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Article

Title: The experiences of black and minority ethnic nurses working in the UK

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Abstract

Evidence suggests that black and minority ethnic (BME) nurses and midwives are more likely to face fitness to practice hearings and less likely to be in managerial positions than white registrants (Gillen, 2012; Kline, 2014). This literature review critically evaluates the literature published since a systematic review on the topic was conducted in 2005 (Alexis & Vydelingum, 2005a). It found that BME nurses and midwives, especially those who registered abroad and subsequently came to live and work in the United Kingdom are 'underemployed' (Likupe & Archibong, 2013) and consequently expressed feelings of loss of self-confidence. This was further compounded by accounts of excessive scrutiny and punishment. Many felt excluded from white networks of power and opportunities for staff development and promotion (Likupe, 2015). The literature also describes experiences of covert as well as overt racism between the white majority and BME staff as well as 'horizontal racism' between BME staff of differing ethnicities (Smith et al., 2006).

Key phrases & words

Black and minority ethnic nurses; racism; midwives; overseas nurses; fitness to practice; discipline; punishment

Introduction

The National Health Service (NHS) has the most ethnically diverse workforce in the United Kingdom (UK) (Archibong & Darr, 2010). In spite of this, there is a growing body of evidence that widespread race inequalities exist which adversely impact on nursing and midwifery staff. Gillen (2012) reports on a Freedom of Information request submitted by the Royal College of Midwives that revealed black midwives are twice as likely to be disciplined as their white counterparts. Despite the NHS implementing its 'Race Equality Action Plan' in 2004 (Department of Health, 2004), there has been a decline in the already disproportionately low number of black and minority ethnic (BME) staff in senior positions across NHS Trusts in England (Kline, 2014). The Nursing & Midwifery Council (NMC, 2014) acknowledge that their data collection on ethnicity and diversity of registrants is voluntary, potentially masking the true extent of the apparent inequality suggested by Gillen (2012). Archibong & Darr's (2010) study confirms the opacity of disciplinary hearings as they were only able to access

20% of 398 Trusts statistical information relating to disciplinary proceedings despite it being a statutory requirement to make it publicly available. These individual reports provide a valuable snapshot of the inequity that exists across the NHS in the absence of a national co-ordinated approach to statistical data collection and analysis. The aim of this literature review is to try and gain a qualitative understanding of the experiences of BME registrants working within such a divisive healthcare system and attempt to explain on a macro level why such inequalities exist. On an individual level it may also aid reflexive non-BME practitioners to ensure they are not unwittingly contributing to the perpetuation of racism and oppression against fellow registrants.

A note on terminology

The author acknowledges the limitations of categorising people according to skin colour or country of origin as it ignores the complex influence of many other contributory factors such as culture, language, religion and education on the way people interact with each other (Bhopal, 2004; Holland & Hogg, 2010).

Throughout this review he has chosen the term BME as it is widely understood to refer to black people and minority populations of non-European origin characterised by their non-white status (Bhopal, 2004). It is this 'non-white status' that is examined here as there is evidence from global literature (Mapedzahama et al., 2010; Etowa et al., 2009) that being 'non-white' in a white majority space is the trigger for inequity.

Methodology

Inclusion and exclusion criteria were drawn up (see Box 1) in order to meet the objectives of the original research question but were kept to a minimum to allow for the full breadth of relevant literature to emerge. The search was limited to literature published within the last ten years as the author had already identified that a systematic review from 2005 (Alexis & Vydelingum, 2005a) looking at overseas BME nurses working in the NHS. The author assessed the validity and rigour of the review using the Critical Appraisal Skills Programme (CASP, 2013a) systematic review checklist and found it to be of good quality and likely to have captured what limited relevant literature existed in this field published up to this point and there was no benefit in duplicating this search.

Box 1. – Inclusion/Exclusion Criteria

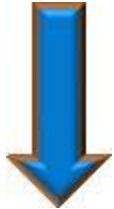
Criteria	Rationale
Literature from 2005 onwards	A systematic review exists reviewing the literature published prior to this date (Alexis & Vydellingum, 2005a).
Literature relating to BME nurses & midwives registered with the NMC.	To explore the experiences of BME individuals with a shared professional identity and recognised level of education, and to understand how their working lives might differ from their white counterparts.
Literature in English	Lack of funding to identify and translate literature published in languages other than English.
Primary research studies	Primary research provides the most robust evidence to inform practice (Aveyard, 2014). There is sufficient primary research published on this topic that there is no need to rely on anecdotal evidence or expert opinion.
Studies carried out in the UK	In order to be able to make recommendations for UK practice as a result of the literature review. The influence of nation-specific political influences and organisation of healthcare make it hard draw generalizable universal recommendations.

An initial reading of the literature suggested the most significant terms to capture literature concerning BME nurses and midwives and new terminology was added in an iterative process as other key words were identified. The key words were systematically combined with each other to encompass all possible variations in five of the most popular databases for nursing and health care research. These were *CINAHL*, *Intermid*, *Internurse*, *Ovid* and *Sciencedirect* and resulted in 60 separate searches (see Box 2). The decreasing frequency with which potential studies for inclusion in the review appeared and the increased frequency with which the same studies were repeatedly identified suggests that the search strategy achieved saturation point.

Box 2 – Key words and search results



AND



Black	Nurse
BME	Midwi*
Asian	Health worker
ethnic	
minority	

Database	Limits	Results
Cinahl	10 Years, primary research, English language, full text, peer reviewed	15 searches 904 results 29 potential
Intermid & Internurse	As above	15 searches 87 results 1 new potential
Ovid	As above	15 searches 1,103 results 12 new potentials
ScienceDirect	As above	15 searches 374 results 2 new potentials

The author was able to quickly assess from abstracts literature which was not relevant and highlighted 44 studies of potential interest. All of these studies were read in full providing valuable background information. From these the author narrowed the focus of his interest to *registered* BME nurses and midwives working *in the UK*. This meant eliminating studies which were not conducted in the UK as the author felt that differing political structures and organisation of healthcare meant it was hard to draw generalisable conclusions from these studies but provided useful background literature.

Eight primary research studies were identified for consideration. A critical evaluation tool was chosen to help the author assess the 'quality' of each study. Although counter-intuitive to make subjective judgements on the 'quality' of qualitative work given the potential multiplicity of theoretical approaches (Green & Thorogood, 2014), the studies selected by the author all used focus groups and semi-structured interviews as their data collection methods making this a less contentious issue (Jensen & Allen, 1996). After critical evaluation using the CASP qualitative checklist (CASP, 2013b), two studies were excluded; Alexis (2015) because it was a quantitative study with a sample size that was not considered statistically significant, and Likupe (2013) because on closer reading the emphasis was on African nurses reasons for migration rather than their experiences in the UK. Snowball sampling from reference lists of the selected studies highlighted a further seven potential studies of which four met the inclusion/exclusion criteria and met the CASP qualitative checklist criteria. The inclusion of these studies was particularly important as they mitigated the potential for researcher bias that had previously existed with two authors being responsible wholly or in part for four of the studies.

In total 10 (n=10) pieces of primary research were included in the literature review and are summarised in Box 3. Using elements of Aveyard's (2014) practice of thematic analysis, the author read and re-read the texts he had identified, noting common words and themes that emerged. The four most commonly occurring themes were then explored in depth.

Box 3 – Summary of studies included in the literature review

Paper	Methodology	Sample size & type	Critically evaluated using CASP tool?
Aboderin, I. (2007) Contexts, motives and experiences of Nigerian overseas nurses: understanding links to globalization. <i>Journal of Clinical Nursing</i> , 16 : 2237-2245	In-depth interviews	Nigerian nurses in UK care homes (n=25); 'nursing tutors' and returnee migrant nurses in Nigeria (n=7)	Yes
Alexis, O., Vydelingum, V. & Robbins, I. (2007) Engaging with a new reality: experiences of overseas minority ethnic nurses in the NHS. <i>Journal of Clinical Nursing</i> , 16 : 2221-2228	Focus groups (x 4)	Overseas (Africa, Asia & Caribbean) nurses working in NHS in south of England (n=24)	Yes
Alexis, O. & Vydelingum,	In-depth	BME (Philippines, South African, Caribbean	Yes

V. (2005) The experiences of overseas black & minority ethnic registered nurses in an English hospital. <i>Journal of Research in Nursing</i> , 10 (4): 459-472	semi-structured interviews.	& Sub-Saharan Africa) nurses working in NHS in south of England (n=12)	
Archibong, U. & Darr, A. (2010) <i>The involvement of black and minority ethnic staff in NHS disciplinary proceedings</i> . Bradford: University of Bradford	Focus groups (x5)	BME (ethnicity not broken down) employees working in the NHS in England & Wales (n=89)	partly
Dhaliwal, S. & McKay, S. (2008) <i>The work-life experiences of black nurses in the UK: a report for the Royal College of Nursing</i> . London: working Lives Research Institute	Focus groups (x3)	BME nurses qualified in the UK & UK born or lived in UK for 30+ years (n=30). 20 identified as African/Caribbean/Afro-Caribbean. London-centric	Yes
Henry, L. (2007) Institutionalized disadvantage: older Ghanaian nurses' and midwives' reflections on career progression and stagnation in the NHS. <i>Journal of Clinical Nursing</i> , 16 : 2196-2203	In-depth semi-structured interviews.	Ghanaian nurses & midwives trained overseas & working in the NHS in London & Home Counties (n=20)	Yes
Likupe, G. (2015) Experiences of African nurses and the perception of their managers in the NHS. <i>Journal of Nursing Management</i> , 23 : 231-241	Focus groups and semi-structured interviews	Black African nurses in the NHS (n=30); Managers working in the NHS (n=10 – 1 was black, the rest white)	Yes
Likupe, G. & Archibong, U. (2013) Black African nurses' experiences of equality, racism & discrimination in the National Health Service. <i>Journal of Psychological Issues in Organizational Culture</i> , 3 (S1): 227-245	Focus groups and semi-structured individual interviews	Black African nurses in the NHS in North East of England (n=30)	Yes
Okougha, M. & Tilki, M. (2010) Experience of overseas nurses: the potential for misunderstanding. <i>British Journal of Nursing</i> , 19 (2): 102-106	Focus groups (x2)	Ghanaian & Filipino nurses recruited from overseas to work in a London NHS Trust (n=13, 7 from Ghana & 6 from the Philippines)	Yes
Smith, P., Allan, H., Henry, L., Larsen, J. & Mackintosh, M. (2006) <i>Valuing & recognising the talents of a diverse healthcare workforce: report from the REOH study: researching equal opportunities for overseas-trained nurses and other healthcare professionals</i> . Surrey: University of	In-depth semi-structured interviews	Overseas trained healthcare professionals (43% Black African) working in 3 different regions in the NHS (n=93)	Yes

Studies shaded in blue are the ones identified through snowball sampling

Discussion

Alexis & Vydelingum (2005a) concluded in their earlier literature review that equal opportunities were 'sporadically applied' and consequently BME nurses suffered from a lack of career advancement. The literature published subsequently continues to portray the experience of being a BME registered nurse or midwife working in the UK as negative, to such an extent that they would discourage their children from following them into their chosen professions (Dhaliwal & McKay, 2008). For nurses who had migrated to the UK for economic reasons, they experienced a sense of 'loss of status' (Aboderin, 2007). There was a lack of opportunity to demonstrate their leadership and management skills and their employment was viewed by managers as a necessity rather than an opportunity (Smith et al., 2006). This was experienced both as being ignored by managers and doctors (Alexis et al., 2007) in favour of their white counterparts and a lack of respect from 'nursing assistants' for their seniority and experience (Alexis & Vydelingum, 2005). There is evidence the inequity persists even for UK born BME nurses or those who have worked in the NHS for a long period of time. In Dhaliwal & McKay's research (2008) interviewees felt that equal opportunities legislation was a 'paper exercise'. Racism took the form of being denied opportunities for study leave, lack of managerial interest in their career development and a fear of 'victimization' (Henry, 2007) or 'bullying' (Likupe, 2015) if complaints were raised. Bullying took the form of being disciplined for 'insignificant things' that were overlooked when carried out by white nurses and BME staff suffering from stereotypical views on how they were expected to behave (Archibong & Darr, 2010). These four emerging themes of underemployment, stagnation, racism and punishment, as identified in the thematic analysis, will now be explored in greater detail.

Theme one – Underemployment.

This theme emerged consistently and powerfully. A strength of Aboderin (2007), Dhaliwal & McKay (2008) & Smith et al.'s (2006) studies is that they were able to capture the voices of registered nurses who work in private care homes rather than the NHS. In Aboderin's (2007) study none of the nurses 'actively chose' to work in care homes and were only able to do 'about 30%' of

the work which they were trained to do. This is echoed in Smith et al. (2006) who found all the respondents in their study had significant clinical experience which would lead the authors to expect them to be in senior positions in the NHS and ten were registered as midwives in their country of origin. However 40 out of 54 were working at the lowest entry level in the NHS. Care homes were frequently the first destination for nurses qualified overseas who did not fully understand the nature of the work – ‘I thought it was a mini-hospital’ (Aboderin, 2007).

Similarly, BME nurses working in the NHS found the skills they had acquired overseas were not recognised. Likupe & Archibong (2013) found that African nurses were frequently graduates with enhanced skills and motivated to work overseas due to lack of opportunities and resources in their country of origin. In contrast to their expectations, they were frequently working under the supervision of support workers which led to feelings of lack of status and loss of self-confidence.

Theme two - Stagnation – ‘You have to be twice as good... to get half as much’ (Dhaliwal & McKay, 2008).

Underemployment is further compounded by lack of training & promotion. Less deserving nurses being promoted above BME nurses was explicitly recognised in all but two of the studies. One of the strengths of Henry’s (2007) study in addressing a cohort with shared experiences and backgrounds - experienced professionals from Ghana - is to be able to address specific cultural issues. In Ghana nurses are promoted automatically every five years in contrast to the UK which operates a system of competitive interviews. Nurses and midwives from Ghana were unprepared for this process and how to engage with it, specifically lacking skills in CV writing and how to articulate the skills they had acquired in a professional discourse and know which ‘buzz words’ to employ. Others focus groups with respondents from diverse background discussed a process of patronage which meant white colleagues were given coaching and access to support not offered to BME staff and given inadequate feedback when unsuccessful. Henry (2007) states this is particularly related to promotion from clinical to managerial posts whereas evidence from Alexis & Vydellingum (2005) & Likupe (2015) suggests it is more widespread. One participant had been at the trust for four years but was denied access to courses whilst white nurses who

had recently joined were prioritised (Alexis & Vydelingum, 2005b), another (Likupe, 2015) saw a white nurse with only 6 months post-registration experience promoted over her and yet another in Likupe (2015) spoke of performance review as ineffectual with managers paying lip service to it. Thus not only were nurses unable to maintain skills achieved outside the UK, they were unable to develop new ones once working here. This may explain why in the quantitative element of Dhaliwal & McKay's (2008) study there was a trend for a reduction in the number of white nurses at 'D' (entry level) grade with a concomitant rise in the number of BME staff employed at 'D' grade.

Theme three – Racism.

The arguably 'covert' racism cited above is compounded by experiences of overt racism in practice. Aboderin (2007) found that white managers frequently supported white carers when faced with complaints from black nurses and nurses in Alexis, Vydelingum & Robbins (2007) recognised that their ethnic features – 'because our skin colour is different' – directly led to difference in treatment. Doctors and relatives would seek information about patients rather than address the BME nurse in charge of the patients care (Alexis, Vydelingum & Robbins, 2007; Likupe, 2015; Likupe & Archibong, 2013) and this behaviour was rarely challenged by managers. In Alexis & Vydelingum (2005b) participants felt racism manifested itself by being given the 'worst patients' implying the patients who were most abusive or labour intensive from a nursing point of view. For others, racism was being excluded from white networks of power. Older participants in Dhaliwal & McKay's (2008) study suggest that white networking revolves around the 'wine bar' which excludes many for cultural reasons although they also observed that younger generations are 'assimilating' more and participating in these events.

Racism was not just from those more powerful like managers or from the white majority, but also 'horizontal' – from other ethnicities. Ghanaian nurses in Smith et al.'s (2006) study reported feeling discrimination from Afro-Caribbean nurses, a sentiment echoed by a manager who refers explicitly to ethnic hierarchies with black African nurses at the bottom. A participant in Likupe's (2015) suggested nurses from the Philippines and India considered themselves superior due to overseas recruitment strategies favouring these countries which was echoed by

a manager who saw Filipino nurses as 'quick' but African nurses as 'not bothered'. Indeed, this is a strength of Likupe's (2015) study in that it includes views of seven managers, only one of whom was BME, and their comments corroborate the nurses' perceptions of discrimination as well as revealing racist attitudes from those with the power to address it. One manager describes BME staff as disinterested and accuses them of being too 'patient-focussed'. They are unable to recognise that being disempowered has led to them 'withdrawing' from competing with white colleagues and finding job satisfaction from the validation they receive from their patients (Dhaliwal & McKay, 2008), in many cases having given up hope of career progression.

Theme four – Punishment & excessive scrutiny.

In Alexis, Vydelingum & Robbins (2007) one nurse described being scrutinised so much she was 'not allowed to do anything' resulting in a loss of confidence. Likupe's (2015) study echoes the veracity of this from a management perspective. One manager says that scrutiny is necessary as he suspects African nurses of lying over their experience and skills and instructed other members of staff to help him in his surveillance. A participant in Dhaliwal & McKay's (2008) study observed excessive scrutiny of a black nurse for working extra shifts but white nurses doing likewise were not questioned.

Respondents in Smith et al. (2006) were clear that 'they won't put it in writing if it's the British', referring to the fact that disputes and problems with practice are much more likely to be resolved at an informal level with white nurses.

Respondents also felt unable to challenge this discrimination through ignorance of their rights (Smith et al., 2006) and fear over having their visa cancelled (Smith et al., 2006; Alexis, Vydelingum & Robbins, 2007). In Archibong & Darr's (2010) study, respondents added that those who do take out grievances are unprepared for the proceedings, assuming they can simply tell the truth and the dispute will be resolved thus do not take representation with them.

Methodological concerns & limitations of the literature review

Literature concerning 'internationally recruited nurses' (Nichols & Campbell, 2010), 'internationally registered nurses' or 'overseas registered nurses' (Alexis & Vydelingum, 2009; Allan et al., 2009) have the potential to include all

countries outside of the UK including white majority countries such as Australia, New Zealand, Ireland and increasingly other European Union countries. For this reason careful reading of the research (e.g Smith et al., 2006) was needed to ensure the voices of black & minority ethnic nurses and midwives could be identified in order to answer the research question.

Whilst there were close consensus of themes amongst nine of the studies, one study, Okougha & Tilki (2010) highlighted cultural differences experienced by nurses but did not present these as either negatively or positively impacting on their work life. This is in contrast to the other studies where participants were explicit that they were unfairly disadvantaged by being BME in the UK with limited expression of positive experiences. With the exception of Archibong & Darr (2010) and Likupe & Archibong (2013) whose stated aim was to explore discrimination, there is the potential for researchers in other studies to have guided participants to focus on negative experiences and this has influenced the themes that have emerged in this review. Equally, the impetus for conducting this literature review was Gillen's (2012) article on black midwives at fitness to practice proceedings and, whilst attempting to remain objective through constant reflexivity throughout the searching and interpreting process, he acknowledges that he may have been subconsciously drawn to literature that addressed this issue.

It is important to note that six of the ten studies used focus groups to collect data. Madriz (2000) suggests that focus groups can be an empowering means of generating a narrative of self-awareness from oppressed groups but this must be balanced against the need to ensure dominant voices do not intimidate others and lead the discussion (Liamputtong, 2011). For example, in Alexis, Vydelingum & Robbins (2007) their purposive sample included nurses from Africa, Asia & the Caribbean but it is not clear if the focus groups were arranged so that BME nurses with similar heritage were grouped together. This is important information missing from the methodology as single ethnic groups may not have generated different insights. In a group of mixed ethnicities individuals might be intimidated or influenced by the 'hierarchy' that is mentioned in Likupe (2015).

Sampling strategies also had an influence on the data. Henry (2007) acknowledges in her study that the sample was self-selecting risking those motivated to air grievances coming forward in lieu of those who feel more positively about their experiences in the UK. Dhaliwal & McKay (2008) acknowledge that their self-selecting sample was made up primarily of nurses from higher pay bands associated with managerial responsibility but argued that the virtue of this was that they had had a long career to reflect on and were able to offer a new perspective not readily available in other studies that existed at the time.

McGinnis et al. (2010) point out that culture – both workplace and within communities – is complex and often highly localised and there is a danger in extrapolate wider generalisable conclusions from small localised qualitative studies. A strength of this literature review is that the literature selected draws on the views of practitioners from across England and Wales adding validity to the findings of this review and mitigating against this potential risk. Studies from overseas (e.g. Etowa et al., 2009 & Mapedzahama et al., 2012; Wheeler, Foster & Hepburn, 2013) also appear to support the findings from this review suggesting a global problem.

Only ten pieces of primary qualitative research literature were identified which addressed the subject under review and arguably this limits the ability to synthesize the literature to generate more widely generalizable conclusions. Despite some academic debate (Rees, 2011) there is no recommended minimum number of pieces of literature required to constitute a credible review. Limiting the search to clearly defined parameters meant focussing on an 'appropriate' rather than 'comprehensive' (Booth et al., 2010) search strategy to make the review both more achievable in a timely fashion and able to answer the targeted question driving the review. Nevertheless, the author acknowledges that broadening the search criteria to incorporate quantitative research and research from outside the UK is likely to generate richer data which could help policy makers and senior healthcare managers effectively address the disadvantages faced by BME nurses and midwives working in the UK.

Conflict of interest

As a white male, the author is aware of the power and privileges his gender and ethnicity have historically conferred upon him. He is grateful to the feedback from the peer review process for minimising the risk of perpetuating racism in his reading, interpretation and representation of the data from the research reviewed.

Conclusion

The literature review took as its starting point the statistical evidence suggesting discrimination against BME staff in the UK and sought to hear the lived experience of BME workers. A systematic search of the literature within pre-defined parameters was undertaken to ensure validity of findings, resulting in ten pieces of primary research for synthesis and analysis. Following thematic analysis the overriding experience of BME nurses and midwives in the UK is one of inequity compared to their white counterparts. The four most commonly recurring themes were discussed – underemployment, lack of staff development, racism and excessive scrutiny and punishment - and some of the key methodological considerations exposed by the studies were analysed.

Reviewing the literature has confirmed that the key issue identified by Alexis & Vydelingum (2005a) of lack of career progression for BME nurses and midwives due to both covert and overt racism persists despite the implementation of a national 'Race Equality Action Plan' (Department of Health, 2004) to tackle the problem. It is concerning that little appears to have changed and it is suggested that the following identified gaps in the evidence base might help the nursing and midwifery professions to start to redress the balance and promote equity for all of its staff:

- The onus has been on BME nurses to voice their experiences but – with the exception of the white managers (Likupe, 2015) – little has been heard from white nurses and midwives on their experiences of working with BME staff. Knowledge generated as a result of research in this area would aid the incorporation of culturally sensitive education programmes for employers and higher education institutions.
- There is only one study (Henry, 2007) incorporating BME midwives and it is important to hear the experiences of this distinct profession in light of the concerns raised in Gillen's (2012) article.

- Finally, it is clear that on a political level there needs to be greater emphasis on a co-ordinated approach to collating and publishing statistics relating to BME healthcare workers and employment practices. This will begin the process of greater transparency and cultural awareness as well as ending the patronage system of white power networks (Dhaliwal & McKay, 2008).

Implications for practice

- BME nurses & midwives who completed their professional education leading to registration outside the UK and have subsequently come to live and work in the UK are likely to have skills that are valuable to the NHS that are not currently being exploited.
- Support with navigating the application and interview processes may help improve upward professional mobility of BME nurses and midwives working in the UK.
- Tailoring equality and diversity training to include examples of covert and horizontal racism in clinical areas may be beneficial.

Word count: 3912 (excluding text boxes).

Summary of revisions:

Thank you for reviewing this work and your supportive comments which have invaluable. The following revisions have been made as requested and highlighted in the text:

- The word 'overseas' has been amended to 'nurses who 'registered abroad and subsequently came to live and work in the United Kingdom' to eliminate colonial overtones and provide a more accurate description.
- Inclusion & exclusion criteria incorporated into one box with justification for criteria offered.
- The word 'qualified' has been amended to 'registered' in relation to nurses and midwives for clarity.
- Clarification to wording in 'Implications for practice section'.
- The last column in Box 3 was removed and a summary of some of the key points offered leading in to a more detailed discussion of the 4 themes identified in the thematic analysis.

- Brief conflict of interest declaration added.
- In the conclusion I have sought to clarify the lack of improvement in opportunities and equality for BME registrants and the gaps in the literature that I have identified.

I hope these revisions address the points that you raised and thank you once again for your time.

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