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

|                  |  |
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3 **'White British Researchers and Internationally Educated Research Participants: Insights**  
4 **from reflective practices on issues of language and culture in nursing contexts.'**  
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9 **Abstract**

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

32 This paper explores how reflexive practices enabled two researchers to achieve a more  
33 nuanced analysis of qualitative data generated from focus groups. Reflexivity is a widely  
34 used methodological tool in qualitative research (Pillow 2002). Feminist researchers in  
35 particular have argued that reflexivity involves knowing responsibly (Edwards and  
36 Mauthner, 2002) through a process of 'critical self-scrutiny' (Mason, 2006: 7),  
37 acknowledging and interrogating the researcher's 'constitutive role' (Gillies and Alldred,  
38 2001: 48) in the research process. It is widely accepted that ethnic and/or cultural  
39 differences in the backgrounds of researchers and research participants shape the research  
40 process (Culley, Hudson, and Rapport, 2007). There are a number of ethical and  
41 methodological issues relating to White researchers conducting research with Black, Asian  
42 and minority ethnic (BAME) research participants (Edwards 1996), particularly relating to  
43 issues of power and privilege (Muhammed et al 2014) and whether non-members of  
44 marginalised communities could or should conduct research with members of those  
45 communities (Carling et al 2013). This article describes and considers our reflexive processes  
46 as two White British researchers, working with BAME research participants and how we  
47 engaged with these tensions to enhance our analyses of qualitative data.  
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54 **Background**

55 Interviewing internationality educated nurses in the UK raises several important issues  
56 around how reflexivity, power and knowledge claims are addressed within this research  
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3 area (Williams 1993; Rudge 1996) as well as ethnic-/cross cultural interviewing (Sands et al  
4 2007; Suh 2009). Allan (2007) in previous work notes the dynamics of working in a team  
5 with researchers of different ethnic and cultural backgrounds when interviewing  
6 participants from a number of ethnic and cultural backgrounds. She shows how these  
7 dynamics, if handled sensitively and reflexively, can be a feature of the data collection as  
8 well as analysis. Allan's reflections on working in this area have been around the fluidity of  
9 ethnic and cultural identities moving away from any essentialist notions of fixed or  
10 determined ethnic/cultural identities. We highlight ways in which it is possible to theorise  
11 the relationships between different social and ethnic groups and within those same ethnic  
12 and cultural groups through reflecting on the research process. As Walby et al (2012) argue,  
13 in exploring intersectionality, we are aware of both the racist and gendered patterns of  
14 discrimination in UK health service while at the same time, cognisant of each individual's  
15 agency within those discriminatory social structures. And we acknowledge that we ourselves  
16 are part of those structures but suggest that our reflexivity allows some exploration of how  
17 those structures may be changed.  
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### 24 Study Description

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26 For over 50 years, each time there has been a shortage of nurses and midwives to work in  
27 the UK National Health Service and latterly, the Independent Health Sector, internationally  
28 educated nurses have been recruited from developing and developed countries alike (Smith  
29 et al 2008). One of the problems of recruiting trained nurses from overseas is that they do  
30 not easily fit into the already established work environment. One of the problems of  
31 recruiting trained nurses from overseas is that they do not easily fit into the already  
32 established work environment. Whilst many of them devise ways to fit in, mostly to their  
33 own detriment, they remain an *outsider* in the system with little hope of ever really fitting  
34 in. The onus is on them to own the cultural differences that exist within the organisation  
35 (Allan et al 2004; Larsen et al 2005). Despite growing demand for internationally educated  
36 nurses to fill the shortage of qualified nurses in the UK (NHS Employers 2014) there is  
37 evidence to suggest that they are working instead as Healthcare Assistants (also described  
38 as Care Assistants, Care Aides, Health Aides, Nursing Assistants, Nursing Auxiliaries, and  
39 Support Workers) on their arrival in the UK (Salami and Nelson 2014). There is an urgent  
40 need to understand the reasons for this and how they might be overcome. A number of  
41 authors have suggested that the International English Language Testing System (IELTS),  
42 especially with the recently raised scoring requirements for internationally educated nurses  
43 (RCN 2014) might block some internationally educated nurses from achieving UK  
44 registration (Buchan 2007). EU rules prevent EU/EEA nurses from being subject to  
45 mandatory testing (NMC 2011). This means that IELTS disproportionately affect non-EU/EEA  
46 nurses, in the context of ongoing concerns about ethnicity and nurse employment in the UK  
47 (Harris et al 2013) particularly with regards to institutionalised racism in the NHS (Allan et al  
48 2009; Batnitzky and McDowell 2011). By contrast, there is no mandatory English language  
49 testing for UK Healthcare Assistants, offering an alternative employment route to those  
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3 non-EU/EEA nurses. The purpose of the scoping project described here was to explore  
4 perceived barriers to UK nurse registration as understood by internationally educated  
5 nurses currently working as Healthcare Assistants in the UK.  
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7  
8 The aim of this study was to explore the experiences of internationally educated nurses  
9 working as health care assistants in the NHS as part of a wider programme to increase  
10 pathways to UK registration for internationally educated nurses. A total of 11 participants  
11 attended two facilitated focus groups during the summer 2014. Participants were recruited  
12 via convenience sampling from a database of previously identified overseas trained nurses  
13 working as Healthcare Assistants in the two National Health Service (NHS) hospitals.  
14 Participant profiles are provided in Table 1. All participants were internationally educated  
15 nurses from outside the EU/EEA. The focus groups were conducted by two White British  
16 researchers (the authors) in off-site venues to facilitate a sense of the focus group  
17 discussion being outside usual work conditions. The interview schedule used open ended  
18 questions to explore participants' experiences of working in the NHS as health care  
19 assistants and any challenges to registration as qualified nurses they might have  
20 experienced. They were audio-recorded and field notes taken. The audio recordings were  
21 transcribed by an administrative assistant and then cross-checked and verified by the  
22 researchers. The field notes were used to inform subsequent thematic analyses and  
23 researcher reflections. The data were analysed using thematic analysis. Themes were  
24 identified independently by the two researchers, then cross-compared. During this process  
25 the researchers also engaged in ongoing reflective discussions during iterative data analysis.  
26 A key moment in the analysis was after one focus group which was led by Allan and  
27 observed by Westwood. After the focus group ended, a discussion ensued about their  
28 respective reactions to the level of spoken English by the focus group participants.  
29 Particularly interesting was the way in which the two participants had different positions  
30 regarding their responsibility for learning English and therefore how they had been able to  
31 respond to perceived barriers to registering as a UK qualified nurse. Analysis then focused  
32 on the interactions between the two focus group participants and the responses to the  
33 focus group by the two researchers which in turn informed the findings thus producing an  
34 interplay of process and outcomes in the research.  
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45 <Insert Table 1 here>

#### 46 Findings

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

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

7  
8 This participant could not see the relevance of being able to discuss nuclear power for being  
9 an effective nurse. She did not appreciate that she might face nursing situations where she  
10 might need to be able to communicate in a broader vocabulary beyond one specific to  
11 clinical issues. Again, IELTS, the testing system, rather than English language competency  
12 itself, was generally perceived to be the problem:

14  
15           *Because my English wasn't good when I was back home and I have been trying IELTSs.*  
16           *So that's the IELTSs is preventing me but I haven't leave, I haven't give up, I just keep*  
17           *on trying. I have got 7 in two sections, but not writing it's quite difficult so the IELTSs*  
18           *is the main thing that is stopping me to be registering here. English, you should have*  
19           *the good communication but that doesn't mean that IELTSs is everything. (RGHCA201)*

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

#### 28 *Interactional analysis of the process of the focus group*

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

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

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

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

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

55 The overarching perspective among participants was of an uneven, unfair system which  
56 unreasonably disadvantaged non-EU/EEA internationally educated nurses. This raised a  
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3 number of questions and tensions in our analysis of the data which we explored reflexively.  
4 We suggest that the process of reflection in the analysis reflected in some ways the process  
5 of reflection in the focus groups, particularly the second focus group and gave rise to the  
6 tensions in reflexive data analysis. We also argue that these tensions in the data analysis  
7 illustrated patterns of discrimination and analyse the relationship between individual  
8 agency and structures of discrimination.  
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### 11 **Tensions in reflexive data analysis**

#### 12 *Tensions*

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15 The overarching narrative from the participants was that they understood their English  
16 language and communication skills to be sufficient to perform the role of a registered nurse  
17 in the UK. They perceived the IELTS system, rather than their language skills, as a block to  
18 registration. Only one participant perceived the IELTS system as fair, and she had already  
19 passed it in her country of origin. She was also well-educated, with multiple degrees, and  
20 stood out amongst the other participants because of this. So the first question we, as  
21 researchers, wrestled with, was 'Are the participants correct in their understanding of their  
22 English language proficiency being sufficient for a UK registered nurse?' The second, and  
23 related, question was 'Are the participants correct in their understanding of the English  
24 language testing system pass level as being too high?' Linked to these two questions was a  
25 question of accountability: 'Do our findings indicate a need to review IELTS requirements, or  
26 a need to encourage individuals such as the participants to take greater responsibility for  
27 improving their English language skills?  
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33 The first tension related to two aspects of standards of care in the UK among internationally  
34 educated nurses working as both registered nurses and Healthcare Assistants. The  
35 participants insisted that they were working alongside internationally educated UK  
36 registered nurses whose English was not as good as theirs, which, if so, is a cause for  
37 concern. Moreover, the participants consistently described having high levels of  
38 responsibility in their roles as Healthcare Assistants, some operating as nurses apart from  
39 administering medication. This raises the question about issues of safety given, according to  
40 their accounts, they were operating as 'almost' nurses while being unable to pass the  
41 English language requirements necessary for UK nurse registration and sets the scene for  
42 the second question, are English language testing pass rates too high?. In engaging with  
43 these tensions, we found it necessary to rigorously interrogate our own personal  
44 standpoints and reflect on the processes and dynamics interwoven with the data. In doing  
45 so we were not only able to improve our shared understandings of the data, we were also  
46 able to see how our respective processes were actually telling us something about the data  
47 as well. We shall now explore this reflective process and the insights it produced.  
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54 The 'how' of our reflective process

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

### 21 *'Good Enough' English*

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

35  
36 By contrast, Researcher A had spent many hours interviewing and/or conducting groups  
37 with internationally educated nurses and had learned to adapt her speaking and listening  
38 style accordingly. In the groups, Researcher A used simplified English, spoke slowly, of which  
39 she was unaware, until Researcher B pointed this out. She also listened to the essence of  
40 what the participants were saying, rather than how they were saying it, while Researcher B,  
41 less attuned, was more attentive to the manner of delivery. In this way, they were 'hearing'  
42 the data in different ways.

43  
44 Both were also informed by feminist, anti-racist, perspectives. Researcher A was concerned  
45 to be as facilitative as possible towards individuals she recognised as belonging to BAME  
46 groups, and therefore likely to have experienced discrimination on the basis of 'race',  
47 ethnicity and culture. She also recognised that not only has she published about  
48 institutionalised racism in the health services in the UK but she is recognised among this  
49 community for having done so. Researcher B, committed to equality and diversity, and  
50 mindful that we all carry internalised prejudices, was concerned that her less favourable  
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3 interpretation of the nurses' English language skills might be informed by racist bias (Davis  
4 2010). Both were aware that more stringent criteria were being imposed upon non-EU/EEA  
5 nurses than EU/EEA nurses (RCN 2014a) and recognised the inherent unfairness of this,  
6 albeit informed by the UK's need to comply with EU regulation.  
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9 The reflective conversations between the two researchers enabled them to achieve a  
10 number of insights. Firstly, they concluded that they, and the focus group participants, were  
11 both holding, and reflecting a wider organisational dynamic. Different English-speaking  
12 countries employing internationally educated nurses (e.g. Australia, Canada, UK, USA, New  
13 Zealand) have varying testing methods and standards for English language competency (Xu  
14 and He 2011). The most commonly used test is IELTS, with variations across countries in  
15 terms of IELTS levels and grades. However, there are considerable tensions within this  
16 framework:  
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20 *While there is broad acceptance that a certain level of language proficiency is critical*  
21 *to practice in a new country, there are other major concerns on equity: who should*  
22 *sit the test; to what level; and the content. There are also concerns whether a*  
23 *successful language test actually guarantees effective communication. (RCN 2014a:*  
24 *7).*  
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28 These tensions, and ambivalences, were expressed in the group, and experienced by the  
29 researchers. In this way the group and the researchers were enacting a gestalt (Ikehara  
30 1999), that is a repetition of the wider system in which they were all located. Rather than  
31 looking for binary explanations (and solutions) then, the researchers concluded that their  
32 analysis should reflect upon the tensions, and what they might mean.  
33

#### 34 *Implications for UK standards: structured discrimination*

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36 The first tension related to two aspects of standards of care in the UK among internationally  
37 educated nurses working as both registered nurses and Healthcare Assistants. The  
38 participants perceived themselves to have, and believed other colleagues to perceive them  
39 to have, sufficiently adequate English language proficiency to operate successfully in clinical  
40 contexts. As explored earlier, there were tensions among the participants and the  
41 researchers over issues of basic competence, but this is a separate issue, one of competency  
42 in nursing contexts.  
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45 In their reflections over these issues, the researchers encountered their most  
46 uncomfortable conversations. They both came from a position of privilege: as White  
47 researchers working in their country of origin. They were also anxious not to place race-or  
48 ethnicity- based value-laden judgements on the participants' linguistic competencies in the  
49 context of nursing proficiency (or any other context for that matter), nor to engage with  
50 racial stereotypes as addressed by one of the authors in previous authorship:  
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55 *The data suggest that racism and institutional racism are understood in more*  
56 *complex ways than previously reported, and that institutional racism may be*  
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3 *reproduced through negative stereotypes of foreigners and professional hierarchies*  
4 *which are forms of structured social relations (Allan et al 2004)*  
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6 The researchers were in particular concerned about capturing and then misappropriating  
7 the narratives of marginalised women:  
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9  
10 *Me as a person of colour giving my story to be 'processed' and 'consumed' by a white*  
11 *researcher, uncomfortably reproduces the dynamics of colonialism (Leela Bakshi, in*  
12 *Bakshi and Traies, 2011)*  
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14 However, at the same time, the researchers found themselves needing to place some kind  
15 of evaluation on the participants' language skills in order to achieve a more layered analysis  
16 of the data. Only when, through reflection, the researchers had been able to own their  
17 respective fears about their own privileged (and partial) perspectives, were they then able  
18 look beyond those fears to take a more focused approach to this aspect of the data.  
19 Through their reflective conversations, they recognised that the issue of status (theirs, the  
20 participants, Healthcare Assistants, registered nurses) was a key thread running through the  
21 data. The participants felt acutely a loss of status in their roles as Healthcare Assistants, and  
22 believed that this loss of status was unjust. At the same time as the role of a Healthcare  
23 Assistant has apparent lesser status, it would also appear to have lowered English language  
24 requirements, with a lack of mandatory English language testing in the UK (RCN 2014b).  
25 This, in turn, raises concerns about issues of patient safety, especially with increasing  
26 reliance by registered nurse on Healthcare Assistants, to act as an interface between  
27 patients and themselves (Munn, Tufanaru and Aromataris 2013). It also suggests, as in  
28 previous work by Allan (2003; 2007; 2009) multiple layers of discrimination within the UK  
29 health service.  
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36 The researchers were then also able to identify cultural differences between views  
37 expressed by the participants. There appeared to be a sense, among the participants, of  
38 nursing as a technical competence, of taking bloods, of inserting needles, of monitoring vital  
39 signs. There seemed to be less of an appreciation of nursing as a social competence, of  
40 being able to engage with, reassure, attune to, the subtleties of the patient experience. This  
41 view of nursing as a technical competence is congruent with their education in their  
42 countries of origin but becomes problematic in a UK cultural context (Allan 2007). Nichols  
43 and Campbell (2010), in a review of the literature on internationally educated nurses  
44 working in the UK reported a recurrent theme:  
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49 *The emphasis on basic, personal care (washing, feeding and toileting) of patients and*  
50 *care of the older person was unfamiliar... This type of nursing would usually be*  
51 *carried out by untrained workers or family in their home... a different culture of*  
52 *nursing... based on a curative medical model rather than the holistic approach*  
53 *favoured in the UK, interventions were therefore based on the technical and*  
54 *therapeutic. Many [internationally educated nurses] had expected that UK nursing*  
55 *would be task orientated (Nichols & Campbell 2010: 2819)*  
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3 However Nichols & Campbell's claim that UK nursing is holistic is itself contested (Allan  
4 2007; Johnson et al 2015). The contested nature of current nursing in the UK was echoed in  
5 the narratives of the participants in this study, and also shed light on the level of English  
6 language skills they perceived to be necessary for nursing competence (technical, task-  
7 orientated). They perceived technical competence to be sufficient for nursing English and  
8 their perception was validated by their skills being relied upon by their colleagues and  
9 managers in their clinical work. However, this reliance and use of their technical skills is at  
10 odds with the espoused view that technical competence requires a certain level of linguistic  
11 proficiency:

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16 *'There is a difference between having a sufficient grasp of a language to cope with*  
17 *day to day living and having the professional communication skills that are required*  
18 *to assess, plan, deliver and evaluate care for a patient or client'. (NMC 2004: 5)*  
19

20 Therefore unsurprisingly, given their experience of being valued as technically competent  
21 workers in their everyday lives, an appreciation of this espoused view seemed to be absent  
22 in the narratives of the participants. So too, was an appreciation of the need for  
23 interpersonal, relational competence, which enables a nurse to both understand and convey  
24 subtle communications with patients and their families, particularly during times of stress  
25 and/or distress (Xu 2008). The risk, of course, is that inadequate language skills in 'cross-  
26 cultural care encounters' (Jirwe, Gerrish, & Emami 2010: 436) could impede the patient-  
27 centred communication that is so essential to the delivery of quality nursing care (McCabe  
28 2004), with implications for 'patient safety and the quality of care, as well as the health and  
29 job satisfaction of overseas nurses' (RCN 2014a: 8). The participants appeared not to use  
30 this as a reference point for their English language proficiency perhaps because this was not  
31 a requirement they encountered at work. This does not mean that there is no requirement  
32 for cultural and linguistic competence, as Xu has observed, in addition to linguistic  
33 competence (which includes pronunciation and accented speech) nurses also need  
34 'sociocultural competence'  
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41 *i.e., dialect and its variety; knowledge of idioms and figurative language; knowledge*  
42 *of culture, custom, and institutions; knowledge of cultural references; and uses of*  
43 *language through interactional skills to establish and maintain social relationships.*  
44 *(Xu 2008: 431).*  
45

46  
47 Even internationally educated nurses with some degree of English language proficiency may  
48 feel they lack sociocultural competence, i.e. they do not have the 'right' English language  
49 skills for the full spectrum of nursing competencies (Stephenson et al 2014). So there is  
50 something here about a lack of understanding of the subtleties of language required for  
51 nursing contexts. If we were to stop here, we would be attributing accountability to the  
52 participants. To do so, would not only do them an injustice, it would also not take the  
53 system in which they find themselves into account or examine the unfair working practices  
54 they encounter, which rely on their technical competence rather than linguistic  
55 competence. If their employers do not expect them to have broad language proficiency as  
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3 Healthcare Assistants, indeed praise them for technical competence instead, why or how  
4 should they appreciate the need to increase their level of proficiency? And in the absence of  
5 tailored courses to help them improve their language skills, in nursing contexts, how can  
6 those who are most challenged by their English language proficiency be expected to  
7 improve it? (Allan and Westwood 2015).  
8  
9

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

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

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42 One simple way of expanding the Whiteness of our research duo and addressing the power  
43 imbalances in the White researcher/BAME research participants relations would have been  
44 to include BAME researchers, if not academics themselves (thin on the ground, which is  
45 itself an issue) then as participative action research participants (Reid 2004) or, at the very  
46 least as an advisory/steering group. This was not possible for this particular project due to  
47 time scales and costings, but it would always be our aim, in terms of good practice, to  
48 include marginalised individuals in the research process. On a larger scale project, with  
49 greater time and resources, we would have done so.  
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52  
53 Our reflexive process has shown us how reflexivity enhances data analysis and enriches  
54 emerging theoretical understandings of both the research process and the topic under  
55 investigation. We hope that sharing our reflexive processes and practices in this article will  
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3 be a useful resource for other qualitative researchers developing their own reflecting  
4 practices as well.  
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### 6 **Key points**

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

- 16  
17 Allan H T (2007) The Rhetoric of caring and the recruitment of overseas nurses: the social  
18 reproduction of a care gap. *Journal of Clinical Nursing Special Edition* 16(12):2204-2212.  
19
- 20 Allan H T, Larsen J, Bryan K & Smith P (2004) The social reproduction of institutional racism:  
21 internationally recruited nurses' experiences of the British Health Services. *Diversity in*  
22 *Health and Social Care*.1(2):117-126  
23
- 24 Allan, H. T., Cowie, H., & Smith, P. A. M. (2009). Overseas nurses' experiences of  
25 discrimination: a case of racist bullying?. *Journal of Nursing Management*, 17(7), 898-906.  
26
- 27 Batnitzky, A., & McDowell, L. (2011). Migration, nursing, institutional discrimination and  
28 emotional/affective labour: ethnicity and labour stratification in the UK National Health  
29 Service. *Social & Cultural Geography*, 12(2), 181-201.  
30
- 31 Bion, W. R. (1952). Group dynamics: a review. *International Journal of Psychoanalysis*, 33(2),  
32 235-247.  
33
- 34 Buchan, J. (2007). International recruitment of nurses: Policy and practice in the United  
35 Kingdom. *Health Services Research*, 42(32), 1321-1335.  
36
- 37 Carling, J., Erdal, M. B., & Ezzati, R. (2013). Beyond the insider–outsider divide in migration  
38 research. *Migration Studies*, 2(1), 36-54.  
39
- 40 Culley, L., Hudson, N., & Rapport, F. (2007). Using focus groups with minority ethnic  
41 communities: Researching infertility in British South Asian communities. *Qualitative*  
42 *Health Research*, 17(1), 102-112.  
43
- 44 Edwards, Rosalind and Mauthner, Melanie (2002). 'Ethics and Feminist Research: Theory  
45 and Practice.' In M. Mauthner, et. al. (eds) *Ethics in Qualitative Research*, pp 14 - 31.  
46 London: Sage.  
47
- 48 Edwards, R. (1996). "White woman researcher-Black women subjects", in, S. Wilkinson and  
49 C. Kitzinger (eds) *Representing the Other: A Feminism and Psychology Reader*, London:  
50 Sage  
51
- 52 Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of  
53 reflexivity. *Qualitative Health Research*, 12(4), 531-545.  
54
- 55 Freeman T. (2006). Best practice in focus group research: making sense of different views.  
56 *Journal of Advanced Nursing* 56 (5), 491–496.  
57  
58  
59  
60

- 1  
2  
3 Gillies, Val and Alldred, Pam (2002). 'The Ethics of Intention: Research as a Political Tool.' In  
4 M. Mauthner et. al. (eds) *Ethics in Qualitative Research*, pp. 32-52. London: Sage.  
5  
6 Harris, R., Ooms, A., Grant, R., Marshall-Lucette, S., Chu, C. S. F., Sayer, J., & Burke, L. (2013).  
7 Equality of employment opportunities for nurses at the point of qualification: An  
8 exploratory study. *International journal of nursing studies*, 50(3), 303-313.  
9  
10 Jirwe, M., Gerrish, K., & Emami, A. (2010). Student nurses' experiences of communication in  
11 cross-cultural care encounters. *Scandinavian Journal of Caring Sciences*, 24(3), 436-444.  
12  
13 Larsen J, Allan H T, Bryan K & Smith P (2005) Overseas' nurses motives for working in the  
14 UK: global perspectives or local prejudice. *Work, Employment & Society*. 19(2):349-368  
15  
16 Likupe, Gloria, et al. (2014). Managers' perspectives on promotion and professional  
17 development for black African nurses in the UK. *Diversity and Equality in Health and*  
18 *Care* 11(2), 113-123.  
19  
20 Mason, Jennifer (2006). *Qualitative Researching* Second edition. London: Sage.  
21  
22 Muhammad, M., Wallerstein, N., Sussman, A. L., Avila, M., Belone, L., & Duran, B. (2014).  
23 Reflections on Researcher Identity and Power: The Impact of Positionality on Community  
24 Based Participatory Research (CBPR) Processes and Outcomes. *Critical Sociology*, 1-19.  
25  
26 NHS Employers (2014) *NHS Qualified Nurse Supply and Demand Survey – findings. Report*  
27 *produced for the Health Education England Nursing Supply Steering Group*. Leeds: NHS  
28 Employers.  
29  
30 Pillow, W. (2003). 'Confession, catharsis, or cure? Rethinking the uses of reflexivity as  
31 methodological power in qualitative research.' *International Journal of Qualitative*  
32 *Studies in Education*, 16(2): 175-196.  
33  
34 Royal College of Nursing (RCN) (2014) *Registration of internationally educated nurses in the*  
35 *UK: International comparisons and key issues for incoming nurses to ensure safe and*  
36 *effective practice. RCN Policy and International Department Policy briefing 01/14*.  
37 London: RCN.  
38  
39 Rudge, T. (1996) (Re)writing ethnography:the unsettling questions for nursing research  
40 raised by post-structural approaches to the field, *Nursing Inquiry*, 3(3), pp.146-152  
41  
42 Salami, B., & Nelson, S. (2014). The downward occupational mobility of internationally  
43 educated nurses to domestic workers. *Nursing inquiry*, 21(2), 153-161  
44  
45 Sands R G, Bourjolly J, Roer-Strir D (2007) Crossing Cultural Barriers in Research  
46 Interviewing. *Qualitative Social Work*. 6(3), 353-372  
47  
48 Smith P A, Allan H T, Larsen J A, Henry, MacKintosh M M (2008) Valuing and recognising the  
49 talents of a diverse healthcare workforce.  
50 [http://www.rcn.org.uk/\\_\\_data/assets/pdf\\_file/0008/78713/003078.pdf](http://www.rcn.org.uk/__data/assets/pdf_file/0008/78713/003078.pdf)  
51  
52 Suh E (2009) Cultural Competence in Qualitative Interview Methods With Asian Immigrants.  
53 *Journal of Transcultural Nursing* 20(2), 194-201  
54  
55 Tsang, N. M. (2007). *Reflection as dialogue*. *British Journal of Social Work*, 37(4), 681-694.  
56  
57 Walby S, Armstrong J, Strid S (2012) Intersectionality: multiple inequalities in social theory.  
58 *Sociology*. 46(2) 224-240  
59  
60

1  
2  
3 Williams, A. (1993) Diversity and agreement in feminist methodology, *Sociology*, 27(4),  
4 pp.575-589

5  
6 Yalom, I. (1998) *Love's Executioner*. London: Penguin.

### 8 **Biographies**

9  
10 Helen Allan is Professor of Nursing at Middlesex University having trained as a nurse at UCH  
11 and qualified in 1978. She held various staff nurse posts until completing her ICU course,  
12 held a ward sister's post at UCH in ICU for four years. She then went into education (1987)  
13 and following a BSc Sociology (1990), a PhD (2000) became a teacher until accepting a full  
14 time research post at the University of Surrey. She is an ethnographer and her interests  
15 include feminist and qualitative research methods, acute nursing and women's health  
16 including fertility and infertility.  
17

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19  
20 Sue Westwood is Research Associate, School of Health Sciences, and a Visiting Research  
21 Fellow, Centre for Research on Ageing and Gender (CRAG), at the University of Surrey. She  
22 also teaches Law at Coventry University and is a freelance researcher. A gerontologist and  
23 socio-legal scholar, Sue is interested in issues of power and (in)equality in health and social  
24 care contexts. The primary focus of her research is on the intersection of ageing, gender and  
25 sexuality from an equalities perspective.  
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Review



| <b>Table 1</b>   | <b>Focus Group Participant Profile</b> |        |                   |                        |             |
|------------------|--|--------|-------------------|------------------------|-------------|
| 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