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‘I feel like I am working in hospitality as opposed to in a clinical environment’: British migrant nurses in the Australian health system.

Introduction

International nurse migration is a well documented phenomenon (Buchan and Sochalski, 2004; Kingma, 2007; Mejia, 2004) and Australia like many other countries actively recruits nurses and midwives amongst other skilled migrants. In this context it has been claimed that nurses from English speaking backgrounds have little trouble entering the Australian nursing workforce (Hawthorne, 2001), and, more specifically, that those who are Western educated are targeted in recruitment efforts for their ‘capacity to fit’ (Eisenbruch, 2001). What lies beyond the recruitment phase for these nurses and midwives receives less attention in the literature.

This paper draws upon a medium scale ethnographic study of female British migrants, predominantly nurses and midwives, now living and working in Western Australia. In the paper I will argue that despite the demand for their skills and qualifications which provided a relatively straightforward entry into Australia that their employment experience is often less than satisfactory, coloured by concerns that they are under-employed and that they are becoming deskillled. I will argue that appropriate recognition of their knowledge and experience is hampered by the continued existence of a core/periphery model of Australian society which permeates, amongst others, the employment
sphere. This model places Anglo-Celtic migrants at the core disadvantaging both them, through presumptions of an easy fit, and those consigned to the periphery.

After a discussion of the literature concerning international nurse recruitment and the place of British migrants in Australian society I will present my findings regarding the employment experience of those women I have interviewed. The paper concludes with a discussion of those findings and recommendations for future research.

**Theoretical and Literature Review**

Doctor Mireille Kingma (2007: 1285) of the International Council of Nurses notes that ‘Professionally active nurses have become prime resources in an increasingly competitive global labour market. In Australia data from the 2006 Census of Population and Housing states that 27.3% of nurses were born overseas, a number expected to increase. Of recently arrived nurses, that is those born overseas and who arrived in the five years prior to the census, 24.9% were born in England, this is more than double the amount from the next most common source country, New Zealand, where 11.7% were born (Australian Bureau of Statistics, 2008). These figures show that a considerable proportion of the Overseas Educated Nurses and Midwives (OENM’s) in Australia are in fact from other English speaking Western industrialised nations despite a focus in the literature on the movement of Culturally and Linguistically Diverse (CaLD) nurses.

Historians James Hammerton and Alistair Thomson (2005:12) argue that ‘the history of post war immigration makes better sense if the British are included’, I argue that this is
also true of any study of contemporary Australian society. Regardless of the demographic reality it has been observed that ‘When Australians talk and think about migrants, for the most part they mean migrants from non-English-speaking countries’ (Hammerton and Thomson, 2005:10). This tendency to normalise white, English speaking migration to Australia is documented in the work of Jon Stratton (2000:34), a Professor of Cultural Studies, who argues that:

Absorbing British migrants directly into Australian culture, and, since the advent of multiculturalism, into the ‘Anglo-Celtic’ core, helped to preserve the ideologically naturalised status of the members of this group as non-migrant Australians.

At the same time Stratton writes of an increasing tendency amongst British migrants to identify as ethnically British and significantly he sees in this tendency the potential for a ‘deconstruction of the core/periphery system of official multiculturalism’. For Stratton the ’self-ethnicisation of the British upsets the claim to a homogeneous ‘Australian’ culture that is set against the variety of migrant, ethnic cultures’ eventually, he proposes, leading to ‘a dismantling of the distinction between core and periphery’.

Highlighting some of the negative effects associated with being on the periphery Torezani, Colic-Peisker and Fozdar (2008:138) discuss some of the difficulties refugees in Australia encounter in their search for employment. They note that they ‘took it as a given that satisfactory employment is the crux of successful settlement for migrants and refugees’ and went on to define satisfactory employment as ‘securing a job appropriate to
one’s qualifications, skills and work experience.’ Similarly Lesleyanne Hawthorne (2001: 213) talks about the low levels of labour market participation amongst migrant nurses from particular backgrounds and contrasts this with English-speaking background (ESB) nurses who Hawthorne sees as ‘passing seamlessly into employment’ no doubt aided by the fact that ‘recruitment efforts largely target those nurses who have been educated in a Western system and who are recruited for their capacity to fit rapidly into the Anglo-Celtic nursing workforce’ (Eisenbruch, 2001).

Highlighting some of the issues I will discuss in regard to my sample British researcher Terri O’Brien (2007), documents numerous reports of underemployment and deskilling in a study of nurses from the Philippines, India and Spain working in Britain’s National Health Service. O’Brien concludes that valuable resources are being wasted and skills lost as the National Health Service and private employers in the United Kingdom apparently struggle to keep up with the diversity of their workforce.

Dealing with diversity in the workplace is an issue tackled by Chandra and Willis (2005:37), who, writing on international nurse migration, argue that there is a need to ensure OENMs are treated on a par with domestic nurses and midwives. Likewise, the Nurses and Midwives Board of Western Australia (2006:43) also recognise at, least on paper, that ‘OENMs need ongoing support after registration to become familiar with Australian custom and practice, legal and ethical norms and even colloquial language.’ They further recommend that ‘It might be sensible to ensure that all OENMs undertake a compulsory unit of professional/cultural issues…whether from an English speaking
background or not.’ Importantly they postulate that ‘This may then assist employers to build on a known level of knowledge in their ongoing support for the nurse/midwife.’ The tabling of such recommendations provides some evidence of official recognition of the situation in Western Australia which I shall report in more detail below.

Methodology

The data in this paper is drawn from fieldwork carried out as part of my doctoral research into the settlement experience of British migrant women in Western Australia. During fieldwork I interviewed forty-five nurses and midwives; I also carried out participant observation at various social gatherings, further interviews with non-nurses and midwives, and read and participated in web based discussion forums run by, and for, British migrants.

Findings

Qualifications in demand

For those nurses and midwives I talked to, the value in their qualifications and experience was in the opportunity that the demand for their skills provided to gain an Australian visa. Only one of the interviewees explicitly expressed that career advancement informed their decision making. The most commonly expressed reason for moving was for ‘a better life for their children’ and most felt that they had achieved this. At the same time, however, despite the fact that work and career did not appear to be a priority for these women it certainly turned out to have an impact on their settlement in Australia. Regardless of the rhetoric regarding their supposedly desirable skills, for many their working experience has been characterised by professional frustration and dissatisfaction, by feelings of being underemployed and of experiencing skills atrophy.
Back to the shop floor: underemployment

Bearing in mind the connection between successful settlement and satisfactory employment noted above it was interesting to find, early on in the in fieldwork process, that job satisfaction was often very low. In the main, the reported dissatisfaction centred on feelings of being under employed and of losing skills. The observations detailed in the following extract from an interview with a registered mental health nurse (RMN) are indicative of concerns which many raised:

Participant 12 - I don’t know if this relates to your study at all but the moment we have a lot of highly skilled nurses coming out who would be in quite senior management posts who are then coming right back down to shop floor posts on the ward. It is an acceptance that they can’t walk straight into that same equivalent, same level of post in Australia, it just doesn’t happen.

Interviewer - So these are people coming from the UK?

Participant 12 - Aha, so they’ll come in, and say they would have been in management, well they’ll actually come back as a senior staff nurse on a ward through the sponsorship and a lot of them haven’t clinically
been on the shop floor for many, many years. And I mean they adapt to it quickly but it is just that they have to do that and then bide their time and then as posts get advertised in the paper they can then apply for them but they never come over and go straight into a senior managers post or a managers post at all. They always have to go into a fairly a lower post and then they can get promotion as people get to know them and their skills (Participant 12, 2007).

In this particular example the RMH talks of sponsorship suggesting that it is not just those that come as Skilled Independent Migrants who feel that their skills are under recognised but also those recruited to fill particular positions.

**Hospitality or Hospital: deskilling**

Whilst I have referred above to both nurses and midwives it is worth noting that the situation for midwives is complicated by the fact that childbirth in Australia is, by many, regarded as over medicalised. Further to this over medicalisation it is suggested that midwifery as a profession is undervalued and that ‘Within this organisational culture, many midwives are unable to fulfill the role for which they were educated and are losing their skills and confidence’ (Brodie, 2002:10) This suggests that when a British midwife
makes comments such as the following that it has little to do with their own employment and educational background and more to do with the context they are working in.

>[E]verything about it is very very hospitality based which is not how I was trained. So I feel like I am working in hospitality as opposed to in a clinical environment. And it is very much that way, that we are there to facilitate the women’s wishes and the doctors wishes but please don’t sort of interfere with that situation because we don’t want to hear your opinion thank you very much (Participant 34, 2008).

At the same time, my belief is that as long as the OEMNs, including those of ESB, believe that they are at a disadvantage as migrants then it impacts upon their settlement experience. There were no evident expressions of solidarity between the British trained nurses and their Australian colleagues during the interviews, that is, there was no suggestion that their experiences were the same. Rather, as expressed below in a quotation from Participant 43, the Australian educated staff were viewed somewhat disparagingly as being obstetric nurses rather than midwives.

The midwife quoted above was, at the time of interview, about to start a new job in a hospital which she noted had a reputation for working more closely to the UK model, a few in Perth have such a reputation amongst the midwives I talked to. In relation to her new position the midwife stated:
I am going to be doing casual work there to see if there is any last vestiges of midwifery in me before I think of changing careers (Participant 34, 2008).

Another midwife who had previously moved to one of the units with such a reputation expressed relief at finding a working environment more suited to the midwifery she was used to and then went on to describe the ways in which her previous position had failed to live up to her expectations of satisfactory employment:

Hallelujah, I am back to doing midwifery the way that it should be done and I mean all the research backs us doing it that way as well and yet they just don’t see it here I mean really I just don’t think they are midwives I think that they are obstetric nurses. So the doctor does all, you know, the assessing and planning and we just do what we are told, and I just […] I’ve been qualified too long to put up with that and I just think that all my skills, they were deskilling me on a daily basis and by the time I got to [hospital name omitted] I was in this sort of junction where I thought oh my god if we go back home I am not going to be able to practice, and you know I was really really scared about that and I suddenly thought they have totally taken away all this skills, you know they, like,
advertise saying they want people to come and they want our skills and they [say], you know, British trained nurses and midwives are, you know, years ahead and they really want all that and then when you get here they don’t want it they want you to just do as you are told and just not answer back (Participant 43, 2008).

Whilst the employment may be deemed less than satisfactory it would be wrong to think that the women passively accept this. Working within constraints which may include such things as finances and childcare the women do have some options available to them in order to address the situation.

As quoted above Participant 34 was suggesting leaving midwifery altogether if she failed to find the job satisfaction she was looking for and she was not alone. Others have taken less drastic action such as electing to work only night shifts as described below:

[T]hat was hard and I didn’t like having to stand back and let the private doctor deliver this woman that I had been looking after all night, that was really hard but I’ve got used to it. I just had to stand back and say well why did I come to Australia, I didn’t really come to Australia for my career I came to Australia because I wanted a change of lifestyle something better for my
children… a lot of the midwives are struggling especially the new ones when they arrive and they can’t do this and this and they don’t agree with the practices and they just have to bite their tongues and they find it so hard. I just keep saying but it will get better and you have to just sit back and say why did I come here and you can always do something to make it better for you, you know I have made a point of doing night duty, most of my deliveries are normal spontaneous deliveries and I manage everything myself (Participant 4, 2007).

This particular woman was not alone in stating that she chose to work nightshift in order to retain some of the autonomy in her midwifery practice which she had been used to in the UK. Arguably at a personal level she has resolved the issues however in the context of recruitment and retention issues mentioned earlier it seems less than satisfactory, as do the actions of those who decide just to accept the change, arguably detrimental to job satisfaction, such as the midwife quoted below:

I thought the midwifery practice was a little bit behind what I was used to and midwives are definitely different here. We don’t have the same autonomy as we do in England but you get used to it, we are at the
other side of the world. I just came and thought well however they do it I’ll do it and so there’s no point in coming here and saying oh at home we do this and do that. If they ask me I told em, if they didn’t I didn’t and so I fitted in because I came and said I’ll do things how you do it unless you want any change (Participant 6, 2007).

Given the effort and expense involved in overseas recruitment and the concurrent issues with retention of nurses in Australia (Nurses and Midwives Board of Western Australia, 2006) it would seem that this is a problem which demands attention.

The paper by O’Brien (2007) regarding deskilling of OENMs in the National Health Service reports findings which echo those of the women I interviewed a further example of which is detailed in the following statement from a nurse who had worked in Australia during a previous working holiday and had returned permanently:

[B]y that stage I had had a management position in the UK. I’d pretty much completed my master’s degree. I was [in] a senior role in Emergency as well as doing this management role in a clinic and I was also a lot older and once again had to go back to being a pleb you know the new girl who wasn’t allowed to
do anything without being supervised and that was so frustrating. Em senior roles like coordinating the shift and triage you know taking charge you just weren’t allowed to do and that was really, really frustrating […] I was seriously considering going to work as a waitress or anything that just meant that I didn’t have to have people who were effectively junior to me telling me what to do.

Similarly a nurse who had recently arrived from the UK told me the following:

[Y]ou know my first day at [hospital name omitted] I was getting in there and working like I would in England. I was putting cannulas in and stitching and then I’d say well what is your drug policy here, can I give this man a tetanus and the doctors were saying “you can’t do that you are not allowed to do that” and nobody had told me (Participant 21, 2008).

The insertion of cannulas and suturing were two tasks mentioned to me as a source of frustration, that is they were tasks which UK nurses and midwives were often not allowed to do in Australia. Surprisingly venipuncture and intravenous cannulation were also mentioned in O’Brien’s discussion of deskilling as tasks which overseas skilled nurses
had to fight for the right to do in the UK. This contradiction suggest, as O’Brien notes that there are issues surrounding role definition which if addressed could counter some of the feelings of professional frustration expressed in both my own study and that of O’Brien’s.

Discussion and Conclusions

Whilst I agree with Hawthorne’s (2001) argument that OENMs from NESB face considerably more obstacles to finding gainful employment in their field I think that my research suggests that this is not the whole picture and that adjustment issues once these barriers are overcome are significant for all. This paper has looked at what happens after the recruitment stage and suggests that whilst the women I have talked to may be participating in the labour market it does not appear to be on their terms. Their narratives do not suggest that their employment is satisfactory in the way Torezani et al describe it above, rather the narratives suggest that ‘satisfactory employment’ can also be fairly elusive in what is a cohort of white English speaking migrants, who were in a position to make choices about their decision to migrate. I believe that this is part of a larger problem which to date has been addressed in the literature on international nurse migration largely by looking at nurses deemed culturally and linguistically diverse from the majority in the country they migrate to (Omeri and Atkins, 2002; O’Brien, 2007).

In contrast the women I interviewed are confronted with a situation in which they are expected to slot in automatically. I believe this is problematic in that it raises expectations of the ESB nurses whilst at the same time promulgating a deficit model of those deemed
culturally and linguistically diverse. If Stratton (2000) is correct in his assertion that a greater recognition of British ethnicity can aid the dismantling of the core/periphery model in broader Australian society then one would also hope that by including ESB nurses and the problems that they encounter in discussion of international nurse migration there is greater potential for resolution of these issues. It is not enough to deem the problem one based in ethnicity and culture whilst we continue to ignore the fact that ESB from Western education systems are also frustrated and concerned that their skills are under recognised and under utilised. Greater recognition of the differences in nursing background is required in the early stages of employment in order to facilitate the transition and reduce the feelings of inadequacy and frustration which are well documented in the literature and which came across quite strongly in the interviews I conducted.

In my arguments above I do not seek to diminish the experience of CaLD nurses nor to understate the hardships they face which, in the extreme, can see them ‘consigned to years of underemployment and skills atrophy (Hawthorne, 2002:81), likewise for the refugees seeking employment referred to by Torezani et al. At the same time it would be remiss not to report the concerns surrounding skills atrophy and the feelings of underemployment and deskilling which I discovered in the course of my research.

In respect to issues of recruitment and retention which are obviously impacted by the achievement or not of satisfactory employment OENMs, no matter their background, need to be better informed in regard to the role they are expected to fulfill. This may be
achieved through the provision of more information prior to migration or a more
exhaustive orientation process than currently exists.
References


