maurice, three other men studied for Open University degrees during this period. Marcia (West Indian) accepted the post of Twilight Services Manager for District Nursing *'because it was innovative work. It was a challenge for me'.* All eleven women respondents categorically refuted that night work was linked intrinsically to childcare, instead they pointed to night work as a *'simply another rung of the career ladder...It allowed a movement up instead of being static'* (Rowena: Jamaican). Banu was approached to consider a hospital wide night nursing officer post. She admitted that she found the *'concept of night duty unpalatable but recognised the opportunity was too good to miss'* pointing out that rather than night duty facilitating childcare *'we had to make more elaborate and financially costly arrangements for childcare'*

7.10. Impact Of the Griffiths Report on Respondents' Career Trajectories

One of the most radical restructurings of the NHS resulted from the implementation of the Griffiths Reports (1983, 1988) through the introduction of general management principles based on industrial models, the introduction of the internal market and competitive tendering. The move to general management principles was devastating for nurse managers who according to Bert (Ghanaian)*'lost out to white managers from industry who were unfamiliar with*

the nature of the work...[They] had no regard for the personal-emotional aspects of the work'. Shobna (Kenyan) noted that while community nursing had escaped the import of general managers from industry, *'Griffiths (reference to the 1988 report) brought in different discipline managers at both team and locality levels – a strategy that ruffled more than a few feathers.... There was much opposition by individuals and nursing unions but to no avail. Gradually we accepted the status quo. In fact some of us benefited from having different discipline managers who [because they did not know our discipline or were unfamiliar with it] let us get on with the job. I think it made me more autonomous'.*

Respondents' summed up the impact of the post Griffiths restructuring in one of three ways: (a) no change to the grade or nature of employment or their careers; (b) a negative impact on their careers or (c) a positive impact on it. Of the 28 respondents (1 in 3) whose careers were unaffected by the post-Griffiths NHS restructuring, 17 (3 male and 14 female) could not identify any changes to their grade, role remit or job title, but in most cases (12 of the 17) they had had to re-apply for their posts. Another 11 respondents who claimed they were unaffected by the restructuring had failed to recognise that they had been disadvantaged by the restructuring process by having to compete for their posts with internal and external candidates, and expansion of their portfolio of duties and responsibilities. The remaining 60 respondents were almost equally divided in their opinion about the negative impact of restructuring (n=31) and career opportunities resulting from restructuring (n=29).

7.11. Nurse Academics Career Trajectories Following the Incorporation of Nurse Education into Higher Education

As stated in Chapter 3, the incorporation of schools of nursing into higher education led to nurse teachers having to re-apply for their jobs according to University criteria. Restructuring in education served as barriers for some respondents, especially if they failed to secure their post at an equivalent level or were prevented from applying for posts they believed they were qualified for. Some respondents experienced discrimination, displacement and redundancy. Roger (Ghanaian) and Eric (Trinidadian) both previously employed as deputy head of school / deputy director of nursing education were *'slotted into HE as principal lecturer at a salary level commensurate with the NHS scale but lost the leadership role in curriculum development, contract management and school management role'*. Rob (Nigerian) was ring fenced out of *'Director of Studies'* appointments, but *'allowed to apply in the second round because the panel hadn't appointed in the first wave'*. For Anita (Indo-Malay) the low point of the power struggle between her and the all white academic staff *'resulted in a vote of no confidence in me as the black manager... I believe I was sacrificed rather than the institution face up to racism'*. Payne (1995) acknowledged the reluctance of statutory professional bodies and employers to challenge racial discrimination by white nurses.

7.12. Growing Support Networks

When respondents talked about their career journeys, the role of mentors, networks or networking emerged as an important issue for career development. I begin by focusing on the purpose, function and types of networks and then look at growing networks as a theme to explore the power and access issues ascribed to networking, and then move on to explore the fit of mentorship with networks.

Membership of formal or informal peer groups, for example work based or in the social sphere normally occurs through the status passage of specific life events, to provide opportunity to access information, develop social links, or engage in specific activities. A network refers to a group of persons linked or connected with each other through a common thread, often one of profession, professional practice or work (Travers and Pemberton, 2000). In recent times, the concept of networking is an American import whereas its origins can be traced to British traditions of the pupil-master relationships, for example in law or in the ties afforded through the alma mater of one's school or university. Networks serve multiple agendas embracing social, political and professional activities (Kanter, 1977; Burke et al, 1995 in Davidson and Burke, 2000; Travers and Pemberton, 2000) by bringing together groups of people from within or outside of an organisation, either formally or informally, for the purpose of information exchange between like-minded people (Travers and Pemberton, 2000; Osler,

1997). Greenhaus et al (1990:65) claim that exclusion from social networks produces cycles of disadvantage.

One of the reasons why black networks were attractive to survey respondents was related to their apparent exclusion from existing 'white' networks. Here, I discovered two contradictions: the first being that none of the respondents could give a specific example of being excluded from a network but there were perceptions about 'being kept in the dark'; secondly, there were no concrete examples of 'formal-white networks'. In nursing, the phenomenon of networks emerged in the 1990s. Examples of these include the Equality Networks developed on a regional basis by the RCN, Research Networks and other professional networks set up under the auspices of professional organisations or special interest groups. The opportunities created by the Internet and electronic communication systems allow geographically dispersed virtual networks to be accessible, for example the Postnatal Depression run by the CPHVA. A re-evaluation of respondents' data and discussion with four respondents, confirmed that the reference to networks was in relation to within employer 'cliques or groups' of influence, as opposed to large scale professional or externally situated networks. The impetus or desire to establish black networks is a reflection of the invisibility of black nurses in employer and professional organisations, combined with the fact that they were prepared to give voice to the inequalities experienced and observed. It is possible that the emergence of black networks was a sub-conscious attempt to reproduce a 'culture oriented community'.

Networks may be intentionally contrived as a component of professional activity, for example as a deliberate activity of professional conferencing or develop as a professional network. A notable difference between contrived and professional networks is the size, as the former tend to serve large groups of people whereas the latter is limited to smaller numbers, up to ten people. Both types of networks offer members opportunities for: information exchange (Burke et al, 1995 in Davidson and Burke, 2000; Bird, 1996 in Davidson and Burke, 2000; Kanter, 1977); combating professional isolation (Davidson and Cooper, 1992); kindling friendships (Robbins and McClendon III, 1997) and receiving social support (Travers and Pemberton, 2000). Burt (1992, 1997 in Fine, 2001:109) contends that the worth of a network to an individual is proportional to its uniqueness in terms of the resources and network connections (Fine, 2001:57).

In professional circles, networking has been a strong career management tool for males (Travers and Pemberton, 2000: 84-99). More recently, women managers, ethnic minority managers and high fliers (White et al, 1992; Burke and McKeen, 1994; Davidson, 1997, Davidson and Burke, 2000) have also recognised the importance of networking as a critical component of promotion into senior posts. Respondents provided some interesting insights about networks and networking in the work place. As a recently promoted ward sister, Terrie (West Indian) allocated the weekly ward managers' meeting a low priority until she witnessed the social and political benefits *'I learnt much from listening to others ..... An eye opener..... A forum for sharing information, seeking and giving advise and*

problem solving..... It was role modelling, coaching, group learning all rolled

into one.'

Prakash (Kenyan) used his professional network to facilitate consultation and assessment of his readiness for promotion, and how best to project his skills drawing on the change initiatives he had collaborated on since qualifying. As a senior nurse, Learning Disabilities (LD), Faisal (Pakistani), was instrumental in contriving a network for others in a similar role. His rationale was to bring together like-minded people in the field to *'tap into pockets of innovative practice.....To shift LD from custodial to nursing care'*. His account pointed to a number of givens of networks: brought experts together to influence professional practice; relationships were based on trust, and there was a desire to learn from each other (Travers and Pemberton, 2000), necessary to *'reduce professional isolation.... [and] problem solve through exchanges, help each other cope with uncertainty, and finding new ways of working'*. James (St Vincent) identified that regular access to his network, that had its origins in a taught course, provided him with professional support and encouragement for his ideas – something he had not experienced before: *'it didn't matter how raw ones ideas were because we played around with them.... [they] helped me see their potential and pitfalls.... I was not embarrassed by my gaucheness.... No one made me feel I was stupid'*. Christian (Mauritian) credited the contrived network (with roots in the MBA small group work) for his discovery of his *'flair for project management'*, which prompted him to seek career guidance about his prospects in clinical services management.

Opportunities for collaboration or working in partnership emerged as a component of group work on taught courses rather than as a feature of networks probably because black networks are still young and not mature enough to encourage or support collaboration. Faisal's experiences of the senior nurses network was indicative of its collaborative potential in taking forward ideas *'trying something out in ones own back yard is low risk, getting others to come on board and implement a new way of working requires others' co-operation, willingness to work with you or take risks...There is no doubt that networking with those at board level helps to take ideas forward. It allows an exchange of views, ideas are discussed, seeds are sown... One can judge when the timing is right to push ahead with an idea'.*

The discussion so far suggests that there were variations in the scope of networks depending on their type. Genderisation of professional networks was not identified as a feature or necessity of the networks in the NHS, research or academia, whereas several respondents evoked the desire for multi-disciplinary networks. According to Nigel (Nigerian), an all male network may evolve either because of the timing of the meetings – often after work for a drink, or may be related to the discipline of practice, and offered forensic mental health, a field dominated by men as an example. The idea of genderisation of a network by virtue of its discipline of practice is resonant of midwifery and health visiting, as both were and remain virtually all female disciplines, thus the potential for all female networks in either of these disciplines remains. According to Travers and

Pemberton (2000), the key differences between male and female networks are that

the former are more utilitarian, being instrumental for obtaining jobs and knowing

what is around. For females the social benefits are deemed to be more important

(Travers and Pemberton, 2000).

Nigel's work related network was *'partly social and partly professional... It was*

a way of measuring how I was doing compared with others at the same level and

get a low down on who was doing what'. Valerie opined that a group could fulfil

both functions, utilitarian and social, depending on what one's own agenda was.

She explained her experiences in terms of the broadly coterminous geographical

boundaries of her work and home, *'living and working in Greater London has*

been good for me.... I've managed to access a lot of the professional meetings

[DoH, RCM] here in London'. Erica (Nigerian) felt *'professionally isolated'* in

her work in sickle cell disease, recognising it as a racialised field, that is one

where the workforce and client group are predominantly of the same ethnic /

racial group. She believed she lacked political muscle in the employer

organisation, such that she developed an alliance with black social workers who

were *'a powerful group, politically active at local and national level..... [they]*

understood the struggles of working in a racialised field'.

7.13. Respondents' Experience of Networks

Access to networks is multifactorial, depending on individual motivations for locating or developing them, seeking membership or participating in them. Networks are not instantaneous but evolve over time, require nurturing and have to be in place before one needs them (Travers and Pemberton, 2000; Davidson and Burke, 2000). Respondents' perceptions about the utility of networks were embedded in their personal experiences. Valerie offered that *'networks are people; therefore you get what you put into it. Ones personality has a lot to do with it as does effort'*, meaning that the chemistry between the people involved in the network was responsible for outcomes and the necessity to invest time and effort to reap any benefits from it. As a self-employed individual, Brenda (Jamaican) was occasionally approached by others requesting her patronage or help with their initiatives *'without mention of what they could offer in return'*. For Brenda, reciprocity was the crux of the issue. She said: *'there is no hesitation giving help or guidance [if one can], but at the end of the day one does not want a non-paying guest who is on the take'*. Other respondents (Faisal, Valerie and Erica) were more charitable in their assessment of the *'non-paying guest'* by suggesting, *'membership was a two way process'* (Faisal), that *'the newcomer should have space to test out the network'* (Erica), or that *'there should be an opportunity to check out if it met their needs and if they would gel with other members'* (Erica). Valerie firmly believed that *'for any network to work, there had to be give and take [reciprocity of resources]... The formula of how much one*

gives or takes is not written in tablets of stone'. The trial and error approach in

trying out networks was advocated by Faisal who believed that *'A person must*

feel comfortable within the group, bond with others, establish rapport and trust

group members before they can begin to function in the group'.

Mala said that she had accessed different groups in her career but always

gravitated back to her family, saying *'to be frank the family fulfils those*

functions'. Others who separated the 'personal' network from the professional-

peer type network and pointed to the transient or long term nature of network

membership offered a different slant on networks. The 'personal' network was

confined to a defined group of people who had known each other often over a

considerable period of time to demonstrate strength of relationship and ties with

each other. Within such groups, geographical location, practice discipline, race or

gender did not seem to play a role, but social relationship between members was

critical. Roger's (Ghanaian) inner circle was a mixed group of Mauritian Asians,

English and Nigerians, who had come together as tutor students in the 1970s:

'we've been rubbing shoulders since the teacher training course....We bonded

because we [males] were the minority ... Ten years on, three of us were together

on another education programme... We've seen each other through good and bad

time. For me the group offers a yardstick to measure my achievement'. Bradby's

(1990:1223) study found that the collective status passage of male nurse teachers

allowed them to gain support from each other, share good and bad times. Roger's

prose implied that the value addedness of the personal network was inclusive of

the degree of reciprocity and individual needs and expectations being met by the members. He alluded to measuring his own success against that of a peer reference group such that the promotion of one network member would acts as a spur for others to evaluate their own career.

Ellie (Barbados) and Belinda (Anglo-Indian) described their experiences of personal networks in derogatory terms. Belinda indicated that her career path had been *'a struggle to break through at each step'*. Similarly, Ellie stated that *'at every step I had problems to contend with. Being black does not go down well with some white people'*. Belinda, a senior educationist, was *'ousted from my post unceremoniously following a vote of no confidence taken when I was on annual leave, therefore I had no idea of what was going on....To this day I have not understood what exactly was so heinous about my leadership'*. She described her emotions as: *'seeing red. I was livid - enraged really....The worst was that no one was loyal to me ......No one picked up the phone to alert me..... Would the management board have dismissed me without a hearing had I been white? ...At the time it was unheard of to be treated so atrociously – I think I was the first person to be dismissed in such a way but to save face it was described as a mutual parting of ways'*. Belinda was extremely distrustful of people, particularly of *'the so called friends in the field'* because *'they failed me by remaining silent'*. Ellie lodged a grievance about her dissatisfaction of the outcome of the interview panel's decision to appoint her as 'Acting Theme Leader' as opposed to being appointed as 'Theme Leader', believing that the selection was flawed. Ellie's

harshest criticism was reserved for her personal-professional network: *'everyone I spoke to agreed I should challenge the decision, which I did.... Not a single friend offered to accompany me (for support) at the internal enquiry. None of my black colleagues supported me.....People I had helped previously did not return phone calls'*.

In sharp contrast to Ellie and Belinda's experiences, Laurette was in the Caribbean nursing her mother when *'a buddy phoned to tell me that my job had been externally advertised'*. Laurette returned to England and initiated a grievance for *'constructive dismissal'* with help from *'the professional organisation and the buddies'*. Laurette effused praise for her *' buddies. They came up trumps, not only was I warned in time, they were there for me, provided written and oral evidence in my support. I was fully vindicated'*.

Transient membership of networks to suit personal agendas encourages a phenomenon I refer to as 'latch and dispatch' characterised by an individual gaining entry to a specific network, latching on and engaging with it insofar as ensuring that their personal agenda is met, then promptly disengaging and departing from the network. Lal (Mauritian) related an incident involving a peer from his work place who had gained entry to his network: *'this chap connected with one or two people, showed interest in our idea for launching a journal ...[he] came to a couple of other meetings before he absented himself...[then] we heard that he was on the editorial board of a journal and using our ideas'*. Lal's

experience demonstrates the 'latch and dispatch' syndrome, as well as abuse of a network.

Although literature (Travers and Pemberton 2000; Davidson and Burke, 2000; Davidson and Burke, 1994; Burke and McKeen, 1994; Kanter, 1977) connects networks to career success, it is virtually impossible to measure the benefits of networking in concrete terms. Without using the terms networking or network, respondents endorsed the personal-social group as a more credible resource for support, mutual problem solving, getting help with career guidance or planning and for information exchange. More recently (Burke, 1999) the RCN has initiated a series of regional networks for black nurses to 'band together to discuss their concerns, receive briefings on the governments latest initiatives and get coaching for job interviews'. It would be useful to evaluate such initiatives.

7.14. Mentors and Mentorship

Within the concept of social-professional networking, respondents' referred to people who had 'been there for them' or 'had their hands held by' or 'befriended them' with regard to their career development, managing problematic situations at a time they needed support. Their talk revealed that while many of the respondents ascribed the label of mentor to these people, most of the people in mentor role were linked to their personal-social network. Respondents', (Valerie, Ruby, Meg, Maurice, Laurette and Babna), whose personal-social network

fulfilled the mentor role, concluded that they had not desired or sought mentors from within or outside the employer organisation because specific friends had fulfilled that very role at every stage of their career. They spoke about the value addedness of such friendships in relation to managing conflict at work and career planning. Their accounts pointed to the essence of the value addedness of the personal social network being a combination of informal coaching, mentoring and critical appraisal.

The concept of the mentor has its roots in Homer's 'Odyssey' in which Ulysses appointed Mentor as tutor-advisor to his son. Historically, the processes of mentoring can be traced to ancient Greece, Roman armies, Indian Rajahs and in scholarship. In classical mentoring, the mentor was a senior, trusted and established figure and role model in the professional world the young man was entering, its crux being that the role was transitional, with the purpose of 'guiding, counselling and training the inexperienced newcomer through the political, professional and behavioural quagmires' (Levinson, 1978:78). In HE and nursing, this type of mentoring has become contractual in nature with little opportunity for the mentor or mentoree (person being mentored) to select each other.

As a newly appointed director of midwifery education, Valerie *'was mentored for 3 months by a person nominated by the executive board. The mentor's remit being to help me transition into the role'*. Davidson and Burke (1994) suggest that organisational mentorship programmes are intended to retain the high fliers in the organisation, a potential that would be difficult to realise unless mentoring was

long term and not strictly circumscribed. Mentoring is viewed as a key developmental experience (Kanter, 1977) that can help the individual to overcome obstacles and act as a buffer from discrimination (Powell, 2000). The potential of mentoring is connected with the nature of mentoring, that is, whether it is long or short term (Gregory, 1999), its density (Fine, 2001) or the social capital associated with it (Fine, 2001:57). Dense mentoring offers many social and professional connections, in terms of mentor roles and access to networks and significant others. Mentoring relationships like networks need time and investment of the persons to grow in thickness.

Fine (2001) maintains that social capital predicts that returns depend on a person's location in the social structure of a market or hierarchy. To a point, Fine's thesis can be supported in that work based opportunities, access to networks and persons of importance within the organisation are related to ones location in that structure. However, it does not take account of the cultural capital that individuals employ to bypass the conventional structures and systems. For example, the idea of a university lecturer having the vice chancellor (VC) or the pro-VC as a mentor would be unusual but for participants of leadership programmes such as the joint King's Fund and Johnson and Johnson Leadership programme, such a dyad would be a pre-requisite. Gregory (1999) concluded that long term mentoring had a more significant impact on academic careers than shorter mentorships in terms of the research and publications output of the academic, their progression and ability to influence policy. Parker and Fagenson (1994) and Burke and McKeen (1994) state

that protégées of powerful people have more promotions, improved job mobility, greater job satisfaction, easier access to powerful individuals in the organisation, have power recognition through their association with a known power base and have greater potential to influence policy (White et al, 1992). None of the respondents' surveyed here saw themselves as a protégée of powerful persons, perhaps they were unwilling to divulge this information.

Broadly speaking, mentor functions (Morton-Cooper and Palmer, 1993; Powell, 1999 and 2000) are located in two domains: the 'personal' for psycho-social support and the 'professional' for the skills, knowledge, sponsorship and know-how of that level of working. The qualities for both domains (as can be seen from Table 7.2) are virtually identical, with the mentor embracing diverse functions, for example counsellor, advisor, role model, coach, sponsor, teacher, resource, guide. The functional overlaps between mentor functions (for example coaching, advising, role modelling, counselling, guiding, resource) with those of personal networks described earlier in this chapter may be attributable to (a) successful mentor – mentoree relationships whereby the mentor acts as the sponsor for the mentoree to gain access to his / her network such that the role of the mentor is extended to include other network members, (b) personal networks were nurtured to provide the functions performed by mentors in classical mentoring relationships, and (c) the mentor relationship may be an artefact interpreted as the value addedness of the personal network.

Not all mentoring was successful (Powell, 2000) because mentoring relationships were dependent on the repertoire of interpersonal skills of each party. *'Caustic mentoring'*, one where the relationship becomes acrimonious, unfriendly or contemptuous, may be triggered if the mentor does not have a full range of skills, is found to be lacking in any way (Morton-Cooper and Palmer, 1993), lacks influence, feels threatened (Flanders, 1994) or does not respect the mentoree. Brenda related a 'caustic experience' of her mentor who wrote a *'damaging report on my ability to manage a curriculum...Much as I loathed having to act defensively, I did so in this instance...[I] had to protect my reputation.'* Age, gender and racial differences between mentor and mentoree can affect the relationship in both negative and positive terms. Julie found she enjoyed being mentored by a younger, white male colleague who was much more experienced in University life: *'we got on very well. We weren't inhibited by each other- actually we learnt from each other'*. Christian's personal dislike of an older female mentor was compared to *'a tense mother-child relationship ... [I] avoided meeting with her'* saying he eventually acknowledges that the relationship would not work and *'[I] asked for a change to a male mentor'*.

There is significant literature (Marshall, 1995; Davidson, 1997; Gregory, 1999; Powell, 1999, 2000; Ragins, 1999; Bell and Nkomo, 2000, Bhavnani and Coyle, 2000) highlighting the difficulties faced by women managers and black and ethnic minority women managers in identifying and negotiating mentors.

Table 7.2: Mentor Qualities for Each of the Domains of Mentorship

Mentor Qualities	Common to both domains	Unique to personal domain	Unique to professional domain
Communication and interpersonal skills	*		
Trust	*		
Expertise and competence			*
Honesty and integrity	*		
Enabling skills	*		
Able to guide	*		
Supportive	*		
Encouraging	*		
Provide constructive feedback	*		
Nurturing	*		
Empowering	*		
Giving time	*		
Listening	*		
Helping analyse	*		
Lets mentoree take risks and making mistakes	*		
Can let go of the mentoree	*		
Promotes confidence building	*		
Promotes mentoree-development	*		
Willingness to open up networks to mentoree			*
Able to build social relations	*		
Sharing	*		
Counselling, guiding, teaching and coaching skills Teaching and coaching skills	*		
Role modelling			*
Resources			*
Sponsorship	*		
Provide information	*		
Coalition of power			*
Negotiating unwritten rules	*		
Acquiring specific management skills			*
Negotiating exposure to specific experiences .			*
Personal friendship		*	
Empathy		*	

Sources: Flanders, 1994; Marshall, 1995; Powell and Mainiero, 1992 in Powell, 1999; Davidson, 1997; Gregory, 1999; Powell, 1999, 2000; Ragins, 1999

Weber and Higginbotham (1997) refer to the parallel discriminations and barriers of sexism apropos differential treatment of males and females such that women

are described as being emotional, hormonal, soft, helpless or not up to the job of managing. For others, ageism comes into play whereby older staff may find it difficult to be mentored. Similarly, racism contributing to a colour-blind approach or behaviours being attributed to the individuals race, may contribute to black staff being confined to lower status jobs. Both Gregory (1999) and Bell and Nkomo (2000) found that cross-racial mentoring might be resisted if it was perceived as being not-politically correct or the high visibility it generated created discomfort for both parties. According to Gregory (1999:65) and White et al (1992), same race 'black on black' mentoring is important role modelling for younger blacks, for them to see that one can make it. Aside from the few specifically engineered mentorship programmes (for example University of East London's undergraduate programme) to provide 'black on black mentorship', a shortage of black and ethnic minority mentors (Gregory, 1999; Davidson, 1997; Bhavnani and Coyle, 2000) inevitably leads to cross-racial and cross-gender mentoring. Barriers to women accessing mentoring (Burke and McKeen, 1994) include the lack of contact with potential mentors, the high visibility of the female protégée, negative stereotypes of women make them less attractive as mentoree, cultural and organisational biases to cross gender mentoring and lack of recognition given to the behavioural differences between males and females in the mentoring process.

Respondents placed different interpretations on the term mentor, the reasons for selecting the mentor and the nature of the relationship. The most popular

definition for a mentor was 'someone who can open doors for me, is willing to listen to me and give me constructive feedback'. Forty of the 88 respondents could not identify any form of mentoring experience/s in their career. It would appear that these individuals had made their career decisions alone, without recourse to any other individual. In view of the emphasis placed on cultural capital (discussed previously) it was poignant to note that parents and other family members were no longer a dominant force in influencing decisions. Cici's (Nigerian) rationale for this was that her family were unfamiliar with the UK nursing structures; therefore they were not in a position to advise or guide her actions.

Forty-eight respondents (18 men and 30 women) employed a total of 200 mentoring episodes during their careers. Mentorship styles (detailed in Table 7.3) embraced the personal and semi-personal spheres, professional and formal mentorship. Kiran and Selena showed a very different picture of mentoring from other respondents, in that each had nine and ten mentoring episodes respectively. Both had a defined modus operandi to identify mentors when they changed jobs, often 'working with two or more mentors concurrently...[these] relationships were functional and purposeful... [The] period of mentorship varied according to need'. Selena commented on the long-term strong friendships that might evolve from mentoring relationships giving rise to another dimension in mentoring.

The managers' role, regardless of the type of mentorship was viewed as critical in relation to receiving feedback or accessing opportunities, and the power they

exerted in getting on. Terrie talked about a manager having the power to *'make or break the situation'* with specific reference to the nursing officer who regularly gave her negative feedback.

Table 7.3: Mentorship Styles

Styles of mentoring identified	Mentorship provided by
Personal sphere (informal, incidental)	- Friends - Family members – parents, siblings, aunts, cousins - Spouse
Semi personal (informal, part of daily discourse)	- Peers - Line Manager - Educationist - Other professionals outside nursing (for example head teacher, consultant)
Professional - Could be formal or informal - More focused in intention	- Nurses in similar roles - Educationist - Education Manager - Family members in nursing - Friends in other professions - ENB Officer - Director of Nursing - Regional Area Health Authority - Director of Education - Nursing Officer/ Senior Nursing Officer / Director of nursing
Formal, being contractual in nature. Offered as a component of the appointment	- Line Manager - Named mentor at same level - Named mentor at the next level up

Terrie explained *'I was on secondment, reporting directly to this nursing officer who produced weekly lists about the problems - specifically my mistakes, what I should have done differently. It was so bad that I elected not to apply for the job when it was advertised .. I could not see me getting on with her'.*

7.15. The Role of Line Managers in Accessing Career Opportunities

A number of respondents (Ellie, Cici, and Rob) said they were blocked by the line manager who either did not recommend or support them in their quest for broader experience, project leadership or management opportunities, going as far as blaming the line manager for slowing down their careers. Faisal, Valerie, Hazel, Maurice, Charity and Prakash were among the group who reported a good rapport with their line managers, felt valued and accessed opportunities with ease. Faisal recalled that the manager was pleased with a report he had written, she *'invited me to present it to the management board'.* He went on to say *'I learnt from that experience. Now I make sure that I give credit to the right person and where possible involve the author or generator of ideas in the subsequent developments or dissemination'.* Mohan's manager had groomed him for the next rung of promotion, to the extent that he helped *'with getting my CV up to scratch'.* The interface between day-to-day discourses between the manager and respondents, the formalised performance review cycle and the manager as a referee was

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complex and inter connected. In-job mentorship could not be differentiated from daily manager-subordinate dialogue except that respondents considered this to be the case where the manager displayed a positive attitude and regular interest in their work or progress that exceeded the level expected from a standard relationship. Stories of others are an emergent theme focusing on racism as an institutional barrier.

7.16. Conclusion

In this chapter I have shown that careers evolved through a series of phases which had a degree of commonality with developmental and person-environment theorists, and phases that were unique to nursing. The notion of becoming careerist emerged either as a conscious decision to pursue career opportunities or a gradual realisation that career progression beyond the standard career grade of ward manager was achievable. Although the reasons why respondents became careerist had their antecedents in a desire for security, personal aspirations and putting down roots in the UK, career trajectories were shaped by the intersection of changing labour market needs; personal motivations and determinations influencing their personal agency to determine which opportunities would be actioned or ignored; personal circumstances; and other structures such as the glass ceiling, relationship with managers, access to networks and mentors.

I have revealed that there were gender differences between male and female respondents specifically in relation to the men favouring moves into nurse education and nurse management, often as a way of concealing their connections with nursing but primarily because those fields were socially and culturally more acceptable as jobs for men. Respondents' agency in dealing with direct and indirect racism was often evident in the decision-making. Contrary to expectations, the roles of geographical mobility and night work to assist career progression were not gender embedded to favour either men or women, as both sexes used these strategies to suit personal career goals. The impact of the NHS re-structuring following the two Griffiths Reports (1983, 1988) on respondents careers was manifest as job losses, role changes or barriers to getting on.

The role of support networks, mentors and professional alliances is considered to be an important element in 'getting on' by educationist and policy making respondents in terms of information exchange, support, provision of informal career coaching and career advice. A crucial benefit of the support networks is the opportunity to talk with like-minded persons and share experiences for mutual learning and support. The growth in contrived black networks has occurred in parallel to the growth of similar generic networks in research, education, practice, management and other foci. The diversity of mentoring relationships is indicative of a lack of same-race mentors and reduced opportunity for black nurses to be mentored. The narratives so far have taken the respondents' stories to the juncture

where they became careerists and grew their own networks. The next chapter elaborates on the respondents' experiences at the top of the nursing career.

Footnote[1]

Please note that where black nurses are referred to by name, the information is from public sources and does not infer that the named person / persons participated in this research.

CHAPTER 8

BEING AT THE TOP IN A RACIALISED

STRUCTURE[1]

8.1. Introduction

Being at the top of a profession is associated with notions of public recognition of the abilities of the individual, reward and influence within the profession. It epitomises the individual's career journey, having made good the opportunities along the way and negotiated glass ceilings and barriers, by drawing on one's social and cultural capital. In this chapter I focus on two key issues related to being at the top in a racialised structure in order to understand: (a) what difference black respondents have made to the nursing profession at both personal and collective levels; and (b) to discover the scope of their sphere of influence and power as black people through their personal and collective agency via the office of employment or personal endeavour. The first issue relates to the notion of respondents' staying power demonstrated by their commitment to nursing through the peaks and troughs of their careers in a racialised structure. It also explores the reasons why some respondents' may not have reached a plateau in their careers. The second issue addresses their personal feelings, positive or negative, in relation to (i) what it means to these individuals at a personal level and community level to be black people who have 'got to the top'; and (ii) the scope of personal and

power exercised by black professionals who are at the top of their professional careers by virtue of their appointment at senior rungs of the nursing profession.

8.2. Staying Power and Room for Further Career Development

Respondents surveyed for this research have demonstrated their staying power through their career journeys by remaining in nursing. Examples cited throughout this thesis include the barriers negotiated at entry gate, such as misrouting into the enrolled nurse pathway, and misuse of the General Nursing Council entrance test; discrimination in allocation to poor quality clinical areas; direct and indirect racism in the work place, and unequal treatment at interview for promotion. It is surprising that given the extremely difficult circumstances many respondents had to deal with and surmount, often on a daily basis, they were willing to remain in the profession. I was interested to know why respondents had stayed in a profession that in reality had treated them badly, like second-class citizens. The respondents accounts point to plurality of explanations for their staying power: First, the lack of fit of individual nursing credentials with broader and specific labour market needs did not support diversification into another sector of work without re-training, and relocating at the bottom of the career ladder. Second, for many respondents, the circumstances and personal reasons that strongly influenced them to come into nursing, such as the need to contribute to the education of younger siblings, were still valid. Third, and perhaps the strongest of reasons articulated was the fact that respondents did not wish to be driven out by their experience of racism. By staying in the profession and dealing with the

issues, they wanted to show that black people were not prepared to be 'hounded out'.

Nigel (Nigerian) was adamant that *'even when things got rough, enough for me to despair, the one thing that kept me going was that I was not going to let anyone drive me out. Why should they?'* Although Belinda (Indian) had been cast out of a managerial post in nurse education, she commented that her *'specialist qualifications were not exactly suited to securing jobs in other fields'*, and preferred to remain in nurse education by accepting fixed term posts which were often well below her level of expertise and credentials. Bridget (Sierra Leone) confirmed that she had almost resigned on several occasions primarily because she was *'frustrated by the lack of employer support and discrimination I had to endure at a personal level. Each time I reconsidered my decisions in the knowledge that if I left, no one would be focusing on ethnicity and health in the area'*. Hazel (Indian) drew on her Christian beliefs to work through problematic times in her career but concluded that *'all careers have rough and smooth periods.... I expected to spend a lifetime in nursing... [I suppose] it was about my personal integrity, tenacity and commitment'*. Pierce (Ghanaian) and Tim (Jamaican) who came into nursing as a second career, both said that their resolve to stay and do well in nursing was influenced by the fact that they were having a second bite at career selection. Pierce said *'I had already walked away from one career, therefore I felt under pressure to do well so that people [family and friends] did not see it as a character weakness'*.

There were variations in personal perceptions and organisational reality about what constitutes senior level appointments both in terms of the nursing discipline and the personal aspirations of the individual. Chapter 7 elaborated the reasons why respondents became careerists and their means of negotiating structural barriers. Respondents achievements can be identified in various ways: for example, changing their training pathway from EN to RN; qualifying as a registered nurse; progressing through the career ladder from staff nurse to ward manager grade; acquisition of professional and academic qualifications; accessing resources and challenging discrimination. With the exception of a small number of respondents who had either taken redundancy or had imposed their own glass ceiling on career progression by electing not to apply for posts at a higher level than the one they were in, others (Valerie, Faisal, Frank, Lal, Babna, Ruby, Patience and Maurice), believed there was still room for further career development in or outside current posts within their local community or at national and international levels. National level opportunities included those via professional bodies or the Department of Health (DoH) to service national committees or participate in key policy making or advisory working groups; selection as non-executive directors or entering politics. Four respondents had either developed parallel careers in local politics and chaired key committees in that role or were considering standing as parliamentary candidates.

The scope for international work (via or with the UN, WHO, and lead charities) is dependant on possession of critical expertise, national visibility and opportunity for appointments. Recently, Karlene Davis, a Jamaican, currently General Secretary of the Royal College of Midwives, has become vice-chair of the WHO's

European forum of nursing and midwifery associations (Nursing Standard, 2001c:8). Nigel (Nigerian) assessed that high visibility was associated with awards such as Fellowship of the RCN, winning the DoH sponsored Mary Seacole Leadership Award or public honours, and high profile appointments such as professor, dean of faculty, director of nursing, CEO or nursing officer at the DoH. He indicated that such appointments were *'a source of pride for our communities and us as black people. It is evidence that some black people are making it to the top '*, and that *'personal knowledge of the individual increased the sense of pride'*. Respondents' expressions about further career progression signified two things: First that the individual has other personal goals and aspirations to fulfil, and second the extension of the career into local community, national and international spheres was about completing the career plateau.

8.3. Being At The Top

One of the issues that challenged me was how the worth of a career could be evaluated. In the previous chapters, I have flagged up that career progression was difficult to negotiate; the barriers were not transparent; and the extent to which ethnic penalty played a role was unclear, but in most instances respondents were able to draw on their stocks of social and cultural capital and seize opportunities to find a way round and get to the top. We know that professional careers were developed simultaneously alongside putting down of roots in terms of citizenship, home ownership, marriage and raising families. Respondents were asked to consider if their nursing careers had been worthwhile. Their responses indicated

that respondents personal feelings were embedded in their personal experiences to include answers that spanned the whole continuum from a definite 'no' to a clear 'yes', with many answers being accompanied by reservations and caveats.

These respondents firmly believed that having got to the top, the intention was to stay there and survive the demands of *'life at the top'*, cope with challenges and adversity in their daily working lives, and ensure that personal output is at optimum level to do just that. As discussed in previous chapters, respondents acknowledged that for them to succeed and realise their ambitions and aspirations, they had to learn to put their own needs first. Respondent perceptions about having got to the top can be summarised as: *'dealing with others from a position of strength... A power base if one is honest'* (Pierce). Erin (Nigerian) commented that *'having the capacity and legitimate authority to take actions that have potential for doing greater good was exciting yet daunting'*. Others like Rose (Barbadian) were *'fearful that the consequences of putting my head above the parapet could damage me at a personal level... I'm afraid that people may see issues I'm asked to take forward as a personal mission rather than as organisational ones'*.

Valerie (Ghanaian) provided an eloquent description about what it meant to being at the top *'it's about harnessing the power of that job – the opportunities it brings, extending the sphere of influence, developing the future.... [and] making a difference for me as an individual and as a black person to the community per se and the profession'*. She was clear that *'there has to be a fit of personal values with those of employer organisation to promote career satisfaction.... My*

personal development is bound up with my ability to deliver as a manager, expert practitioner and lead academic'. Babna (Kenyan) referred to the *'cascade effect of success. It's good for black nurses to know that we are achieving and that our contribution is being valued.... It should boost their morale and encourage them to aspire higher'.* Similarly, Ruby and Rowena both referred to the *'visibility associated with success and its value to the personal portfolio',* in terms of securing career progression. Like Valerie, Maurice (Jamaican) was more tuned into *'influencing and contributing at a broader level'.* Maurice noted that the Mary Seacole Leadership award, funded by the DoH and managed jointly by the RCM, RCN, CPHVA and UNISON, is the first and only award dedicated to the developing leadership of black nurses, and voiced his disappointment that *'unlike other traineeships, the Mary Seacole winners do not have a fast tracking programme into nursing leadership'.*

Respondents vision for being at the top was about having the opportunity to reach out to people to help and enable them in a way that made a difference to their working lives, through education, changing practice or influencing employment practices. Virtually all the female respondents acknowledged their responsibility as role models to other black *'by doing a good job so that those coming behind them have an easier status passage through the ranks'* (Ruby). Babna acknowledged that she was keen to mentor *'aspiring ethnic minority nurses... It is important that they have a role model and support should they want it'.* Babna like others had extended her sphere of influence through active research. For example, her research into pain relief for minority, non-English speaking clients is likely to influence practice, curriculum development and policy development.

Above all, the female respondents wanted to ensure that change was enabled constructively, by promoting inclusion rather than exclusion and sharing information and knowledge in order to improve communication between people. Terrie (West Indian) as senior ward sister and Shobna (Kenyan) as assistant general manager (LD) gave credit to the role played by other black nurse managers in their respective workplaces, suggesting that the positive regard in which these managers had been held had made their transition smoother.

In contrast with the women who identified altruism in their motives for doing well in their jobs, the men (Anil, Rob and Len) had a different more egoistic view. Len (St Kittts) said *'I do not dwell on who is behind me; I haven't got the energy to take on that responsibility'*. Anil (Mauritian) was more blunt in his assertions that *'my hard work is for me, the time and effort I invest is for the purpose of my advancement.... Perhaps when I have got to the very top [of where I wish to be], I will refocus on more altruistic activities like mentoring others'*. Similarly, Rob (Nigerian) was more focussed on his own goals, stating *' if my reputation and achievements help others that's okay but I'm not making decisions with that as priority'*.

The above accounts demonstrate that there were clear gender differences between female and male respondents in respect of their perceptions about their influence in nursing and the effort invested in the career. Accounts provided by Len, Anil and Rob suggest that the men may have made the transition to individualism by pursuing personal goals in a strategic way. The female respondents seemed to have retained their collectivist approach by focussing on the needs of the

profession, the ethnic groups or client needs, and placing more importance on the role modelling or doing a good job. It is possible that the women have unwittingly adopted the role of nurturer to the newer members of the profession.

8.4. Was the Nursing Career Worth It?

There was almost a reluctant admission that the cost was high especially on the level of personal relationships. Jacqui (West Indian) commented that *'the time taken to get to the top has not been easy on personal relationships and family life.... As I moved up the career ladder the job demands were more intense...My own insecurities were such that I allowed it to encroach on my family life.'* Valerie (Ghanaian) also admitted that *'it was not easy nurturing relationships... They were in competition with one's goals or the demands of the jobs.... I suppose like many managers I wasn't even aware of the fact that I was working longer hours or regularly taking work home.... It was very easy to let work become the driving force'.* Eric (Trinidadian) talked about the impact on his family in relation to *'it goes without saying that getting to the top required a focused attention on the job, but I did not expect it to cut into family time.... It is only recently that I have felt secure enough to take steps to ensure that I get to key events in my childrens' diary.'* Anthony (Indo-Malay) believes that while his career goals were assisted by *'slave-like devotion to the work and gaining credentials, sacrifices were made without even thinking about the consequences to my marriage or affect on the children not seeing their father... In some ways the family was a single parent one, with my wife being the sole parent... I was the absentia parent'.* Len

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blamed his career for the *'break up of the first marriage...The family saw little of me...[I] was too busy working long hours...When I was home I was still working'.*

Deirdre (Jamaican) compared her career with her US domiciled siblings and concluded that her appointment as Head of Department in 1996 brought her to approximately the same level as her siblings who were already established in their careers. Her assessment was that she *'lagged behind by 5 to 7 year, probably more if note was taken of our age differences and their career breaks'.* Banu's (Tanzanian) perception was that her *'career progression was smooth...[It] felt like I had the Midas touch.. There were no major hitches. On one or two occasions when I didn't get what I had pursued, I found myself being offered something better. The only criticism, and it is a self-criticism, is that I did not seek the opportunity to pursue a higher degree'.* Unlike Banu, other respondents recognised the process to get to the top had been achieved with a price tag of 'personal sacrifices' related to relationships; physical and mental health; much time and resources being invested; and costs associated with balancing family and professional lives. Cynthia (Jamaican) and Thom (S. Rhodesian) concluded that their appointment as senior educationists was long overdue because the organisational culture had been unfair to them on a personal level. Cynthia thought *'the system was unfair. It operates on the hidden, the unspoken – making it difficult to fight an unknown enemy. Each time I applied for promotion [to head of section], the criteria were interpreted differently'.* Thom referred to the lack of opportunities for interview coaching or insider information about the conduct of promotion panels. He said *'[my] white colleagues received coaching from the*

vice-principal, I was told to use the job description as the framework for preparation...the advice was probably pertinent but I felt I had been treated less fairly'.

8.5. Work Related Ill-Health

Certain types of health problems were associated with the stressors connected with the nature of work, working practices and lack of strategic support. Ill health, especially a diagnosis associated with mental health, had an impact on the respondent's subsequent career especially their ability to continue in that post or their employability. The recommendations of the Allitt Inquiry (Clothier et al, 1994) make it more difficult for the NHS to appoint individuals with a mental health history. It is well documented that absenteeism, mental and physical ill health, and job satisfaction are associated with occupational stress (Nelson and Burke, 2000: 181-183; Davidson and Fielden, 1999:413-426; Davidson, 1997:63-77). The sources of occupational stress include tokenism, discrimination, isolation, harassment, bullying, sexism, racism, long working hours, job insecurity, and unrealistic workload (Cooper and Lewis, 1999:43; Davidson and Fielden, 1999:416-419). Davidson and Fielden (1999:421) have identified gender differentials in male and female manifestations, coping mechanisms and outcomes to occupational stress.

Ellie (Barbadian) became clinically depressed as a result of occupational stress related to a series of major restructuring initiatives resulting in serial changes to her employment contract and role. Occupational stress resulted in clinical

depression, leading to four months of certificated sickness absence during which she was treated with anti-depressants and received psychotherapy. She said: *'nursing does not tolerate mental ill health. I returned to work after 4 months - nothing had changed. Any problems however trivial were linked to the depression. I suppose by making it my problem the organisation did not have to look at its working practices. The price I paid is unacceptable.'* Nikki (West Indian) resigned her NHS post on medical advice and was bitter on two counts: lack of help and support from the NHS sector and a premature end to her career. Nikki described her experience as *'I was always fatigued. I took work home. I felt I was fighting fires all the time.. There was no respite from work...[Everything was needed yesterday] the pressure was constant.... It took me longer and longer to get the work done... The senior managers did nothing to alleviate it ... I was burnt out. My health problems persisted.. I could see that I had to get out of the organisation. It's left me very angry because my career has been slashed by 15 years... It's like bereavement; I am grieving for the lost opportunities'.* Belinda recognised the price she had paid trying to *'drag the SON into the 1980's',* and was angry with herself for not questioning why the post *'had gone to a 3rd round of interviews before an appointment was made... When I had a mental breakdown I was told it was post traumatic shock related to my experiences in post, the manner in which I had been dismissed and my post dismissal experiences with the organisation'.* Belinda was anxious about *'the impact of my ignominious departure on the minority staff in post, the way they dealt with me did not bode well for race relations in that place... In time, many of the black nurse teachers voted with their feet'.* Similarly, Nikki was concerned that her protracted health

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problems painted a negative picture of her as a black person ' *one who is unable to*

function at that level. I have heard it said that I was hiding behind my ill health '.

Six other respondents had physical manifestations of stress, for example

hypertension, exacerbation of skin conditions such as eczema, irritable bowel

syndrome and rheumatoid arthritis. Respondents with health problems leading to

enforced changes in their working and social lives were critical of the employers

for their lack of support. At the same time they were concerned that their removal

from the senior posts further reduced the number of black nurses employed at

senior level.

8.6. The Treadmill Effect

The treadmill effect in senior management was a concept described by Jo-Jo

(Jamaican) with reference to having to meet impossible deadlines and service

objectives. The potential dangers of the treadmill effect are stress, staff burnout

mental or physical illness, increased absenteeism, exhaustion, poor performance,

and job dissatisfaction (Nelson and Burke, 2000: 181-183; Davidson and Fielden,

1999:413-426; Davidson, 1997:63-77). Jo-Jo described her working week '*as a*

constant challenge.. [The] short deadlines pose a problem for quality and scope of

the report. It's virtually impossible to manage the service efficiently, keep abreast

of all the developments and ensure that staff development, recruitment and

retention remain at optimum levels. I'm on a treadmill, go from one task to

another without any time for reflection'. Cheri (Barbadian) found the challenges

of an objectives led academic department were impossible to deliver: '*there were*

departmental objectives; my personal objectives which were always an issue for APR [annual performance review] — basically we were all trying to outshine each other; it included things like how my courses or research could contribute to the income generation targets or what my research output was going to be for that year. There is no way that I can meet all the objectives if I take account of the number of hours I was required to teach, undertake a day in practice, support students in clinical practice. The objectives are unrealistic...I've lost many opportunities for conference presentations or joint research bids because of the competitive demands placed on me. [The] lack of admin support is another issue'.

She identified the problem as the university's dual demands of nursing as *'a teaching department to meet the contracts, have a high pass rate so that future contracts were secure but at the same time we are expected to integrate into the HE culture for scholarship, and research to contribute to future RAEs [research assessment exercise]'*. She was aware that the competing demands between professional and personal life had become a threat to her personal and external professional profile and that her personal life was relegated *'as less important'*.

James (St Vincent) recognised that the treadmill effect had an adverse impact on his team because he was *'frequently delegating tasks to others... The pressures were being cascaded through the rest of the team... Over time I recognised that staff sickness and turnover had increased'*.

8.7. High Visibility and Benefits of Being At the Top

High visibility often accompanied appointment to the senior management tier (Davidson, 1997; Stroh and Reilly, 1999, Modood et al, 1997). This high visibility was due to the scarcity of people of colour appointed to senior posts and, the implicit expectations of the appointee by the organisation and its ethnic minority work force. At an organisational level, such appointments were supposed to send out clear signals of their commitment to equal opportunities, race equality, and meritocracy, whereas for the individual it was a public display of their achievements bringing with it potential for power and influence in decision making (Hugman, 1991), inspiring other ethnic minority staff and also having the potential to stoke ones own career at national or international levels. There was concern from several respondents that *'sudden appointments of black nurses into middle and higher management'* were tokenistic with the intention of making the institution look good. Faisal (Pakistani) indicated that a negative impact was more likely if there were misunderstandings between the employer organisation and appointee, for example *'if either [party] changes the agenda... Employers shouldn't shift the responsibility for race equality or ethnic issues on the appointee just because the person is a black individual... Equally, it would be wrong of the appointee to use the office to which they've been appointed as a platform to push forward black issues, especially if that aspect wasn't a component of the appointment'.*

Ellie brought the *'down side of high visibility'* to my notice by saying that *'she is always in the public eye. It adds to the stress of the job. I had not considered that when I took the job... With time, I learnt to accept it'.* Laurette was conscious

about the ease with which reputations were destroyed, saying *'mistakes are commonplace - somehow mine were more visible. I think being black made it so. Often my mistakes were compounded by short deadlines, inaccurate data sets or incompetence of others. I accepted that as the senior most person the buck stopped with me... but it left me feeling very vulnerable'.* Faisal's opinion was that *' mistakes have the potential for defensive reactions with potential to point to guilt and or incompetence. If one can demonstrate the learning from the experience, then people take a humanistic view and make allowances. However, if there is no learning or there is an automatic defensive action, the individual gets the blame and in time the attitudes displayed are ascribed to stereotypes of the ethnic group'.*

Several respondents (Valerie, Erica, Ruby, Anil, Scot, Pierce and Jane) constructed the notion of *'walking a political and cultural tight rope'* meaning that while they tried to do their best, they were working within structures that were racialised and rigid, where the barriers were not transparent and there were high expectations of them at a personal, employer and professional level. Respondents perceptions about high visibility were based on personal and organisational experiences which in turn influenced their own reactions and actions to the phenomenon. The joys and rewards of the career mobility were assessed in relation to personal development, developing networks, broadening personal horizons through education and life experiences, influencing nursing practice and contribution to nursing per se.

Two respondents worked with their professional organisation to develop policies tackling workplace bullying, racism and discrimination. Both these respondents

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believed that their potential to do good was increased by working at organisational level but at the same time anonymised their contribution to such sensitive issues. Veronica (Indo-Malay), as a consultant on equality issues, maintained that it never failed to surprise her that when she was contracted to undertake work on equality issues *'the briefing invariably came from a white manager, but the people round the table, the ones I would be working with were usually black and female'*. As case law goes, there are numerous examples of racism, harassment, unfair practices and bullying experienced by ethnic minority staff in the NHS (Beishon et al, 1995; CRE, 1987a. 1987b, 1988, 1992, 2000; Alexander, 1999; Agbolegbe, 1984a, 1984b; Baxter, 1988; Torkington, 1985, 1987). Similarly, there is anecdotal evidence pointing to *'pre- tribunal agreements being reached'* for undocumented cases involving racism, harassment, unfair practices and bullying experienced by ethnic minority staff in the NHS and Higher Education. The concept of not *'making waves for the sake of others'* (Veronica) was a reference to the dilemma of pursuing personal grievances that may produce a backlash for the ethnic minority nurses.

Without exception, respondents admitted to being proud of their achievements at a personal and professional level. A number of female respondents evaluated their achievements in relation to their contribution to the black community through their impact on service and practice development, nurse education and research. The drive to continue to achieve was interpreted as an attempt to secure their position at the top (Robbins and McCelland III, 1997) or a fear of having reached a plateau from where on the career is likely to decline or reach an exit point. Ruby (Trinidadian) explained *'the terrain at the top is ever-changing... Our jobs are no*

longer lifetime posts but dependent on output... Employers, out there want the

best for their business...If I cannot provide that some one else will. To be the best

one has to achieve'. Similarly, Valerie's (Ghanaian) drive to continue achieving

was to fulfil dual agendas of professional and organisational goals and personal

aspirations, to *'develop an external profile to enhance the University's external*

profile in a relatively new field of business for them'. Fears about a career

declining or reaching the point from which an individual exits, enforced or

personal decision, were expressed by a few of the respondents, primarily those

who had experienced threats of redundancy or had to compete for their own jobs

internally or with external candidates. There were three expressions, all from

African-Caribbean female respondents, to return to the Caribbean to *'use my skills*

in community development'. Self employed respondents thought that their

business interests would continue to engage them in the field either as owners or

for their networking skills. Laurette (Trinidadian) planned to work with the VSO

or British Council to teach health care overseas.

Respondents recognised the intersection of structures at societal and professional

levels, and personal agency in their career journeys, nevertheless, they identified a

total of eight key 'person oriented' facets of being at the top: having people

oriented behaviours relating to professionalism, trust, honesty and integrity;

mastery of communications skills to share vision, build new paths and build

bridges across gaps (Robbins and McCelland III, 1997); belief in self (Robbins

and McCelland III, 1997) which is similar to the concept of self efficacy

(Greenhaus et al, 1990); being passionate about the focus such that it energises

and drives the individual to reach the goal; a strategy to network, open doors for

others; build and shape opportunities; having a clear vision of the goal in the knowledge of what is important to them and the price that may be extracted; and giving credit where it is due so that others may be encompassed in the success cycle.

8.8. National and International Visibility

Valerie, Erin and Ruby stated *'at the very least we are individuals with ability, have professional and personal integrity and a drive to do well'* and at a collective level they saw themselves as *'having capacity to contribute to shape the future of the profession, and health care both here in the UK and overseas'*. It is impossible to discuss respondents' work at national and international level without revealing their identities, therefore examples of black nurses cited here are from the public domain. Karlene Davies, DBE (Jamaican) has received recognition at three levels: at national level for her 'services to midwifery and the NHS' (Nursing Standard – News, 2001a:8), at an academic level through being awarded an honorary doctorate by Brighton University (www.RCM.org.uk: June 2001) and at international level via her appointment to the WHO (RCN – News, 2001c: 8). Others like Professor Mel Chevannes CBE (DeMontfort University) (McMillan, 1996:30); Professor Elizabeth Anionwu, CBE (Thames Valley University) (Nursing Standard, 2001e:7); Shirla Philogene, MBE (former Nursing Officer at the DoH) and Nola Ishmael, OBE, Nursing Office at the DoH (Stephen, 1999:20-22); Veena Bhal, ethnic advisor to the Department of Health (DoH); and Neslyn Watson Druee, MBE (Stephen, 1999:20 -22), are well known for their work at

local and national level via the DoH, NHSE, RCN, ENB, UKCC, their international work (EC, UN or WHO) or entrepreneurship. Since the mid 1990s, there is an emergence of black nurse leaders, many combining practice, scholarship and research, such as David Sallah, who was awarded the first Mary Seacole Leadership award to take forward his seminal work in forensic nursing (DoH, 2000).

8.9. Power, and Black and Asian Nurses

Without question, high profile posts at national, international or local levels symbolise power. Power as we know is socially structured (Hugman, 1991:32; Porter, 1996; Cole, 1998), being an integral part of social life. Mann (1986 in Cole, 1998: 278) argues that there are four sources of social power: economic, political, ideological and military, and that power offers a means of control over other people through knowledge based discourses. Foucault (1979 in Porter, 1996) views power as being generated at the point of interaction, and while he does not deny the existence of institutional power, he does not see it as 'something that some people have and others do not' (Porter, 1996:59-60). Porter on the other hand explicates that power is possessed (1996:61) and that some groups have more power than others by virtue of their occupancy of positions within the social structures, allowing them to engage in particular practices (Porter, 1996:66).

Generally, power differentials in business, professions and politics, are hierarchically organised in favour of white male managers with access to personal and collective social capital (Adler, 1999: 245; Collinson and Hearn, 2000:268).

In British nursing the power differentials are accentuated by ethnicity (Culley and

Mayor, 2001; Culley et al, 2001), organisational structures (Doyal et al, 1981),

managerialism (Carpenter, 1977a, 1977b, 1993; Hugman, 1991:40), and other

powerful disciplines such as medicine (Hugman, 1991:32-40; Porter, 1996). The

hierarchical organisational structure of nursing has been previously discussed in

Chapter 3 in relation to, for example the case of EN subordination to the RN and

the control exerted by senior grades on the work of their junior nurses, and the

inter-occupational control on nursing by doctors, at the level of controlling

nursing actions (Hugman, 1991; Porter, 1996).

The respondents' accounts indicate that in nursing power is operationalised at four

levels: the professional, personal, organisational and collective level. Professional

power was viewed in terms of the professional status of nursing in comparison to

the status of other professions allied to medicine, its long term rewards and

community value. Nursing was identified as *'a poor relation to other professions'*

(Rowena: Jamaican) when compared with the career ladders, financial rewards

and work patterns of similar careers. In addition the time needed to get to a *'stage*

where earnings were reasonable' was said to be unacceptable (Ruby:

Trinidadian). Maurice identified that the issue of being *' a black individual with*

little power in this society working in a marginalized profession was a dual

jeopardy – a triple one if you consider that it is a poor relation in academia'.

Interview data revealed that 90% of those surveyed would dissuade their offspring

from considering nursing as a profession, primarily because there *'were other*

alternative careers to consider' (Mamta: Ugandan), or the experiences of their

own career journeys were such that they would not allow their children to

consider nursing. Thom (S. Rhodesian) said he could not even bear the idea of *'his*

children considering nursing as a graduate career, let alone as a P2000 student.

The career experiences of graduates are no different'. Terrie admitted to

dissuading her own children or those of friends and other relatives from nursing

because *'I feel obliged to spell out the difficulties they are likely to encounter in*

the world of nursing, study or other work. I see it as a part of guiding young

people to make the right decisions. I think their potential destinations are much

wider and they should have the opportunity of setting their goals higher by having

access to the information'. Lal (Mauritian) overtly discouraged his twin daughters

from nursing: *'financially, I would not advise nursing as it offers poor rewards*

even for the graduates. Why not put the same effort into something else'?

Personal power was described in terms of individual contribution or influence in

developing scholarship and research; policy, curriculum, practice and service;

mentorship, through personal expertise and status in those fields. Personal power

had its base in concepts of empowerment, and influencing from behind the scenes

(Adler, 1999:245). Organisational power was associated with influence through

the authority of the individual's office, that is, level of appointment either as an

officer of that organisation, as a non-executive director or through membership of

key committees. An example of authoritative power within a professional

organisation is the key appointment in the RCN, CPHVA and RCM, of three

black female nurses, (a nurse, a health visitor and a midwife), who have been

appointed as General Secretary, Deputy Director and President, respectively. For

example, Karlene Davis, DBE (Jamaican) (Cole, 1998:279; Nursing Standard

News, 2001a), in her role as RCM General Secretary has authoritative power with

potential for extensive power to organise RCM members or build alliances with other trade unions, and in parallel she has intensive power that could be harnessed to call upon the membership to organise tightly to address a particular issue. In contrast, the authoritative power of black non-executive directors or office holders would be limited to the organisational structures of the appointing body.

Collective power was perceived as the solidarity or unity of a group of people to influence and lobby on behalf of that group, for example the National Black Police Association. It is likely that black nurses have not organised as a collective either through lack of a unifying symbol or attempts to unify have been resisted in preference to working through the established professional organisations. To date there is no evidence of black networks exercising collective power (Cole, 1998) but there is evidence of respondents' capacity to exercise pastoral power (Porter, 1996) through their networks and mentoring, an aspect that has been discussed in Chapter 7.

8.10. Do Black Nurses Have Personal and Collective Influence In The Profession?

Respondents were easily able to identify their direct and indirect personal power and influence in their working and professional lives depending on the discipline and level of appointment. For example those working in forensic mental health, midwifery, community nursing, education and professional organisations, were able to identify their contributions in policy development, research, curriculum development, practice development, commissioning services and education, and

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standard setting. Their contribution in these activities, with a few exceptions, was invisible, in that it did not come into the public gaze through publications or debate, as well as being confined to the local area in which these individuals worked. In real terms there was little factual evidence to demonstrate that black nurses had contributed to any developments. Veronica (Indo-Malay) described her role in policy development for equal opportunities and combating racial harassment, as *'I initiated the work at locality level to improve the work environment.. Although I shared my experiences of managing the project with another locality, there was little interest at senior managerial level to recognise it as an area of good practice through publication or conference presentations'.*

Unless the individual was involved in critical decision-making activities at local or national levels, their sphere of influence was both difficult to measure and nebulous. How does one assess the visibility of contribution by a 'nursing board registry expert' to a curriculum validation process? The contribution of senior managers in developing specialist services, for example haemoglobinopathies can be assessed in terms of client satisfaction or outcomes through regular audit. It is clear that certain black nurse scholars, for example Professors Chevannes and Anionwu, have influenced nursing curricula and practice through their debate, research, practice and publications about cultural competence and culturally appropriate nursing care. The potential for broader influence by the winners of the Mary Seacole Leadership Award, is yet untapped. While the influence and academic contribution of some respondents' was often extended to developing inter-professional education initiatives such as combating female genital

mutilation, their contribution was more likely to have more local relevance and value than being bench marked at national level. My personal views are that political correctness and avoidance have prevented black nurses from influencing nurse education. For example, literature on the physical and mental health of ethnic minorities (Luthra, 1997; Nazroo, 1997) confirms the inverse relationship of health with social class and ethnicity, yet nursing curricula rarely offers any specialist preparation on the specific issues, instead it chooses to address them from a generic perspective.

In the workplace, authoritative and managerial power is located in people who hold senior management positions. Faisal (Pakistani), Valerie (Ghanaian), Ruby (Trinidadian) and Maurice (Jamaican) were clear that their power was relational to their employment grade that relegated the individual's ethnic and cultural identity to a secondary position. Faisal summed it up by saying *'the higher up one is in the organisation, the more life is circumscribed. The power of my office is seeing things from a broader perspective, without being afraid to challenge miscarriages of justice, poor practice, and so on'.* Valerie argued that higher management roles such as those equivalent to Deans or Director of service were a *'means for harnessing power. I would like to think that I use my personal power and influence to empower others and bring together skills, knowledge, personnel and vision.... My mission is that it should be used for the good of the profession: to push out its frontiers, not from just a racial stance but a global one to benefit the client group'.* Adler (1999:255) writes that women leaders tend to be 'vision driven' rather than the hierarchical status of the office.

The potential for exercising personal power in making appointments to suit one's own agendas was raised by several respondents. Fred (Jamaican) drew my notice to the restraints on power through his concern about the need to be careful so that *'one is not accused of nepotism when making appointments or giving one's friends opportunities to lead projects'*. He noted that while white managers often made appointments in their own image (Adler, 1999), without paying any regard to the ethnic identity of the appointee, he felt compelled to ensure that the processes were transparent and overt. Valerie also identified making appointments as a source of anxiety, especially in the early days of her director role. She saw appointments as *'a catch 22 situation. The worst scenario for me was that who ever was appointed, at least one faction of the team would be unhappy with the decision. If a black person was appointed, I expected accusations of nepotism and favouritism from the white staff and if a white person was appointed I anticipated accusations from black staff that I was pulling up the drawbridge after me by not giving other black people the chance of climbing the ladder'*. She continued, *'my fears were unjustified, probably because I ensured that all the team members were involved in developing person and job specifications. Also, by rotation a member of team was always included in the selection panel, and they were involved in presentations and informal visits'*.

8.11. Nursing Power and Political Manipulation – Targeting Health of Ethnic Minorities

A consideration in any appointment was whether it was politically motivated to meet government agendas; appease professional or client groups; signalled change or was tokenistic in nature. Here I wish to demonstrate that political manipulation can create chasms between professional groups, undermine the very people the appointment was intended to help and promoted racist ideologies about ethnic health (Pearson, 1986 in Rodmell and Watt, 1986: 50-51). In 1980, Veena Bhal, a Kenyan-Indian health visitor, was appointed as the Asian face to lead the DoH and Save the Children's Fund joint campaign known as the 'Asian Mother and Baby Campaign', giving her a high public and professional profile. Ms Bhal's appointment was important on two levels: it was the first occasion on which an ethnic minority nurse was appointed to lead a project at national level, and second it was a departure from the norms associated with developing and implementing large-scale public health projects because she did not have a track record in such initiatives. As Ms Bhal did not have a credible power base or the authority to organise health care professionals, her appointment was viewed as a political one – as an attempt to deflect accusations of the campaign being racist by appointing an Asian professional person. Furthermore, as the Asian face of the campaign, she colluded rather than challenged the stereotypical perceptions of midwifes and obstetricians about antenatal Asian women being irresponsible by accepting the status quo. In real terms Ms Bhal's appointment brought her very little power or influence.

Belinda (Indian), Ellie (Barbadian), Jack (Malaysian) and Tim (Jamaican) were adamant that initiatives such as the Asian Mother and Baby Campaign had an adverse effect on ethnic minority nurses shaping the NHS policy or professional practice. Jack insisted that *'he would not touch something that was clearly politically driven and blatantly racist. What sort of message would I be giving to the ethnic community'?* Tim said *'as people of colour, we are a marginalized group, we may be involved in delivery but we are rarely involved in shaping things – probably because we lack political clout within society and within the profession'.* Babna questioned why more black nurses did not *'make it to the DoH – did they not apply or were they not getting through'?* Her question could now be extended to include the appointment of nurse consultants and nominations to the new shadow Nursing and Midwifery Council that replaces the UKCC from 2004.

From a political perspective, black nurses have only recently begun to articulate the inequalities, discrimination and disadvantages associated with racialised social and professional structures. In the last two decades, from 1980 onwards, a number of black nurses have negotiated the glass ceiling to be appointed to higher management posts. The expectation of these individuals to influence the NHS at local, regional and national levels, in relation to developing policy, service and curriculum, service delivery, management, and identifying research agendas has not been realised. Their potential to address inequalities, discrimination and barriers in health care, was negligible in the absence of a concerted commitment to alter social structures. It is possible that the individuals who have negotiated the glass ceiling to get to the top either do not have the scope to influence change or developments at that level or they have elected to safeguard their emotional and

psychological well-being by not becoming embroiled in issues which require a more sustained and strategic level of support. The potential for collective action while having a greater chance of success may not succeed for reason of inter-ethnic group rivalries that have not been explored for this research or by other researchers.

8.12. Conclusion

This chapter has confirmed the staying power of black respondents through the processes of putting down routes in their adopted country and staying with nursing in the knowledge that long term rewards were going to be limited in comparison with other professions; their career achievements were harder to come by, and that the racialised structures were likely to continue influencing their career. In fact the reasons for staying in nursing were rather reminiscent of the reasons why they had originally decided to choose nursing as a career. They saw themselves as individuals influencing nursing developments in practice, education, research or service development; contributing to black communities in England and therefore to society in general. Furthermore, some of them recognise their contribution to the field of 'race' through their individual work on 'race and health', 'race equality', and racial harassment and bullying' in the work place. Respondents demonstrated that being at the top was not about maintenance of the career but rather about ensuring that output remains at an optimum level to ensure that the individual remains employable, and there was opportunity to further or complete the career plateau at local community, national and international levels.

Respondents' accounts showed that for some people the personal cost of stoking and developing the career was insurmountable in terms of personal losses related to mental and physical ill health; redundancy or downgrading; and personal relationships. The constant demands on people to deliver to competing agendas in ever-decreasing time frames was compared with the concept of being on a treadmill and becoming task focussed. The high visibility of 'black appointments' was identified as a feature of the scarcity of such appointments at senior level, a phenomenon that brought both positive and negative attention to some respondents. Respondents were acutely aware of the constant demands they placed on their stocks of social and cultural capital to ensure their equilibrium.

The discussions about power pointed to the potential for political manipulation that support existing structures rather than dismantling them. I have shown that while respondents' perceptions allude to power being exercised at the personal level in relation to contributions to policy, service, practice and education developments, and decision-making; the public evidence for much of their efforts remained weak. An aspect that needs further attention is that of mobilising black nurses as a collective power force to spear head initiatives.

In the next chapter, I shall be summarising the findings and discussions of earlier chapters to focus on the research questions.

Footnote[1]

Please note that where black nurses are referred to by name, the information is from public sources and does not infer that the named person / persons participated in this research.

CHAPTER 9

SUMMARY AND CONCLUSIONS

9.1. Introduction

This is an elite study of eighty-eight, male and female, black nurses in a marginalized profession, who have negotiated their careers to be appointed in senior managerial, academic, practice or research posts. It aims to: (a) understand their staying power in British nursing and a racialised social world, (b) celebrate their achievements, and (c) understand how they have managed any challenges, obstacles or barriers along the way. The research is set in the context of nursing as a career in England to map and identify patterns in the experiences of these respondents, from the decisions relating to entry into nursing to their employment at the point of data collection. While this thesis offers an opportunity to focus on these individuals' careers and their contribution to nursing, it also sets these against the overlapping 'structural' framework of the history of the NHS and the staying power of black people in Britain (Fryer, 1984).

The NHS as the primary healthcare agency in the United Kingdom (UK) is the largest employer in Europe (Ward, 1993), and the largest employer of black people in the UK (Culley and Leatham, 2001:63). British nursing has an approximate ratio of 1:9 ethnic minorities to white nurses. In terms of the international mobility of nurses, the UK is the second most important destination country (Buchan, 2000:24-27, 2001; Kenny, 2001:5). There is a dialectic in the collective position of ethnic minority nurses in the NHS: on one hand they are

visible at the lower rungs of the nursing profession (Beishon et al, 1995) but invisible at middle and senior levels of the nursing organization (Beishon, et al, 1995; Mayor 1996; Culley and Mayor, 2001); and there is systematic racism at the entry gate (Agbolegbe, 1984a, 1984b, 1988; Iganski et al, 1998; Mahoney, 2001).

Prior to the Policy Studies Unit's research (Beishon et al, 1995) much of the literature (for example Agbolegbe, 1984a, 1984b, 1988; Akinsanya, 1988; Baxter, 1988) was either based on opinions or on small samples. Furthermore, the literature made no reference to the social or political context in which the black nurses were employed; did not address issues about their entry gate into nursing, the domains of practice they were channelled into or their experiences throughout their nursing careers; did not focus on how the black nurses negotiated and managed their career; and neither did it make reference to the history of black people in Britain, their social mobility or their contribution to nursing. Instead black nurses were portrayed as being the problem without examining the social and political structures. Daye (1994) and Modood et al (1997), provide a more sophisticated understanding of black peoples social mobility, pointing to the relationship of structures, namely- 'class', 'race' and 'gender', but do not illuminate individual processes to explain intra and inter-ethnic group diversity. While Modood et al (1997) and Brah (1992 in Kirby et al, 1997) argue that each ethnic group experiences different patterns of disadvantage and develops distinct responses within their own culture and community, they do not explore the structure and agency in the lives of black professionals.

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The aims of this research were therefore to:

(a) Illuminate and understand the black nurses experiences of nursing as a career beyond the ward manager grade within the social and political context of British nursing, and against an overlapping 'structural' framework of the history of the NHS and of the history of black people in Britain. Respondents' personal experiences were captured through narratives using the oral biography and questionnaire for data collection.

(b) Acquire a greater understanding about the social mobility of black people through professional and academic accreditation, the development of networks and strategies adopted to get to the top of the nursing profession.

(c) Redress the paucity of available research about black nurses in nursing history and broader literature pertaining to social sciences, organizations and occupations by focusing on issues that hitherto had been excluded from the research agenda.

This chapter begins with a summary of the findings discussed in earlier chapters of this thesis, addresses the research questions together with their implications for policy and education in nursing, and then introduces an emergent theoretical model. Lastly, I consider the limitations of this research. Throughout this thesis, the intersection of the structures with processes and personal agency has been emphasised. It must be noted that structures may remain constant, or change over time, and new structures may emerge. For example, while race discrimination appears to be constant, our understanding of its antecedents, the actual processes,

types of racism and their impact on the personal level, and knowledge about attitude development is much more sophisticated than it was three decades ago. In nursing, credentialisation through higher degrees; the introduction of P2000 at diploma and degree level; and the growth of new specialisms are three of the new structures introduced into the profession. The inter-relation of structures exacerbates the ethnic penalty for black professionals.

9.2. Summary

The staying power and career journeys of leading black nurses discussed in previous chapters show that the intersection between social structures of class, 'race'/ethnicity and gender, and personal agency is important in shaping careers and is influenced by the respondents' domestic considerations; nursing labour market; health policy changes; social and cultural capital; organisational changes or constraints; and/or professional constraints. The intersection of social structures and personal agency were different at an inter-ethnic group level for male and female respondents, for example in relation to the centralisation of practice domain. In addition, there were clear differences between respondents who were parents and those who were non-parents, especially where geographically mobility was concerned.

The respondents in my thesis were a cohort of male and female black nurses, living and working in England, who had successfully negotiated the career ladder in their discipline by engaging in lateral and or vertical career moves; used geographical mobility and/or night duty as strategies to mobilise their career; managed parallel careers as student-employee-parent-and other roles; invested

personal resources to acquire social capital by pursuing academic studies; developed and participated in social-professional networks; and found personal strategies to combat discrimination. Many of these respondents had a steep learning curve very early in their careers with reference to direct, often covert discrimination. Earlier discussion showed that race discrimination was manifested at different levels and in different forms, for example the exploitation of some black applicants by segregating them into the EN pathway; the employment of some female respondents as nursing auxiliaries prior to commencing nurse training; confiscation of the passport of eleven female respondents who were channelled into the EN pathway; and the allocation of some respondents to poor quality clinical placements. Evidence of race discrimination in relation to the respondents was found in all disciplines of nursing, including nurse education, regardless of the geographical location of respondent.

In order to succeed, the women often emulated or mimicked a masculine career trajectory characterised by minimal time taken out of nursing for maternity and childcare, and full time continuous careers: a pattern that is similar to women in other professions, namely law, accountancy and medicine (Dumelow, 1997), due to the lack of part-time career ladders and training opportunities in nursing. Contrary to the experience of other professional women (Dumelow, 1997) and previous findings on the careers of senior nurses (e.g. Buchan, 2001; Davies and Rosser, 1986), the female respondents of this research did not delay child bearing until they were established in their careers. Women were primarily responsible for organising and managing childcare. Although a variety of childcare agencies and methods were used, there was a heavy reliance on family, especially grandparents and older children, and family friends registering as child-minders, to safeguard

the transmission of cultural influences and ensure stability in provision. Live-in childcare or foster-care was a rarity.

Male and female respondents used both geographical mobility and permanent night duty as strategies for career progression or to acquire a broader level of experience in a larger organisation. While night work was welcomed by a number of men for its increased income potential and as an opportunity to read for an Open University degree, it was not a method of choice for those with childcare responsibilities, mainly women.

Gender segregation in favour of men was evident in mental health and learning disability nursing; but in favour of women for community nursing, midwifery and nurse education. Over-representation of women in community nursing and nurse education may be a reflection of working practices that are considered to be more conducive to family life. Empirical evidence suggested that there was a high level of participation, for both male and female respondents, in professional activities, conference attendance, and professional and academic study. As shown in 6.10, a significant number of respondents self-funded their professional activities. Respondents believed that they were more likely to experience glass ceilings as the career moved to the higher grades.

I now return to the fundamental research questions posed in Chapter 1 and address each in turn. The questions were formulated to redress the gap in research about the social world the black nurses live and work in to focus on the processes that allow some people to get on in a world that has rendered black people as invisible in research terms and continued to maintain their subordinate position in the labour market by not challenging the inequities of their working lives. To date

there has been a lack of focus on black people rising within structures, as mostly the research focus has been on those at the bottom. Thus the research questions set out to discover the rationale for respondents selecting nursing; how they arrived at the decision; what other choices did they realistically have and their personal aspirations or goals of the chosen career. I wanted to discover if there were any inter and intra ethnic group differentials that may be explained by the intersection of class, race and gender, in relation to opportunities available or negotiated by black nurses to secure mobility against the odds of social, organisational and professional structures; and discover how their cultural capital contributed to career decisions in adult life. Lastly, I wanted to know if respondents who had 'got to the top' thought their efforts and investment in the career had been worth it on personal and professional levels.

9.3. What were the principal push and pull factors that resulted in respondents either selecting nursing or ending up in nursing?

The reasons why respondents chose nursing in preference to other career choices were influenced by a combination of 'person-oriented' reasons such as wanting to acquire professional qualifications; the opportunities or lack of labour market opportunities available to individuals in their home countries; and the level of resources individuals could call upon to pursue higher and further education in their quest for professional qualifications. A number of female respondents expressed a strong desire to become a nurse or referred to the concept of having a

vocation. School leaving qualifications, and cultural receptivity of nursing further influenced career choices, whereas, career advice, based on the individual's personality, skills acumen and personal goals, was virtually absent. Of these, the two most important influences on the career destination were the family resources the respondent could call upon and the restricted labour market opportunities in the country of origin.

9.4. What were the patterns of similarity and difference between respondents by gender, ethnic group, nursing discipline, recruitment, entry gate and migration pattern?

Empirical data showed that the men, with the exception of Mauritian Asian men, came into nursing opportunistically, often via other professions, as a second career or having aborted initial further or higher education studies for financial reasons. Thus, nursing was not the first career choice for the majority of male respondents. The African, Caribbean and Asian ethnic groups' cultural receptivity to men in nursing evolved as a response to the need to accommodate the limitations of the labour market and lack of opportunities in the source countries.

As a group, male respondents were older than their female counterparts and their knowledge of the nature of nursing at entry gate was poor. In contrast with the male respondents, nursing was either the first or second career destination for a large proportion of female respondents. A small number came into nursing via other studies or professions. Under the reciprocal registration arrangements, the

General Nursing Council (GNC) accepted the qualifications of the six women who had qualified in their home countries of India, Jamaica, Kenya or Nigeria.

The entry gate for overseas applicants was either through agents in home countries or as direct applications to named hospitals. There was a lack of clarity about the level of training or discipline respondents were being admitted to. There is strong evidence to suggest that the GNC entrance test was misused by applying it to candidates who met the entry criteria for admission to the registered nurse pathways; that respondents were misrouted into enrolled nurse training even when they had passed the GNC entrance test; and that two staff grades, the Matron and senior tutor obstructed respondents from transferring from the EN to RN pathways.

9.5. What were the opportunities and barriers to mobility in nursing for black nurses?

Theoretically black nurses had the same opportunities as indigenous white nurses to participate in professional activities, access professional development and seek career promotion. In reality, the opportunities available to black nurses were nebulous in that they received little or no career advice from senior nurses, and often pursued opportunities according to either the 'custom and practise' of the time, for example men would be dual qualified as general and mental nurses, and women would be dual qualified as general nurses and midwives; or were guided by their peers' experiences.

Respondents created their own opportunities to participate in professional activities and access professional and academic study to enhance their career progression, or as a means of safe guarding their employability within the health sector. For example, by matching their study foci closely with organisational goals, some respondents managed to negotiate either full or partial resources for their academic study. A number of female respondents negotiated the off duty rota to accommodate their professional activities. One in two respondents held a teacher qualification, suggesting that nurse education was an important strategy for career progression or development. A number of female respondents self-funded the teacher training course, either because they had been rejected for ENB funding or they undertook it while remaining in practice or the course was not ENB approved and therefore not eligible for ENB funding.

Although respondents acknowledged that permanent night work was anti-social, disruptive to family life, and had potential for adverse effects on health (Halford, et al, 1997: 129, 177), some of them were receptive to using the career opportunities night work brought. For example, the negative features of night work were ignored or over looked where the respondent saw long-term benefits of that appointment to their personal profile and curriculum vitae. Similarly, a number of men used night work to enhance their income through payment of unsociable hours allowances and undertook to pursue higher education by distance learning.

From 1992 onwards, respondents had begun to develop and participate in their own professional networks for professional support, sharing information and access a level of peer-mentorship. At present the networks are more social in

nature, they are not gender segregated or discipline specific. Male and female respondents' use of networks showed a clear differentiation, in that the women welcomed the social discourse over and above the opportunities to test out ideas or help with problem solving; whereas the men used them more instrumentally to ascertain what jobs were available or to measure their own progression against those of peers.

There is strong evidence to suggest that some respondents had begun the process of identifying niche markets, especially in the fields of 'race and health or race equality', haemoglobinopathies, forensic mental health and learning disabilities. At the moment, a small number of female respondents are engaged in education or 'race' consultancy. Mauritian men dominated the field of business interests outside of nurse education and race work by diversifying into residential home business.

The incorporation of nurse education into higher education brought some respondents both opportunities in career terms, as well as an increased the level of instability of employment contracts in academia. Following incorporation, a few male respondents found themselves appointed to posts in higher education at a salary commensurate with their previous NHS salaries, but found that their portfolio of school wide responsibility was substantially reduced. Male and female respondents experienced inequalities in the processes for selection at incorporation. One female respondent found that the quality of her 'master degree' was subjected to innuendo and gossip.

Some female respondents, either by virtue of the positions they held or through their committee work in the professional organisations were able to challenge race discrimination by influencing policy and implementing change in the work place. The contribution of these respondents can be mapped in relation to service development, education policy and curriculum development, research and development, policy, mentoring and initiating professional activities. There are numerous examples of female black nurses beginning to influence the national and international nursing agendas with reference to haemoglobinopathies, midwifery and 'black-health'; and men influencing learning disability nursing and forensic mental health.

In many ways the barriers to mobility in nursing acted as spurs for some of these respondents, who through their agency set out to discover ways to circumvent the structures. The men were more likely to use geographical mobility as a means for removing themselves from a hostile work environment, whereas, the female respondents tended to find other ways of managing similar situations. An important area of dissatisfaction for both male and female respondents was the difficulties they had in securing resources to pursue professionally relevant academic studies and the lack of opportunity for personal development. Secondly, more female respondents believed that their skills were not valued and that others saw them in stereotypical and racialised ways in relation to their self-presentation, ability, speech patterns and attitudes.

Another major barrier that male and female respondents shared was the level of racism experienced on a regular basis from patients and their relatives/carers, nurse peers, doctors and colleagues from allied professions. Examples of racist practices included overt rudeness, occasional name-calling, referring to them in derogatory terms; denigrating their professional and academic qualifications and questioning their professional ability and integrity. Male respondents described the selection and promotion interviews as an area where they were more likely to experience direct racism and offensive lines of questioning. In contrast a number of female respondents noted that they were questioned aggressively about their childcare arrangements or felt belittled by the selection processes. Discrimination and inequalities at the entry gate, channelling into the appropriate training pathway and/or post registration courses; and the diversity of the employment contract, were a feature of the respondents' careers. Lack of access to developmental opportunities, for example serving on critical policymaking and decision-making committees or shadowing the 'next clinical grade up' - was something that female respondents rarely came by, while a few male respondents were more successful. However, the number of female respondents accepting fixed term posts with leadership or charge of one-off projects was ten times that of male respondents. Only one man managed to negotiate a full time period of secondment to another department for personal development. Thus the potential for their contribution to nursing at local, national and international level went largely untapped.

9.6. Was the respondents' cultural capital, i.e. existing resources and capacities at the entry gate to nursing an asset or constraint to the nursing career?

A number of male and female respondents benefited from their family's collectivism through accessing resources to complete high school education or as the means of paying the fare to the UK to begin nurse training. For female respondents, collectivism enhanced their sense of belonging to the family, emphasised the need for family group members to pull together for the good of the family. However, these values became a barrier, especially to female respondents, when self-promotion and self-interest were required to demonstrate a strong personal profile or the individual was required to assert himself / herself for personal gain, for example to lead a project, secure employer support to undertake further study or ask for block period of annual leave to visit their home country. Similarly, the core-cultural values, such as having respect for those in authority, those with professional qualifications or ones' elders, prevented some female respondents from challenging discrimination and inequalities, because to do so would have required them to discard or set aside these core values they had grown up with. Respondents had to learn to adapt their cultural values, for example, in their responses to people in authority or their readiness to speak without being cued in to the conversation, in order to become more integrated into the British culture. A constraint of the culture capital of their childhood was evident in the black nurses reluctance to discuss their 'personal problems' with people who were not of the family's inner circle, a non-action that stripped them of any potential for

support from peers or others. The men appeared to become more instrumentalist and individualist more readily.

Respondents demonstrated a strong drive to succeed in the chosen career and subscribed to the notion that their career progression would be determined on a meritocratic base. Often female respondents committed themselves to investing their own resources to build on their human capital through education. The contradiction in terms was that on one hand these respondents accepted that their professional and academic qualifications and their clinical experience were necessary for career progression and yet there was an element of acceptance that they would have to surmount structures of the glass ceiling, racism and discrimination.

9.7. What feelings do respondents have about the costs and benefits of succeeding in nursing as black people?

For female respondents, the most frequently mentioned personal rewards of having got to the top in the nursing career were in relation to being acknowledged as a role model to other nurses: black and white. For male respondents, the most important personal reward was the public status associated with the office of employment. All respondents stated that they enjoyed the personal satisfaction of seeing their hard work pay off. Many female respondents acknowledged that their public profile was more visible within the local employer organisation, rather than at regional, national or international levels. A number of male and female black nurses have received public awards, for example, the Queen's Honours in recognition of their services to nursing, awarded the fellowship of the Royal

College of Nursing and as winners of the Mary Seacole Leadership Award. Generally, respondents assessed their contribution in making a difference to the health service, for example, in service development, or making a difference to the profession in terms of education development, research and publication, potential to influence policy, as being limited to the employer organisation. However that is not to say that black nurses have not made a significant difference in the fields of mental health, haemoglobinopathies and nurse education.

The costs of getting to the top and being at the top were primarily related to experience of physical and mental ill health, which was attributed to occupational stress; redeployment following structural changes in the NHS and nurse education; discrimination for promotion and adverse effects on personal relationships. The lack of redress through the legal system or industrial tribunals was a double jeopardy for respondents not wishing to mount a challenge that could be emotionally and financially very expensive and the reluctance of professional organisations to support their members.

9.8. What does this study contribute to the understanding of black people and their social mobility in Britain?

This research has found that a significant number of black nurses have ability and drive, and often adopt the value systems of professional middle classes in order to rise in the hierarchy. The loyalty of black nurses to the 'British nursing' is evident through their commitment to nursing such that their collective labour has enabled the NHS to deliver a service; their staying power to remain in nursing regardless of the racism, inequalities and discrimination they faced; and their intention to

ensure that there were benefits to the black community. They have used professional and academic qualifications as a vehicle for career and social mobility. However, black nurses continue to be discriminated against even when the individual has relevant clinical, experiential, academic and professional credentials and aptitudes. Black nurses are no longer prepared to shore up the NHS as a cheap source of labour, as is evident by the fact that nursing is typically not promoted as a career for the children of these respondents. There is evidence to indicate that some male and female respondents are actively dissuading their own children and those of kith and kin from considering nursing as a career. A few of the black nurses have diversified into self-employment either as a response to racism and a few men, mainly Mauritian men, have capitalised on the policy changes in the NHS to provide independent residential homes for clients with learning disability.

9.9. What can employers learn from this thesis? - Policy implications

The policy implications from this research are four-fold: (a) to address issues of education and training about racism; (b) to proactively challenge inequalities and discrimination to improve employment practices; (c) to combat racism in employment and working practices; and (d) develop strategies to promote inclusiveness of a diverse nursing profession. In order to develop an effective approach to education and training about racism, the goal should be combating racism at the institutional, professional and individual levels. The process of combating racism must be seen as a shared responsibility that requires each

employee as the public face of the employer; as a practitioner, student or manager to recognise his or her agency in producing, reproducing and or challenging racism (Bhavnani, 2001: 113). Blackness or otherness or difference should not be constructed as the problem in order to explain differences in outcomes or experiences of individuals. As long as blackness is constructed as a problem, then the approach to employment practices, service delivery and education and training remains one of approaching it from the perspective of their unique needs, perpetuating differences as the problematic. The processes for challenging inequalities and discrimination should not be about 'punishing wrong-doing' but about discovering what is not working and remedying it with the intention of doing greater good for many. Organisational goals cannot be met unless its workforce feels valued and individual's talents can be fully utilised to improve service development, delivery and professional practice. In the short term, promoting diversity of the workforce requires managers and selection panels to set aside their middle class value systems and instead ask the question 'how can the issue be best managed'. In the long term, changes in approach should improve recruitment, return to practice and retention; contribute to patient empowerment, and have a positive effect on performance.

9.10. Future Research

There is a substantive potential for future research in this field. At a pragmatic level research could further develop areas from this study and extend the focus to other minority ethnic groups including those who have arrived recently in

response to the British nursing shortages. In addition it could adopt a multi-agency approach to examine issues relating to diversity and equal opportunities.

9.10.1. Developing This Research

Areas that warrant further development are associated with the specific professional activities of respondents, such as becoming active in the professional union organisation, committee work, working-parties, getting published or conference presentations, in relation to the ease with which they acquired resources or organisational support to pursue these activities. Another issue that is pertinent to career-focussed couples is the division of domestic labour in relation to supporting their own or their partner's career.

9.10.2. Extending The Research Focus To Other Minority Ethnic Groups

In addition to the recruitment from the New Commonwealth countries, the British nursing labour has come from other white countries, for example Ireland, Canada, Australia and European countries such as Latvia and Poland. The contribution of these countries has not been studied. For example, while Ireland continues to be a reliable source for recruitment, anecdotal information suggests that Irish nurses have been treated less favourably through their location in two cultures: one of otherness related to their overseas origin, and the other of being white but being treated differently to English nurses. A comparison of the careers of Irish and English nurses would provide insight about similarities and differences between the two groups. Given the current intense focus on the international recruitment of

qualified nurses, it would be useful to undertake a longitudinal study of their contribution to British nursing, the structures that these nurses have to manage and their career development.

9.10.3. Multi-Agency Approach to Examining Issues Related to Diversity

The NHSE is committed to multi-agency working and, sharing and promoting good practice. In many instances, the voluntary and local government sectors have a broader experience of dealing and working with diversity. One such example is the advocacy services developed for asylum and refugee seekers. I am proposing that a multi-agency approach would enable a more holistic focus on how the statutory, voluntary and independent sectors deal with issues of race / ethnicity / diversity.

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