Middlesex University London

Middlesex University Research Repository

An open access repository of

Middlesex University research

http://eprints.mdx.ac.uk

Allan, Helen T. and Westwood, Sue (2015) White British researchers and internationally educated research participants: insights from reflective practices on issues of language and culture in nursing contexts. Journal of Research in Nursing, 20 (8). pp. 640-652. ISSN 1744-9871

Final accepted version (with author's formatting)

This version is available at: http://eprints.mdx.ac.uk/17576/

Copyright:

Middlesex University Research Repository makes the University's research available electronically.

Copyright and moral rights to this work are retained by the author and/or other copyright owners unless otherwise stated. The work is supplied on the understanding that any use for commercial gain is strictly forbidden. A copy may be downloaded for personal, non-commercial, research or study without prior permission and without charge.

Works, including theses and research projects, may not be reproduced in any format or medium, or extensive quotations taken from them, or their content changed in any way, without first obtaining permission in writing from the copyright holder(s). They may not be sold or exploited commercially in any format or medium without the prior written permission of the copyright holder(s).

Full bibliographic details must be given when referring to, or quoting from full items including the author's name, the title of the work, publication details where relevant (place, publisher, date), pagination, and for theses or dissertations the awarding institution, the degree type awarded, and the date of the award.

If you believe that any material held in the repository infringes copyright law, please contact the Repository Team at Middlesex University via the following email address:

eprints@mdx.ac.uk

The item will be removed from the repository while any claim is being investigated.

See also repository copyright: re-use policy: http://eprints.mdx.ac.uk/policies.html#copy

For Peer

White British Researchers and Internationally Educated Research Participants: Insights from reflective practices on issues of language and culture in nursing contexts.

Journal:	*Journal of Research in Nursing*
Manuscript ID	JRN-15-0027.R2
Manuscript Type:	Original Manuscript
Keywords:	Ethnicity, Focus groups, Methodological inquiry, Nurses, Qualitative
Abstract:	This paper explores how reflexive practices enabled researchers to achieve a more complex analysis of qualitative data generated from focus groups. Drawing upon our experiences as two White British researchers, conducting a study with internationally educated nurses from Black, Asian and Minority Ethnic backgrounds, we consider how our analysis led us to a more nuanced understanding of the data than might have occurred without reflexivity. We identified our respective standpoints, confronted our feared biases, particularly in relation to social stereotyping and prejudice, and located ourselves as co-producers of the data. This enabled us to consider how we might be representing, holding and paralleling, systemic patterns of discrimination, leading to several new insights. Reflexive practice is often referred to in theory, less often in application. We hope that sharing our reflexive process will benefit other researchers navigating the complex waters of identifying themselves in their research.

SCHOLARONE™
Manuscripts

'White British Researchers and Internationally Educated Research Participants: Insights from reflective practices on issues of language and culture in nursing contexts.'

Abstract

This paper explores how reflexive practices enabled researchers to achieve a more complex analysis of qualitative data generated from focus groups. Drawing upon our experiences as two White British researchers, conducting a study with internationally educated nurses from Black, Asian and minority ethnic (BAME) backgrounds, we consider how our analysis led us to a more nuanced understanding of the data than might have occurred without reflexivity. We identified our respective standpoints, confronted our feared biases, particularly in relation to social stereotyping and prejudice, and located ourselves as co-producers of the data. This enabled us to consider how we might be representing, holding and paralleling, systemic patterns of discrimination, leading to several new insights. Reflexive practice is often referred to in theory, less often in application. We hope that sharing our reflexive process will benefit other researchers navigating the complex waters of identifying themselves in their research.

Introduction

This paper explores how reflexive practices enabled two researchers to achieve a more nuanced analysis of qualitative data generated from focus groups. Reflexivity is a widely used methodological tool in qualitative research (Pillow 2002). Feminist researchers in particular have argued that reflexivity involves knowing responsibly (Edwards and Mauthner, 2002) through a process of 'critical self-scrutiny' (Mason, 2006: 7), acknowledging and interrogating the researcher's 'constitutive role' (Gillies and Alldred, 2001: 48) in the research process. It is widely accepted that ethnic and/or cultural differences in the backgrounds of researchers and research participants shape the research process (Culley, Hudson, and Rapport, 2007). There are a number of ethical and methodological issues relating to White researchers conducting research with Black, Asian and minority ethnic (BAME) research participants (Edwards 1996), particularly relating to issues of power and privilege (Muhammed et al 2014) and whether non-members of marginalised communities could or should conduct research with members of those communities (Carling et al 2013). This article describes and considers our reflexive processes as two White British researchers, working with BAME research participants and how we engaged with these tensions to enhance our analyses of qualitative data.

Background

Interviewing internationality educated nurses in the UK raises several important issues around how reflexivity, power and knowledge claims are addressed within this research

area (Williams 1993; Rudge 1996) as well as ethnic-/cross cultural interviewing (Sands et al 2007; Suh 2009). Allan (2007) in previous work notes the dynamics of working in a team with researchers of different ethnic and cultural backgrounds when interviewing participants from a number of ethnic and cultural backgrounds. She shows how these dynamics, if handled sensitively and reflexively, can be a feature of the data collection as well as analysis. Allan's reflections on working in this area have been around the fluidity of ethnic and cultural identities moving away from any essentialist notions of fixed or determined ethnic/cultural identities. We highlight ways in which it is possible to theorise the relationships between different social and ethnic groups and within those same ethnic and cultural groups through reflecting on the research process. As Walby et al (2012) argue, in exploring intersectionality, we are aware of both the racist and gendered patterns of discrimination in UK health service while at the same time, cognisant of each individual's agency within those discriminatory social structures. And we acknowledge that we ourselves are part of those structures but suggest that our reflexivity allows some exploration of how those structures may be changed.

Study Description

For over 50 years, each time there has been a shortage of nurses and midwives to work in the UK National Health Service and latterly, the Independent Health Sector, internationally educated nurses have been recruited from developing and developed countries alike (Smith et al 2008). One of the problems of recruiting trained nurses from overseas is that they do not easily fit into the already established work environment. One of the problems of recruiting trained nurses from overseas is that they do not easily fit into the already established work environment. Whilst many of them devise ways to fit in, mostly to their own detriment, they remain an *outsider* in the system with little hope of ever really fitting in. The onus is on them to own the cultural differences that exist within the organisation (Allan et al 2004; Larsen et al 2005). Despite growing demand for internationally educated nurses to fill the shortage of qualified nurses in the UK (NHS Employers 2014) there is evidence to suggest that they are working instead as Healthcare Assistants (also described as Care Assistants, Care Aides, Health Aides, Nursing Assistants, Nursing Auxiliaries, and Support Workers) on their arrival in the UK (Salami and Nelson 2014). There is an urgent need to understand the reasons for this and how they might be overcome. A number of authors have suggested that the International English Language Testing System (IELTS), especially with the recently raised scoring requirements for internationally educated nurses (RCN 2014) might block some internationally educated nurses from achieving UK registration (Buchan 2007). EU rules prevent EU/EEA nurses from being subject to mandatory testing (NMC 2011). This means that IELTs disproportionately affect non-EU/EEA nurses, in the context of ongoing concerns about ethnicity and nurse employment in the UK (Harris et al 2013) particularly with regards to institutionalised racism in the NHS (Allan et al 2009; Batnitzky and McDowell 2011). By contrast, there is no mandatory English language testing for UK Healthcare Assistants, offering an alternative employment route to those

non-EU/EEA nurses. The purpose of the scoping project described here was to explore perceived barriers to UK nurse registration as understood by internationally educated nurses currently working as Healthcare Assistants in the UK.

The aim of this study was to explore the experiences of internationally educated nurses working as health care assistants in the NHS as part of a wider programme to increase pathways to UK registration for internationally educated nurses. A total of 11 participants attended two facilitated focus groups during the summer 2014. Participants were recruited via convenience sampling from a database of previously identified overseas trained nurses working as Healthcare Assistants in the two National Health Service (NHS) hospitals. Participant profiles are provided in Table 1. All participants were internationally educated nurses from outside the EU/EEA. The focus groups were conducted by two White British researchers (the authors) in off-site venues to facilitate a sense of the focus group discussion being outside usual work conditions. The interview schedule used open ended questions to explore participants' experiences of working in the NHS as health care assistants and any challenges to registration as qualified nurses they might have experienced. They were audio-recorded and field notes taken. The audio recordings were transcribed by an administrative assistant and then cross-checked and verified by the researchers. The field notes were used to inform subsequent thematic analyses and researcher reflections. The data were analysed using thematic analysis. Themes were identified independently by the two researchers, then cross-compared. During this process the researchers also engaged in ongoing reflective discussions during iterative data analysis. A key moment in the analysis was after one focus group which was led by Allan and observed by Westwood. After the focus group ended, a discussion ensued about their respective reactions to the level of spoken English by the focus group participants. Particularly interesting was the way in which the two participants had different positions regarding their responsibility for learning English and therefore how they had been able to respond to perceived barriers to registering as a UK qualified nurse. Analysis then focused on the interactions between the two focus group participants and the responses to the focus group by the two researchers which in turn informed the findings thus producing an interplay of process and outcomes in the research.

<Insert Table 1 here>

Findings

The findings are now briefly presented as they formed the focus of the reflective discussions between the two researchers which are the focus of this paper. The findings are reported elsewhere (citation to be inserted post-review) in more detail as the focus of this paper is the impact of the findings on the interactional process of analysis which mirrored the interactional process in one particular focus group. In our findings we observed that the participants we interviewed experienced an uneven, unfair system which unreasonably disadvantaged non-EU/EEA internationally educated nurses.

Frustration with the system

The participants expressed a sense of frustration with the system of English language :

> *I was the good student in back home (sic) but because of my English and because of my IELTs I'm working as a HCA so of course that is frustrating me. (RGHCA201)*

Participants experienced IELTS as nebulous, with shifting, uncertain, criteria:

> *Sometimes you are confident enough that you know you answer everything, but when you receive the scores, like you don't know how they score this one, how you manage to. (RG1HCA4)*

They saw others able to progress, when they were not able to, including students they had supported,

> *And sometimes when you see the students you know, they are already hired and you are still there as a Healthcare [Assistant], which is so frustrating. (RGHCA105)*

A sense of injustice

Participants also expressed a sense of injustice which added to their sense of frustration. Many felt their nursing skills were being relied upon, even though they were not employed as qualified nurses:

> *Then my manager asked me 'Do you mind to take whether a student or the banking staff do they do it properly and then I have taken and I found that the student nurse she was doing you know incorrectly… (RGHCA201)*

So we can see here how the participants were being asked by their managers to exceed their role responsibilities, including supervising other staff, which informed their sense of unfairness. The strongest sense of injustice related to double standards for EU/EEA and non-EU/EEA internationally trained nurses.

> *Really, that's not fair! (RG1HCA7)*

> *The EU they don't need to take IELTS. But I have a [nurse] colleague she is from EU, from Spain and she doesn't speak [good] English… And we are speaking English from birth and we can't apply for registration… They need to balance the rules. (RG1HCA3)*

Divided views on IELTS

The participants expressed divided views about the degree of English language proficiency necessary to operate successfully as a UK registered nurse. Participants reported repeated difficulties in passing IELTS, and identified this as the main barrier to being able to achieve nurse registration. There was a sense that IELTS required standards of English language not necessary for nursing contexts:

> *… but the only problem with that is if they give you a scenario that you don't have really idea [sic], like I have experienced about nuclear [power] and I don't know, I just can't say something. It's um I have no idea so I lost it. (RG1HCA9)*

This participant could not see the relevance of being able to discuss nuclear power for being an effective nurse. She did not appreciate that she might face nursing situations where she might need to be able to communicate in a broader vocabulary beyond one specific to clinical issues. Again, IELTS, the testing system, rather than English language competency itself, was generally perceived to be the problem:

> *Because my English wasn't good when I was back home and I have been trying IELTs. So that's the IELTs is preventing me but I haven't leave, I haven't give up, I just keep on trying. I have got 7 in two sections, but not writing it's quite difficult so the IELTs is the main thing that is stopping me to be registering here. English, you should have the good communication but that doesn't mean that IELTs is everything. (RGHCA201)*

IELTS testing requires a greater degree of precision (e.g. use of grammar and exact words) than necessary for 'survival' English. But the nurses did not see why, if their spoken English was good enough to work as Healthcare Assistants, it was not good enough to work as nurses.

Interactional analysis of the process of the focus group

Only one participant challenged this view. Speaking about another focus group participant who does not speak English at home (she came to England through marriage; her husband and family speak the language of their country of origin), this participant observed:

> *All day I talk English at work and when I get home… we meet in English. So it's a good thing as well because 24 hours talking in English…. Maybe on your part you can encourage your husband maybe to speak in English when you are at home. (RGHCA201)*

So this participant located the problem (and solution) in the other person practising her English full-time. However, most participants located the problem (and solution) with the testing system. Those who had been working as Healthcare Assistants for many years, with apparent success, thought they should be required to meet less stringent IELTS scores:

> *Just lessen the score. … not make it too tough for us, who are already here for 5 years, working in healthcare setting, I think we have given enough experience that we are able, capable to communicate well. (RG1HCA4)*

> *Like in my point of view, people who are already overseas nurses and who is working as a nursing assistant here, I think they should have decreased IELTS level because you know they do have qualifications and everything. (RGHCA201)*

The overarching perspective among participants was of an uneven, unfair system which unreasonably disadvantaged non-EU/EEA internationally educated nurses. This raised a

number of questions and tensions in our analysis of the data which we explored reflexively. We suggest that the process of reflection in the analysis reflected in some ways the process of reflection in the focus groups, particularly the second focus group and gave rise to the tensions in reflexive data analysis. We also argue that these tensions in the data analysis illustrated patterns of discrimination and analyse the relationship between individual agency and structures of discrimination.

Tensions in reflexive data analysis

Tensions

The overarching narrative from the participants was that they understood their English language and communication skills to be sufficient to perform the role of a registered nurse in the UK. They perceived the IELTs system, rather than their language skills, as a block to registration. Only one participant perceived the IELTs system as fair, and she had already passed it in her country of origin. She was also well-educated, with multiple degrees, and stood out amongst the other participants because of this. So the first question we, as researchers, wrestled with, was 'Are the participants correct in their understanding of their English language proficiency being sufficient for a UK registered nurse?' The second, and related, question was 'Are the participants correct in their understanding of the English language testing system pass level as being too high?' Linked to these two questions was a question of accountability: 'Do our findings indicate a need to review IELTS requirements, or a need to encourage individuals such as the participants to take greater responsibility for improving their English language skills?

The first tension related to two aspects of standards of care in the UK among internationally educated nurses working as both registered nurses and Healthcare Assistants. The participants insisted that they were working alongside internationally educated UK registered nurses whose English was not as good as theirs, which, if so, is a cause for concern. Moreover, the participants consistently described having high levels of responsibility in their roles as Healthcare Assistants, some operating as nurses apart from administering medication. This raises the question about issues of safety given, according to their accounts, they were operating as 'almost' nurses while being unable to pass the English language requirements necessary for UK nurse registration and sets the scene for the second question, are English language testing pass rates too high?. In engaging with these tensions, we found it necessary to rigorously interrogate our own personal standpoints and reflect on the processes and dynamics interwoven with the data. In doing so we were not only able to improve our shared understandings of the data, we were also able to see how our respective processes were actually telling us something about the data as well. We shall now explore this reflective process and the insights it produced.

The 'how' of our reflective process

Both researchers have undergone psychodynamic counselling training, which has three essential components which informed our reflective process. The first is the ability to

recognise one's own part in co-constituted processes and that we 'are all in this together' (Yalom 1998). The second is the recognition that group facilitators may be 'holding' and/or mirroring group themes (Bion 1952). The third is that there is an ongoing need for a supervising third eye, to help see what is out of sight (to know what we cannot know), and this supervising eye can be a two-way co-supervising one (Tsang 2007). We drew on each of these approaches in three forums: post- focus group debriefs; data analysis process meetings; and intentional dialogic spaces where we chose to speak to our fears and anxieties about our responses to the data, and offered each other co-supervision feedback. In each of the forum we considered: our respective places in the data collection and analysis; how our reactions to the data might be reflecting themes emerging from the focus groups; what we each saw in the other's responses which might be out of sight to the other person. Using these reflective processes we were able to develop the insights outlined below.

'Good Enough' English

A core tension in our analysis of the data was what constitutes 'good enough' English for safe, competent nursing practice. Researcher A, with greater experience in this field than Researcher B, sympathised with the participants, often observing during their post-group reflections, that she perceived their English to be 'good enough' for a registered nurse. Researcher B, by contrast, considered the majority of the participants' English language skills to be flawed, and not 'good enough' for a registered nurse. Upon further mutual reflection, they observed a range of factors informing their respective positions. Researcher B had access to an additional source of information compared with Researcher A: she had been engaged with various emails with the focus group participants and had observed major shortcomings in their grammar, vocabulary and sentence construction. These were not as apparent in the focus groups, but when they were evident, Researcher B was more sensitised to this than Researcher A.

By contrast, Researcher A had spent many hours interviewing and/or conducting groups with internationally educated nurses and had learned to adapt her speaking and listening style accordingly. In the groups, Researcher A used simplified English, spoke slowly, of which she was unaware, until Researcher B pointed this out. She also listened to the essence of what the participants were saying, rather than how they were saying it, while Researcher B, less attuned, was more attentive to the manner of delivery. In this way, they were 'hearing' the data in different ways.

Both were also informed by feminist, anti-racist, perspectives. Researcher A was concerned to be as facilitative as possible towards individuals she recognised as belonging to BAME groups, and therefore likely to have experienced discrimination on the basis of 'race', ethnicity and culture. She also recognised that not only has she published about institutionalised racism in the health services in the UK but she is recognised among this community for having done so. Researcher B, committed to equality and diversity, and mindful that we all carry internalised prejudices, was concerned that her less favourable

interpretation of the nurses' English language skills might be informed by racist bias (Davis 2010). Both were aware that more stringent criteria were being imposed upon non-EU/EEA nurses than EU/EEA nurses (RCN 2014a) and recognised the inherent unfairness of this, albeit informed by the UK's need to comply with EU regulation.

The reflective conversations between the two researchers enabled them to achieve a number of insights. Firstly, they concluded that they, and the focus group participants, were both holding, and reflecting a wider organisational dynamic. Different English-speaking countries employing internationally educated nurses (e.g. Australia, Canada, UK, USA, New Zealand) have varying testing methods and standards for English language competency (Xu and He 2011). The most commonly used test is IELTS, with variations across countries in terms of IELTS levels and grades. However, there are considerable tensions within this framework:

> *While there is broad acceptance that a certain level of language proficiency is critical to practice in a new country, there are other major concerns on equity: who should sit the test; to what level; and the content. There are also concerns whether a successful language test actually guarantees effective communication. (RCN 2014a: 7).*

These tensions, and ambivalences, were expressed in the group, and experienced by the researchers. In this way the group and the researchers were enacting a gestalt (Ikehara 1999), that is a repetition of the wider system in which they were all located. Rather than looking for binary explanations (and solutions) then, the researchers concluded that their analysis should reflect upon the tensions, and what they might mean.

Implications for UK standards: structured discrimination

The first tension related to two aspects of standards of care in the UK among internationally educated nurses working as both registered nurses and Healthcare Assistants. The participants perceived themselves to have, and believed other colleagues to perceive them to have, sufficiently adequate English language proficiency to operate successfully in clinical contexts. As explored earlier, there were tensions among the participants and the researchers over issues of basic competence, but this is a separate issue, one of competency in nursing contexts.

In their reflections over these issues, the researchers encountered their most uncomfortable conversations. They both came from a position of privilege: as White researchers working in their country of origin. They were also anxious not to place race-or ethnicity- based value-laden judgements on the participants' linguistic competencies in the context of nursing proficiency (or any other context for that matter), nor to engage with racial stereotypes as addressed by one of the authors in previous authorship:

> *The data suggest that racism and institutional racism are understood in more complex ways than previously reported, and that institutional racism may be*

> *reproduced through negative stereotypes of foreigners and professional hierarchies which are forms of structured social relations (Allan et al 2004)*

The researchers were in particular concerned about capturing and then misappropriating the narratives of marginalised women:

> *Me as a person of colour giving my story to be 'processed' and 'consumed' by a white researcher, uncomfortably reproduces the dynamics of colonialism (Leela Bakshi, in Bakshi and Traies, 2011)*

However, at the same time, the researchers found themselves needing to place some kind of evaluation on the participants' language skills in order to achieve a more layered analysis of the data. Only when, through reflection, the researchers had been able to own their respective fears about their own privileged (and partial) perspectives, were they then able look beyond those fears to take a more focused approach to this aspect of the data. Through their reflective conversations, they recognised that the issue of status (theirs, the participants, Healthcare Assistants, registered nurses) was a key thread running through the data. The participants felt acutely a loss of status in their roles as Healthcare Assistants, and believed that this loss of status was unjust. At the same time as the role of a Healthcare Assistant has apparent lesser status, it would also appear to have lowered English language requirements, with a lack of mandatory English language testing in the UK (RCN 2014b). This, in turn, raises concerns about issues of patient safety, especially with increasing reliance by registered nurse on Healthcare Assistants, to act as an interface between patients and themselves (Munn, Tufanaru and Aromataris 2013). It also suggests, as in previous work by Allan (2003; 2007; 2009) multiple layers of discrimination within the UK health service.

The researchers were then also able to identify cultural differences between views expressed by the participants. There appeared to be a sense, among the participants, of nursing as a technical competence, of taking bloods, of inserting needles, of monitoring vital signs. There seemed to be less of an appreciation of nursing as a social competence, of being able to engage with, reassure, attune to, the subtleties of the patient experience. This view of nursing as a technical competence is congruent with their education in their countries of origin but becomes problematic in a UK cultural context (Allan 2007). Nichols and Campbell (2010), in a review of the literature on internationally educated nurses working in the UK reported a recurrent theme:

> *The emphasis on basic, personal care (washing, feeding and toileting) of patients and care of the older person was unfamiliar… This type of nursing would usually be carried out by untrained workers or family in their home… a different culture of nursing… based on a curative medical model rather than the holistic approach favoured in the UK, interventions were therefore based on the technical and therapeutic. Many [internationally educated nurses] had expected that UK nursing would be task orientated (Nichols & Campbell 2010: 2819)*

However Nichols & Campbell's claim that UK nursing is holistic is itself contested (Allan 2007; Johnson et al 2015). The contested nature of current nursing in the UK was echoed in the narratives of the participants in this study, and also shed light on the level of English language skills they perceived to be necessary for nursing competence (technical, task-orientated). They perceived technical competence to be sufficient for nursing English and their perception was validated by their skills being relied upon by their colleagues and managers in their clinical work. However, this reliance and use of their technical skills is at odds with the espoused view that technical competence requires a certain level of linguistic proficiency:

> *'There is a difference between having a sufficient grasp of a language to cope with day to day living and having the professional communication skills that are required to assess, plan, deliver and evaluate care for a patient or client'. (NMC 2004: 5)*

Therefore unsurprisingly, given their experience of being valued as technically competent workers in their everyday lives, an appreciation of this espoused view seemed to be absent in the narratives of the participants. So too, was an appreciation of the need for interpersonal, relational competence, which enables a nurse to both understand and convey subtle communications with patients and their families, particularly during times of stress and/or distress (Xu 2008). The risk, of course, is that inadequate language skills in 'cross-cultural care encounters' (Jirwe, Gerrish, & Emami 2010: 436) could impede the patient-centred communication that is so essential to the delivery of quality nursing care (McCabe 2004), with implications for 'patient safety and the quality of care, as well as the health and job satisfaction of overseas nurses' (RCN 2014a: 8). The participants appeared not to use this as a reference point for their English language proficiency perhaps because this was not a requirement they encountered at work. This does not mean that there is no requirement for cultural and linguistic competence, as Xu has observed, in addition to linguistic competence (which includes pronunciation and accented speech) nurses also need 'sociocultural competence'

> *i.e., dialect and its variety; knowledge of idioms and figurative language; knowledge of culture, custom, and institutions; knowledge of cultural references; and uses of language through interactional skills to establish and maintain social relationships. (Xu 2008: 431).*

Even internationally educated nurses with some degree of English language proficiency may feel they lack sociocultural competence, i.e. they do not have the 'right' English language skills for the full spectrum of nursing competencies (Stephenson et al 2014). So there is something here about a lack of understanding of the subtleties of language required for nursing contexts. If we were to stop here, we would be attributing accountability to the participants. To do so, would not only do them an injustice, it would also not take the system in which they find themselves into account or examine the unfair working practices they encounter, which rely on their technical competence rather than linguistic competence. If their employers do not expect them to have broad language proficiency as

Healthcare Assistants, indeed praise them for technical competence instead, why or how should they appreciate the need to increase their level of proficiency? And in the absence of tailored courses to help them improve their language skills, in nursing contexts, how can those who are most challenged by their English language proficiency be expected to improve it? (Allan and Westwood 2015).

Internationally educated nurses who do not use everyday English in a range of contexts including at work (i.e. those who do not speak and write English in their personal communities, who are also more likely to be from BAME communities, MacGregor, 2007) may be inadvertently disadvantaged compared with those who do. Without additional support in this area they may remain stuck in their roles as Healthcare Assistants, repeatedly failing IELTS, without ever fully appreciating why, especially if there is a certain degree of tolerance among employers who value their compensatory (low-cost) technical nursing abilities. The participants' observations that some UK registered internationally trained EU/EEA nurses speak English less well than they do, is also a further cause for concern. Although employers 'have the right to require evidence of English language competence to ensure that they employ nurses and midwives who are able to communicate effectively' (NMC 2011: 6) it is unclear to what extent they are currently doing so in the UK, and we would suggest this requires further research as a matter of urgency.

Limitations

The decision to reflect on our reflective practice was a retrospective one. As such we did not undertake as much process recording as we might have done had we planned to address this area in advance of commencing the study. Our reflective process was ad hoc, unstructured, not formally recorded and as a result our account of it is impressionistic. The presence of a third party commenting on our reflective process would have provided a more nuanced understanding of what it involved. For that third part to have been from a BAME background would have also added greater depth of analysis.

Conclusions

One simple way of expanding the Whiteness of our research duo and addressing the power imbalances in the White researcher/BAME research participants relations would have been to include BAME researchers, if not academics themselves (thin on the ground, which is itself an issue) then as participative action research participants (Reid 2004) or, at the very least as an advisory/steering group. This was not possible for this particular project due to time scales and costings, but it would always be our aim, in terms of good practice, to include marginalised individuals in the research process. On a larger scale project, with greater time and resources, we would have done so.

Our reflexive process has shown us how reflexivity enhances data analysis and enriches emerging theoretical understandings of both the research process and the topic under investigation. We hope that sharing our reflexive processes and practices in this article will

be a useful resource for other qualitative researchers developing their own reflecting practices as well.

Key points

- Reflexivity enhances data analysis and enriches emerging theoretical understandings;
- Reflexivity can help identify parallel processes between research and the subject of that research, adding new insights ;
- Imbalances of power and privilege between researcher and research participant can in and of themselves be sources of information when reflected upon in an informed way.

References

Allan H T (2007) The Rhetoric of caring and the recruitment of overseas nurses: the social reproduction of a care gap. *Journal of Clinical Nursing Special Edition* 16(12):2204-2212.

Allan H T, Larsen J, Bryan K & Smith P (2004) The social reproduction of institutional racism: internationally recruited nurses' experiences of the British Health Services. Diversity in Health and Social Care.1(2):117-126

Allan, H. T., Cowie, H., & Smith, P. A. M. (2009). Overseas nurses' experiences of discrimination: a case of racist bullying?. *Journal of Nursing Management*, *17*(7), 898-906.

Batnitzky, A., & McDowell, L. (2011). Migration, nursing, institutional discrimination and emotional/affective labour: ethnicity and labour stratification in the UK National Health Service. *Social & Cultural Geography*, 12(2), 181-201.

Bion, W. R. (1952). Group dynamics: a review. International Journal of Psychoanalysis, 33(2), 235-247.

Buchan, J. (2007). International recruitment of nurses: Policy and practice in the United Kingdom. *Health Services Research*, *42*(32), 1321-1335.

Carling, J., Erdal, M. B., & Ezzati, R. (2013). Beyond the insider–outsider divide in migration research. Migration Studies, 2(1), 36-54.

Culley, L., Hudson, N., & Rapport, F. (2007). Using focus groups with minority ethnic communities: Researching infertility in British South Asian communities. *Qualitative Health Research*, 17(1), 102-112.

Edwards, Rosalind and Mauthner, Melanie (2002). 'Ethics and Feminist Research: Theory and Practice.' In M. Mauthner, et. al. (eds) Ethics in Qualitative Research, pp 14 - 31. London: Sage.

Edwards, R. (1996). "White woman researcher-Black women subjects", in, S. Wilkinson and C. Kitzinger (eds) *Representing the Other: A Feminism and Psychology Reader,* London: Sage

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.

Freeman T. (2006). Best practice in focus group research: making sense of different views. *Journal of Advanced Nursing* 56 (5), 491–496.

Gillies, Val and Alldred, Pam (2002). 'The Ethics of Intention: Research as a Political Tool.' In M. Mauthner et. al. (eds) *Ethics in Qualitative Research*, pp. 32-52. London: Sage.

Harris, R., Ooms, A., Grant, R., Marshall-Lucette, S., Chu, C. S. F., Sayer, J., & Burke, L. (2013). Equality of employment opportunities for nurses at the point of qualification: An exploratory study. *International journal of nursing studies*, *50*(3), 303-313.

Jirwe, M., Gerrish, K., & Emami, A. (2010). Student nurses' experiences of communication in cross-cultural care encounters. *Scandinavian Journal of Caring Sciences*, 24(3), 436-444.

Larsen J, Allan H T, Bryan K & Smith P (2005) Overseas' nurses motives for working in the UK: global perspectives or local prejudice. *Work, Employment & Society. 19(2):349-368*

Likupe, Gloria, et al. (2014). Managers' perspectives on promotion and professional development for black African nurses in the UK. *Diversity and Equality in Health and Care* 11(2), 113-123.

Mason, Jennifer (2006). Qualitative Researching Second edition. London: Sage.

Muhammad, M., Wallerstein, N., Sussman, A. L., Avila, M., Belone, L., & Duran, B. (2014). Reflections on Researcher Identity and Power: The Impact of Positionality on Community Based Participatory Research (CBPR) Processes and Outcomes. *Critical Sociology*, 1-19.

NHS Employers (2014) *NHS Qualified Nurse Supply and Demand Survey – findings. Report produced for the Health Education England Nursing Supply Steering Group.* Leeds: NHS Employers.

Pillow, W. (2003). 'Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research.' *International Journal of Qualitative Studies in Education*, 16(2): 175-196.

Royal College of Nursing (RCN) (2014) *Registration of internationally educated nurses in the UK: International comparisons and key issues for incoming nurses to ensure safe and effective practice. RCN Policy and International Department Policy briefing 01/14*. London: RCN.

Rudge, T. (1996) (Re)writing ethnography:the unsettling questions for nursing research raised by post-structural approaches to the field, *Nursing Inquiry*, 3(3), pp.146-152

Salami, B., & Nelson, S. (2014). The downward occupational mobility of internationally educated nurses to domestic workers. *Nursing inquiry*, *21*(2), 153-161

Sands R G, Bourjolly J, Roer-Strir D (2007) Crossing Cultural Barriers in Research Interviewing. Qualitative Social Work. 6(3), 353-372

Smith P A, Allan H T, Larsen J A, Henry, MacKintosh M M (2008) Valuing and recognising the talents of a diverse healthcare workforce. http://www.rcn.org.uk/__data/assets/pdf_file/0008/78713/003078.pdf

Suh E (2009) Cultural Competence in Qualitative Interview Methods With Asian Immigrants. Journal of Transcultural Nursing 20(2), 194-201

Tsang, N. M. (2007). *Reflection as dialogue*. British Journal of Social Work, 37(4), 681-694.

Walby S, Armstrong J, Strid S (2012) Intersectionality: multiple inequalities in social theory. Sociology. 46(2) 224-240

Williams, A. (1993) Diversity and agreement in feminist methodology, *Sociology*, 27(4), pp.575-589

Yalom, I. (1998) *Love's Executioner*. London: Penguin.

Biographies

Helen Allan is Professor of Nursing at Middlesex University having trained as a nurse at UCH and qualified in 1978. She held various staff nurse posts until completing her ICU course, held a ward sister's post at UCH in ICU for four years. She then went into education (1987) and following a BSc Sociology (1990), a PhD (2000) became a teacher until accepting a full time research post at the University of Surrey. She is an ethnographer and her interests include feminist and qualitative research methods, acute nursing and women's health including fertility and infertility.

Sue Westwood is Research Associate, School of Health Sciences, and a Visiting Research Fellow, Centre for Research on Ageing and Gender (CRAG), at the University of Surrey. She also teaches Law at Coventry University and is a freelance researcher. A gerontologist and socio-legal scholar, Sue is interested in issues of power and (in)equality in health and social care contexts. The primary focus of her research is on the intersection of ageing, gender and sexuality from an equalities perspective.

Review

Table 1	Focus Group Participant Profile				
Participant	Age Group	Gender	Country of Origin	Current Role	Years in UK
Participant (1)	30-39	F	Philippines	Nurse assistant band 3	10.5
Participant (2)	30-39	M	Philippines	Nurse assistant Band 3	9
Participant (3)	40-49	F	Philippines	Nurse assistant Band 3	1.5
Participant (4)	30.-39	M	Philippines	Nurse assistant Band 3	10
Participant (5)	40-49	F	Philippines	Nurse assistant Band 3	5
Participant (6)	30-39	F	Philippines	Nurse assistant Band 3	4
Participant (7)	30-39	F	Philippines	Nurse assistant Band 3	6
Participant (8)	30-39	F	Philippines	Nurse assistant Band 3	7
Participant (9)	30-39	F	Nepal	Nurse assistant Band 3	6
Participant (10)	30-39	F	Nepal	Nurse Assistant Band 3	4
Participant (11)	30-39	F	Philippines	Nurse Assistant Band 3	4

Table (1) Profile of focus group participants

For Peer Review