

Institutional Racism within Health Care and Academic Institutions: The Experience of Overseas-Trained Registered Nurses

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A) Introduction and background

Racism has been an issue in nursing since the era of Florence Nightingale, famous for her work as a nurse during the Crimean War. Nightingale's contemporary was Mary Seacole (1805-1881), a black nurse born to a Scottish naval officer and a Jamaican healer and Nightingale's rival after the war. Unlike Nightingale who came from an aristocratic family and was paid to care for wounded British soldiers, Mary Seacole paid her own way to the Crimean War. She self-funded the establishment of the British Hotel near Balaklava, near the front lines, which she used as quarters for wounded British soldiers. This initiative came after Seacole's application to the British War Office to assist in the war was rejected three times, as was a personal offer to Florence Nightingale herself. This rejection was, in Seacole's own words, due to her "somewhat dusky skin", Britain was not just ready for black nurses. Seacole went bankrupt after the war, but the public raised money to pay her debts because of her personal contribution to the Crimean war. However Seacole died a miserable woman. Until recently, Seacole's contribution in the Crimean War has been in the shadows, although straight after the war itself Seacole received honours from the governments of Britain (the Crimean Medal), France (the Legion of Honour) and Turkey, and possibly Russia too. Seacole's experiences of rejection continue to happen today in the nursing profession and nursing institutions. Does this mean the nursing profession (including Australia) is not yet ready for nurses of colour?

The nursing shortage in wealthy countries, combined with the forces of globalisation, has caused nurses from many less wealthy countries to immigrate to wealthy countries such as UK, USA and Australia (Smith et al., 2006). Nurses are often recruited to work in health institutions, usually hospitals or residential aged care facilities. Other nurses who started in similar positions have chosen to further their education and work in academic institutions, or to work in the public service. Overseas Recruited Nurses (ORN) feel different State health practices as well as forces of racism are to blame for them quitting hands-on nursing.

Racism is alive and well in our healthcare institutions despite years of cultural safety education (Grant-Mackie, 2006, Lancet, 1999, Wilson, 2007).

Institutionalised racism “consists of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people” (The Stephen Laurence Inquiry, London stationary office, 1999).

Nursing is a profession based on humanitarian efforts; therefore it is hard to imagine that those within the profession can be victims of racism. However racism is very much alive and ingrained within the nursing professions (Fang et al., 2000). Racism has prevailed in nursing since the Seacole and Nightingale era, yet has gone unacknowledged. Barbee (1993) states there are 4 reasons for the ingrained racist attitudes in the nursing profession and its continuous persistence: “(1) the emphasis on empathy, leading nurses to believe that they treat all clients the same; (2) the individual orientation, which focuses attention away from social, economic, or political structures in society which impact on health; (3) a preference of faculty in nursing schools for homogenous student bodies, because nursing education to these homogenous groups is perceived as more efficient (because teachers and students come from the same Eurocentric backgrounds); and (4) the need to avoid conflict.” ORN have reportedly experienced racism in one way or another in the different health institutions. Experiences of racism may be different but there are general similarities. The reason for such negative experiences is attributed to differences in cultural, ethnic and racial background.

“Racialisation” defined as a process whereby people are defined by their skin colour or appearance, their ethnic background, or just because they look different from the majority of the population (Robb and Douglas, 2004). Does it matter if we look differently, speak differently or dress differently? Racialisation is one of the many ways in which racism is expressed and unfortunately race is not genetic but has been socially constructed by humans. Racism can take different forms; racism can be overt and blatant, or subtle (Babacan, 2005). In the nursing profession racism is mostly expressed in a subtle manner by fellow Caucasian nurses or patients and relatives of patients towards their nurses from different cultural, ethnic or racial origin. OTRN are therefore not only victims of racism but experience multidimensional racism from various people at their work.

This paper is an outcome of research into the experiences of racism of ORN and the different manifestations of racism and also looks at responses to racism by ORN in healthcare settings and institutions. The research delved into the experiences of 6 female nurses and 1 midwife, all of whom had been residing in Australia at least for 5 years. Nurses whose experiences are included in this paper include nurses from China/Germany, Zimbabwe, Maldives, India and

Zambia. All participants had worked in at least 2 countries including India, South Africa, Singapore, Zambia, Zimbabwe, China, Saudi Arabia, Germany, United Kingdom and Australia.

B) Themes Arising

Some of the themes identified in this research are similar with themes identified in previous studies with ORN in the UK and USA; Wilson carried out a phenomenological study with 13 African American nurses working in the southeast of Louisiana (Wilson, 2007). The African American nurses described their lived experiences as registered nurses providing nursing care to individuals, families and the community. 2 main themes arose from the study: "(a) connecting with the patient; (b) proving yourself and 4 incidental themes: (a) fulfilling a dream; (b) being invisible and voiceless; (c) surviving and persevering; and (d) mentoring and role modelling (Wilson, 2007). Therefore one can say that racism in nursing is not an isolated problem faced by ORN in one country, but is a common experience by ORN across the globe.

1) Invisibility & Silence

Nurses were not only invisible to colleagues but most often to the relatives of their patients. Nurses were treated as if they are not there. This was often very difficult to deal with as well as difficult to accept on the part of the ORN. These nurses however used silence and not complaining as a survival tactic, which worked very well though on in the short term (Smith et al., 2006). Nurses felt they had to be 'silent' other wise they would have to resign. This is what some participants had to say:

P2 Invisible... If there is a new staff member, no introduction is done for us... During the next handover, the new person is introduced to their fellow white nurses. This is when you get to know the person's name. So you feel invisible & isolated...the other staff resigned. We have to remain silent, else we will be fired.

P1 Yeah... how many examples can I give? This person [relative of a patient] has never spoken to me since their mother was admitted, then they went to someone else, a Div. 2 nurse, and wanted to make enquiries about their mother's progress. So he went to this nurse, who said Have you spoken to X about this? And the relative's response was I don't think she would understand me, I don't think she can speak English.

Silence...You know if you really have to keep your job, then you have to shut up... there is no dignity in this job sometimes.

2) Oppression (Multiple and simultaneous)

ORN were treated as if their training and knowledge was substandard. These made them think they were bullied and oppressed. If this attitude was not directed directly to them it was directed towards a colleague. This is what a nurse had to say regarding feelings of isolation at work by colleagues, though not directed towards her, she witnessed it and it is quite disturbing:

P3 Hmmmm... No. I can't speak for others. I know a few people who have been. This guy does not get told everything [about the patient during handover]; therefore he does not know what is going on with the patient. Therefore he does not carry out the duties, and then the Unit Manager says he is incompetent. So after he receives handover from the Unit Manager, he will ring for example a colleague (like me) who is off duty, and ask: X, you were here yesterday, can you tell me what is happening with this patient? I think he is quite intelligent, but is scared to report this to a higher authority in the hospital as it will not mean anything.

The ORN often felt they were sometimes treated like students. This did not only leave them feeling oppressed but made them frustrated.

P1...the 3 of us black nurses were treated like students. She (unit manager) does not treat others like that, only us. She asks questions like: why are the patient's vital signs like that? Why is this that? Why are the blood sugars like that? She will be trying to twist as much but not to the other white staff. We feel that she just wants to make us feel stupid... I feel much oppressed

Sadly ethnocentrism has existed in healthcare institutions since the Hippocrates era who believed that Asians were feeble; while Down associated Trisomy 21 with the Mongolians as they were perceived to be inferior (the Lancet, 1999). This is true in nursing today, where such beliefs still exist. Such blatant acts of racism directed towards ORN were not only from colleagues but common from patients' relatives and ward staff. Prejudice in the society plays a vital role.

P2... I know this family who did not speak to anybody Indian; instead they would go to other wards to get help. I asked them why they wouldn't speak to Indian nurses and they said, how would you ask something from an Indian...?

P1...a white someone, I was wheeling my patient to the ward, then I met this other guy. He asked why I was doing nursing duties and he was sweeping. I just told him that I was qualified, that is why, while he had not had any nursing qualifications or diploma, that's why he has to sweep

3) Deskilled – skills & capabilities not validated – “hopeless”

Overseas trained registered nurses felt they were limited from performing the duties that they have been trained to perform and are competent to perform. Such limitations were often imposed on the OTRN without any explanation. Nurses felt that qualifying as an RN outside Australia made your colleagues and others to assume that your training was 'inferior'. You were not given responsibilities that reflected your experience. There was the perception that you are unable to perform duties as competently as your Australian educated

counterparts; and even when you are carrying out basic nursing duties, your colleagues check on you always.. This is what a participant had to say:

P5... X has 10 years experience, 4 years in Australia... gets a graduate nurse to be in charge... They just won't give her responsibility! They counter-check everything she does, as if she is dumb. Then they find she has done it all ...they constantly ask her "Do you need help?" while their job is still pending...

P1...I feel very oppressed, I feel that I'm not being treated like a qualified someone

P4...I feel like I am in the wrong profession... I am small, so I can't have the brains, you know? Of course, this is false.

Feelings of regret and humiliation are not uncommon to ORN. In a study carried out by Smith et al. (2003), ORN from Australia and other countries were treated in like manner. In the UK, ORN have to undergo a mandatory "adaptation" period prior to obtaining a full registration. A British RN is usually assigned to mentor the OTRN regardless of their experience, though these mentors are actually trained to mentor British nursing graduates. A British mentor had this to say about mentoring OTRN:

...We basically treat them as newly qualified members of staff with no experience until we find out what their experience is...

Another British mentor: "the only difficulty I found was that the nurse I mentored had more experience than I did. And she was only having to be mentored and trained because she was coming over to Britain and practising here. And I just felt... not out of my depth but she had years and years more experience than me and yet I was having to train her almost and that was difficult for me"(Smith et al., 2006).

Most African nurses are educated to use their initiative and to be able to improvise when necessary. In Australia using your initiative is highly restricted often leaving the nurses with feelings of worthlessness. African nurses are educated to be autonomous and not to just obey orders from the doctors (Ngum Chi and Watts, 2007). ORN are faced with tolerating not only their patients and colleagues prejudices and stereotypes but that of patient's relatives too. This is how a patient reacted after realising that he had an African nurse:

... I walked into the room and the patient requested to see the team leader, and after that, she changed the assignment and I was given another patient, then after inquiries I was told that the patient was "not comfortable that I was the assigned nurse" ...The other one was an Afrikaner and he just changed in the face red...

With such experiences nurses felt humiliated but on the other hand they have to persevere. Nurse feel they had joined the nursing profession because it is a 'caring' profession; and to some it was a life long dream being fulfilled (Wilson, 2007). Nursing remains a profession that most societies hold in high esteem.

Unfortunately these people (especially relatives) are often unaware of the feelings of rejection and humiliation that most nurses have to experience. OTRN felt strongly about proving themselves as qualified registered nurses.

4) Proving yourself

Carrying out nursing duties competently was something nurses felt strongly about; proving oneself and convincing oneself that they were good nurses and not what others perceived.

P5...you have to cope with [this type of thinking] every day, that I can do it like every other person ... I just have to prove it every day. It just makes me not enjoy nursing. At the end of the day, you don't feel you have achieved anything. It is very stressful, as it is necessary to work hard to meet patients' needs...

5) Support

Support is vital for the survival of any species or individuals regardless of the environment. Nursing is team work and each member deserves to be supported and included within the team to function optimally. However the experiences of the ORN are different. This is what an ORN had to say...

I and my husband are both nurses, we were both rostered for night shift. We both requested that one person work in the morning, so that the other person can pick up the kids. None of us was able to change the shift. When I asked the unit manager to give me Annual Leave, she said she couldn't because the boss wouldn't give her a replacement. So I had to ring in sick as the only option. The problem here is that you are only allowed 5 paid Sick Leave [days] with a certificate per year. So that day I was not paid.

ORN perceived that they are victims of racism and prejudice due to the structure of the nursing system including lack of support from some senior staff members. ORN do not have the extended family support that is available in their countries of origin. These nurses therefore depend on the good will of friends. Nurses felt that their supervisors did support them when they experienced racism from patients, patient's relatives or from colleagues; instead their supervisors turned a blind eye to racism, discrimination and prejudice. Complaints were not dealt with appropriately, leaving the nurse feel helplessness.

P4...I don't know. It is so hard, you find that it is not the patient it's a colleague. These people are adults and normally they will just change the patient. From the business point of view, they won't lose business either so it's hard. People have got their own preferences. In my hospital they say "Don't talk back! Just walk away!"

This was the experience of another ORN:

P2...one of the patients told the co-ordinator that she didn't want me to look after her and her baby after she gave birth. And I think the coordinator was also racist because she encouraged it by changing the allocation.

Nurses are not supported appropriately. In a very hierarchical profession like nursing, senior management will have to act if change is to occur.

C. Responses to racism

ORN responded in different ways to racism. Nurses felt discussing racist experiences was not of much importance as 'nothing is going to change'. This suggests that victims accept racism as part of their jobs. Such an attitude of acceptance of racism suggests that victims need support and encouragement to be able to speak up against racism. The common responses to racism were: (1) Denial; (2) silence, Isolation and abandonment; and (3) Resignation!

1. Denial

The denial that racism does occur explains why racism is deeply rooted in the nursing profession. Denial is not only on the part of perpetrators who do not consider themselves racist but is the case with victims of racism. Some victims of racism found it difficult to discuss freely about racism for fear of being perceived as being inferior. I contacted some nurses who were referred to me by their colleagues and their responses to me were 'I have not had any experiences of racism'. The perpetrators of racism say 'I treat everyone the same, I do not see another colour; If you are colour blind then you must be suffering from 'colour blindness' you therefore need 'treatment' (Gutierrez-Jones, 1988). Denial of the racist experiences is served as a survival mechanism for victims.

2. Silence, Isolation and Abandonment

Silence and not complaining is a survival tactic also used by ORN in UK (Smith et al., 2006). Keeping to oneself was identified as a good survival tactic. Isolation made you 'invisible', and prevents you from getting into conflict with colleagues. Nurses were also tactfully excluded by their managers by not giving them any responsibilities.

P1... We have to remain silent, else we are fired.

3. Resign

ORN chose to resigning once silence was not working or when they opt not to be silent. Other ORN waited patiently for the end of their contracts, so they could move on. One of the participants said

...Oh! I am resigning ... I have had enough; I quitting hands on nursing to go into research, leaving Australia in 2 weeks...

Nurses saw no future as RN as they felt disempowered and worthless. Some nurses choose to take another career pathway in other disciplines that they felt

will value them as individuals and their skills will be valued too. Such attitudes were not healthy and this was acknowledged by participants.

D. Health problems

The degree of coping with racism and the way racism affected one was highly linked to past experiences with racism. A participant had this to say when asked if racism affected her health in any way:

Oh yes ...depression, especially if you are emotionally fragile and if you have never experienced racism ... but when you grow up in South Africa, you are immune to it... at least there are no signs that say... Whites only...Err... maybe other people will have a low self esteem. When it comes to salaries, they are not colour coded...

To other ORN racism was very agonizing as it did not only make you feel an outcast but made you begin to question yourself and try to substantiate your actions.

... It is very stressful, as it is necessary to work hard to meet patient's needs, but then you have to cope with this type of thinking everyday ...

Another ORN said:

...you get so stressed, anxious and thinking oh my god I am going back to work

E. Discussion

All this begs the question: Why is nursing or perhaps the health sector in general so prone to racism?" Why is one group seen as the 'other'? These negative attitudes of otherness are based on the culturally biased judgements about others or ethnocentrism and the lack of awareness on how to manage a culturally diverse workforce (Smith et al., 2006)? Racism is a subject nursing educators and others rarely discuss. In a profession where in Australia nurses are voted as the most trusted people within the community this is hard to believe. Though the audience in point (3) (a preference of faculty in nursing schools for homogenous student bodies, because nursing education to these homogenous groups is perceived as more efficient) has changed significantly; some if not most nursing educators attitudes have yet to follow the new trend. What is lacking is the non structured part of the nursing curriculum which deals with race and ethnicity. There is the current discussion on "cultural diversity" and cultural competence in nursing, but I argue, whether cultural diversity and cultural competence are new ways of reinforcing stereotypes? This I will leave to another forum.

The effect of dehumanisation as a result of racist experiences is what ORN find difficult to deal with. Where does the dehumanisation come from in nursing / health practice? A reflection of Florence Nightingale model of nursing "military"

obeying orders without questioning needs deeper examination. This dehumanising “military model” of nursing – STILL is the predominant culture in Australian nursing, though nursing today is “evidenced based”. But it doesn’t have to be this way? Mary Seacole’s model of nursing was based on initiative and support rather than just obeying. If we are to prepare nurses to manage and tackle the future challenges in health care such as: obesity; an aging population: and the nursing shortage effectively, then issues of racism and working effectively with ORNs may have to be discussed more openly amongst nursing profession, nursing forums and nursing institutions. Having nurses in the culturally diverse workplaces of the 21st century would mean we have to get rid of the 19th century “military model of nursing”

F. Synthesis

“In-your-face” racism is usually from patients & relatives; “More polite” forms of racism from colleagues; Cultural racism – it’s just not in their culture to be organised; Institutional racism – “that’s just the way things work here, and they have to fit in like everybody else”; Paternalistic racism – “it’s up to us to show them how to do it right”; “Colour-blind” racism – “we treat everybody the same – they can be just like us if they really want to”; “Denial” racism – “there’s no racism where we work – none of us are racists”;

Changing jobs is only a short term solution. Changing the current way in which nursing institutions are organised may mean a brighter future for ORN. Supporting ORN to broaden their knowledge base and having nurses of ‘colour’ in the upper echelons of the profession is but imperative and will help break down institutional barriers in the nursing profession.

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