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Interrogating the language of integration: the case of internationally recruited nurses

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Interrogating the language of integration: the case of internationally recruited nurses

Aims. This paper suggested the need to interrogate the notion of ‘integration’ to facilitate the retention of migrant nurses.

Background. The growth in internationally recruited nurses in the UK’s health system has led to a raft of policies that aim to ensure that such nurses are well ‘integrated’ into their ‘new environment’. It is assumed that integration will improve the quality of internationally recruited nurses’ experience in the UK, improve their retention rates and thus improve the quality of health delivery within the UK. However, most of the steps through which integration is sought tend to move between some version of assimilation and ‘respect for difference’.

Contributions. This paper aimed to add to existing literature on the integration of internationally recruited nurses in the UK by suggesting three steps towards rethinking ‘integration policies’. It suggests the need to recognize migration as only one of the differentiating factors within the nursing sector, to ensure that integration does actually become a two-way process and to be cognizant of the multiple shapes that racism can take. The first two steps will prevent a slip between integration and assimilation while the last will help rethink any anti-racist training that may form part of integration policies.

Conclusions. There are many factors influencing the experiences of internationally recruited nurses and not all of them can be addressed within current integration policies.

Relevance to clinical practice. Rethinking integration can help improve the experience of internationally recruited nurses.

Key words: discrimination, integration, internationally recruited nurses, migration, racism, workforce

Introduction

In the last decade, the number of internationally recruited nurses (IRNs) admitted to the UK’s register of nurses has grown rapidly (NMC 2005) spurring a great deal of research on nurse migration. Much of this research has adopted a human resources perspective, focusing on issues of ethical

recruitment and brain drain from the global south (Buchan & Dovlo 2004, Buchan *et al.* 2005). However, several studies have also aimed to trace their career trajectory within the UK health sector. For instance, some studies have attempted to identify blockages to IRNs’ career development and to improve the quality of their working and living environment in the UK. This is done both to increase the rates of retention

of IRNs within the UK health sector as well as to enable them to provide a 'quality service' to patients in the UK (Winkelmann-Gleed & Seeley 2005, Buchan *et al.* 2006). As a result, our knowledge of how nurses are deployed within the health and social care sector, the extent to which their qualifications and expertise are recognized and the ways in which discriminatory practices, particularly racism, impede nurses' integration into the labour market is growing (Allan & Larsen 2003, Mensah *et al.* 2005, Ruth Matiti & Taylor 2005). This research is also beginning to provide a framework for the development of manuals of good practice towards the integration of overseas nurses (Gerrish & Griffith 2004, Smith 2004).

This emphasis on integration is happening within the context of wider moves towards the language of integration in policies for migrants and refugees (Sackmann *et al.* 2003) both within the UK (Home Office 2000, 2005, Vertovec *et al.* 2003) and in Europe more generally (Kam *et al.* 2001, Penninx 2005). For instance, the UK government has proposed a white paper *Integration Matters: A National Strategy Towards Refugee Integration* (Home Office 2005), while the European Union too has produced a range of documents to ensure parity in the integration of migrants into constituent EU countries (Niessen & Schibel 2004) as well as funded networks such as IMISCOE (International Migration, Integration and Social Cohesion) that aim to define the contours of integration.

The integration of migrants has been conceptualized as occurring along a range of vectors such as economic (ensuring that they obtain jobs proportionate to their skills), social (framed largely within languages of cohesion) and cultural (recognition and provision of specific needs) (Penninx 2005). A key component of economic integration is the establishment of mechanisms to recognize and accredit the knowledge that migrants bring with them, through special accreditation programmes. This is especially important amongst migrant health professionals, who are seen to have much to contribute to the UK's health service (Department of Health. 2003, Stewart 2005). Along with anti-discrimination policies, accreditation policies aim to facilitate the labour market integration of such migrants.

These emphases mark much of the literature on the integration of IRNs too with most research on the topic emphasizing the institutional framework within which IRNs work and hence conceiving of nurses primarily in their professional capacity. The tools towards integration include recognition of the qualifications of nurses, removing language barriers and acquisition of work specific skills (Winkelmann-Gleed & Seeley 2005), thus privileging labour market integration. Attempts at such integration focus on provision

of training to migrant nurses to address these barriers and training of other nursing staff and nursing management to improve awareness of the needs of migrant nurses, as well as to address any racism that new migrants may face. However, concerns over the retention of IRNs have made it necessary to address the nurses' migration experience as a whole and to improve nurses' integration into the wider society (Buchan *et al.* 2004, 2005). A variety of other factors such as the ability to avail of family reunification policies, access to housing, ability to practise personal religion are thus also increasingly being addressed. Thus, frameworks that aim to facilitate the integration of nurses into the nursing labour market are overlaid with attempts to help their integration into wider society in the UK.

Although these moves undoubtedly make some contributions towards smoothing the transition of IRNs into the UK, this paper suggests the need to step back and examine some of the implications of deploying the language of integration for envisioning the future of overseas nurses in the UK.

Interrogating 'integration'

Integration is one of a package of terms that attempts to come to grips with the relationship between migrants and the societies into which they move. Along with assimilation, acculturation, multiculturalism and social cohesion (among others), integration aims to provide a normative guide to how these relationships should ideally be shaped. Conceptually integration clearly sets out to be a two-way process, which 'implies on the one hand the responsibility of the host society to ensure that the formal rights of immigrants are in place in such a way that the individual has the possibility of participating in economic, cultural and civil life and on the other, the immigrants respect the fundamental norms and values of the host society and participate actively in the integration process, without having to relinquish their own identity.' (EU 2003, p. 17–18). Thus, integration is professedly multi-faceted as well as normative. In contrast, assimilation requires migrants to merge in with the 'indigenous' culture and assumes that the society into which they merge becomes a 'melting pot'. However, a closer look at the notion of integration suggests that within the context of nursing in the UK, 'integration policies' may be plagued by a number of limitations.

What is integration?

One key question we need to ask ourselves is 'what exactly do we mean by integration'? Despite the conceptual difference

between the language of integration and that of assimilation, in practice much integration policy seems to slide into notions of assimilation. The launch of papers such as *'Integration Matters'* (Home Office 2005) signals the importance of the language of integration in the treatment of refugees. However, this language also spills over to the wider treatment of migrants and ethnic minorities in contemporary migration and settlement policy because of increasing political concerns over social cohesion in the UK.

A series of events around the world has pushed social cohesion and its many variants higher and higher up the political agenda. In the UK, the language of cohesion, which increasingly came to be adopted after the riots in northern cities in 2001, acquired a new urgency at the realization that those responsible for the suicide bombings in London on 7 July 2005 were 'home-grown'. The most overt forms of racism have been targeted at Muslims (Silverstein 2005) and asylum seekers, whose visibility has been increased by recent policy developments (Sales 2005). The media as well as policy makers have, in the garb of reflecting public concern, shaped much of this racism. And the answer to the 'migrant as problem' lies either in their ejection (deportations and repatriation) or their integration as difference once again comes to be seen as a threat (Lewis & Neal 2005). Policy-makers, it appears, are increasingly retreating from multiculturalist policies; social cohesion and integration are instead becoming the key players in 'domopolitics' (Walters 2004). For instance since July 2004, those applying for naturalization have been required to demonstrate knowledge of English and on the advice of the newly established Advisory Board on Naturalisation and Integration, now also need to pass a *Life in the UK* test (introduced November 1, 2005), which is designed to test applicants' knowledge of history, culture and institutions within the UK. Those whose knowledge of English is below a required level are required to take an English test as well as attend citizenship classes. These tests are also being extended to other categories of migrants such as those entering through the Highly Skilled Migrant Programme (<http://www.ind.homeoffice.gov.uk/aboutus/newsarchive/newregimeforhighlyskilledworkers>). In assessing migrants' knowledge of the UK, the government is prescribing knowledge of existing systems and practices as the basis for integration. Hence, the knowledges necessary to obtain citizenship in the UK knowledge economy go beyond the scope of marketable skills envisaged in the skill-based selection of migrants or the labour market-based criterion utilized to select IRNs.

This is the discursive field within which all integration policies must be placed. It skews the language of integration and the possibilities of its practice. Just as the racism that

IRNs experience may be inflected by the structured social relations that are extant in wider society (Allan *et al.* 2004), so too 'remedies' to racist practices that are wrapped up in integration policies are shaped by the discourses around integration and social cohesion which have become increasingly compelling in UK Home Office policies. Thus, integration policies that aim to 'help' IRNs to learn systems and practices that are already in place in the UK are influenced by these wider policy discourses around the treatment of migrants and refugees. In practice, then integration largely aims to remove or at least limit differences between IRNs and non-migrant nurses by incorporating IRNs into existing systems of nursing. In these versions of integration, the double-edgedness of integration is lost – rather integration becomes the duty of the migrant and providing the routes to integration, that of an imagined indigenous nursing body. It also, therefore, presumes nursing practices in the UK as given, rather than being available for shaping. It is the nurses who have to integrate into current practices; they cannot shape practices through the knowledges they bring with them. They have to learn how nursing is done in the UK; they are not encouraged to tell their employers how nursing is practised in other places to see how nursing practice in the UK can learn from experiences elsewhere. The normative element of integration means that the vectors of integration are therefore largely already prescribed, i.e. we know what a 'well-integrated' nurse looks like.

This assimilationist tendency is combined with elements of policies that are based within notions of inclusion, participation and equality that respect difference rather than trying to eliminate it (Rudiger & Spencer 2003). Although this is well intentioned, in practice, 'integration' may only involve measures such as providing prayer areas, allowing IRNs to take religious holidays and ensuring that special dietary requirements of IRNs are met. Difference is often reduced to an essentialized cultural difference while differences in power, which are shaped by larger geopolitical formations, are largely ignored. Moreover, the racialised, often Islamophobic discourses around migration and cohesion outlined above overlap with those of international recruitment of nurses influencing the nature and shape of integration packages. The concept of integration and the measures that will facilitate it both need to be interrogated if integration is to be successful. In particular, we need to ensure that the definition and the objectives of integration do not become either one-sided or minimalist. On the other hand, we also need to move beyond an exploration of the 'cultural conditions of disjuncture and difference' (Silverstein 2005, p. 377) to look at the possibilities for convergence of values in nursing practice.

An important element of integration policies is anti-discrimination, particularly racial discrimination. In considering issues of racism, it is almost always presumed that the IRNs are the victims of racism and either patients or the nursing management, perpetrators of racist practices (see for instance, Allan & Larsen 2003). While this literature has done much to explain the social reproduction of institutional racism, it also 'fixes' the direction of racist interactions (Allan *et al.* 2004). However, migrants from countries with relatively homogenous ethnic populations or different histories of race relations may well bring with them racial prejudice, either against other IRNs or indeed against black patients or nursing managers. Mc-Neil Walsh (2004) offers one example of this complexity when she outlines how the racial stratification in South Africa – itself a result of British colonial rule – has been transported into the UK and influenced race relations between South African nurses. 'Any analysis of current migration cannot ignore this historical context. There no doubt remains a 'presence of empire within the quotidian existence of the imperial homeland' (Parry, cited in Goldberg & Quayson 2002, p. 67). To understand the migration experiences of South African nurses and how they articulate with the health care sector, this continuing 'presence of empire' must be acknowledged in that it highlights that different histories are evident within the broad category 'South African nurse' (122). The racism between different members of one national group or between IRNs from different parts of the world is, however, often missed in narratives of discrimination. This issue is likely to become more pressing with the increasing presence of European migrant nurses who may be racially classified as 'white' but are often targets of racism suffered by other 'white' hidden minorities (Nagel 2001). Moreover, the complexity of racialization may present particular problems in the less regulated environment of care homes and the housing that nurses from different parts of the world are expected to share during their adaptation period. Narrow definitions of integration that prescribe a method for reworking a dualistic relationship between migrants from a sending country on the one hand and institutional frameworks within the receiving country on the other often miss this complexity.

Besides, it is not only nurses who have a long history of migration to the UK. The kaleidoscopic nature of migration into the UK means that the vectors of racial discrimination are not easy to foretell. Given the increasingly multi-ethnic population that is being nursed, the dimensions and directions of racism may indeed be complex. If 33% of London's population is foreign-born and 28% of the nurses are internationally recruited, there can be no simple equation of

how racism will map out, or indeed of the service requirements of the population (Buchan 2003, Buchan *et al.* 2004). Hence language can act as a barrier between IRNs and those at other points in the nursing workforce hierarchy who have been trained largely in English but knowledge of other languages also offers IRNs advantages within the context of the changing population that is being served.¹ Integration must be viewed not only within the context of a changing nursing workforce, but also a changing population that will be nursed. The definition of integration must be sensitive to the multi-dimensionality of racism within the UK.

Integration into what?

A second key question which troubles discussions of integration is '*what is it that migrant nurses are supposed to integrate into* (Flavell 2003)? Much literature on integration of nurses still presumes that migrant nurses are being introduced into a relatively homogenous 'indigenous' nursing framework without adequately training the lens on what that framework is. The language of integration seems to imply that there is a single coherent set of nursing practices that constitute UK nursing before the arrival of IRNs, into which IRNs may be integrated. IRNs become marked as the bearers of difference while local nursing practices come to be seen as largely coherent and homogeneous. The differences among UK nurses, their differentiated practices and the local situational aspect of nursing are all foreshadowed in favour of recency of migration. The variations *within* are occluded in the presence of the difference *without*. In practice, nursing is marked by considerable internal variation, by grade, level of qualification, age, gender and ethnicity which further vary between regions – producing an inherently stratified system into which IRNs will be integrated. Recognizing this stratification will lead to greater sensitivity about what it is that IRNs are being integrated into. For instance, it can lead us to ask difficult questions such as how does the age distribution of nurses in a ward create complementarities or axes of commonality across divides based on country of training? Or what are the implications of recognizing the qualifications of IRNs for promotion possibilities of nurses who have been trained in the UK? Integration policies need to take a more nuanced account of nursing within the UK.

Moreover, nursing practices can vary locally between hospitals and even between wards, so that indigenous nursing

¹Here, it is worth remembering that nurses are both providers of care and receivers of care and themselves contribute to the diversity of the 'client population'. These complexities are often lost in discussions of integration which position nurses primarily in the first role.

may be best seen as a set of modalities within particular contexts (RCN 2004). Nurses shape and define nursing practice within their remit and although this occurs within the broader framework of the UK health system, the local variations in practice can be significant. IRNs who move from hospital to hospital are then integrating into a range of practices within the UK and not a wholly unified code system of providing care. Integration packages must recognize these internal variations if they are to be effective.

Also, asking what IRNs are integrating into can remind us of the extent to which migrants have always played a key part in nursing in the UK² Discussions of 'integration' of IRNs almost always privilege current rounds of migration, forgetting that new IRNs only represent the latest stream of migrant labour into the NHS (Beishon *et al.* 1995). The dynamicity and fluidity of the constitution of the nursing body is occluded in manuals of integration which fail to recognize how migrant nurses have gone on to form and shape the nursing labour force in this country. If IRNs have helped constitute nursing in the UK, then we cannot speak of a body of nursing into which IRNs can be integrated. Rather the aim must be to try to overcome the structural limitations that have prevented many of these migrant nurses who constitute the nursing body from actually shaping nursing practice in the UK. A truly integrative practice should aim to address these limitations and to validate the knowledges that migrant nurses bring with them.

Who is integrating?

A third set of questions that we can ask is '*who is integrating?*' Manuals of integration are an act of responsibility and so a laudable enterprise. They provide guidelines for action that institutions such as hospitals and care homes can adopt to enable integration and a framework through which their success can be assessed. One key player in integration is then the institution where the IRN is employed. It is through institutional provisions that IRNs are to be integrated and IRNs must then play their part in this

²Postcolonialist: 2003 postcolonialist theorists would argue that nurses from the Commonwealth are already integrated into the British medical system through hundreds of years of history (see Kyriakides and Virdee 2003 for a similar analysis of overseas doctors). A still longer time frame in our analysis of integrative practices would involve a recognition that the history of nursing in many of the sending countries is significantly influenced by the history of empire so that the continuities and dissonances between UK and the countries from which nurses are recruited cannot easily be foretold. The dynamics of present-day integration then needs to be contextualized within longer temporal frames.

integration process. However, while the UK nursing's integration strategies are largely systematized at an institutional level, the IRNs are individually responsible for integration. Or to put it another way we do not ask what a British-born nurse is doing towards integrating IRNs, rather we ask this of the institutions that employ the IRNs. The role that such nurses should be playing in integration is institutionally prescribed and arises from their responsibility to the institution and cannot be ascribed to them individually. The action of these nurses is also then refracted through their institutional positions and the power this bestows on them. This scalar difference between the two sides involved in integration means that integration is not a process that happens among equals. While individual IRNs can be marked out as having to take some steps towards integrating, we cannot say the same for individual 'non-migrant' nurses. As a result, we have barely begun to ask questions such as what 'non-migrant nurses' should be doing towards integration or how the efficacy of integrative practices by non-migrant nurses is to be judged.

Conclusion

In sum, this paper suggested the need for caution in adopting the language of integration in designing the policies for the reception and retention of IRNs. It suggested the need to recognize migration as only one of the differentiating factors within the nursing sector, to ensure that integration does actually become a two-way process and to be cognizant of the multiple shapes that racism can take. The first two steps will prevent a slip between integration and assimilation while the last will help rethink any anti-racist training that may form part of integration policies. A circumspect attitude to the language of integration can ensure that we are not simply swept along the path of a very limited assimilation project.

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