

Overseas nurses in the National Health Service: a process of deskilling

Terri O'Brien PhD, MA, BA, RGN

Research Associate, International Observatory on End of Life Care, Institute for Health Research, Lancaster University, Lancaster, UK

Submitted for publication: 10 July 2006

Accepted for publication: 27 February 2007

Correspondence:

Terri O'Brien
Research Associate
International Observatory on End of Life Care
Institute for Health Research
Bowland Tower East
Lancaster University
Lancaster
LA1 4YG
UK
Telephone: +44(0)1524 592 729
E-mail: t.obrien@lancaster.co.uk

O'BRIEN T (2007) *Journal of Clinical Nursing* 16, 2229–2236

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Aims and objectives. This paper shows that overseas nurses (OSN) recruited to UK hospital trusts become deskilled in technical aspects of clinical practice.

Background. Existing research reports that many newly recruited OSN are prevented from using technical skills acquired in training abroad, to the detriment of the National Health Service (NHS) and the concern of the nurses themselves.

Design. The author conducted case study work in three NHS hospital trusts in the northwest of England. The findings reported are part of a wider investigation into the assimilation¹ of OSN from the Philippines, India and Spain into NHS hospitals. Semi-structured interviews were undertaken with members of four groups of actors: managers, OSN, home nurses (HN) and mentors, which were analysed thematically.

Results. The research confirms the finding that many OSN are prevented from using technical skills in the UK, but also suggests reasons why this is so. The finding of deskilling emerged strongly in all three cases and is singled out for discussion in this paper.

Conclusions. The experience of OSN highlights ambiguity surrounding the role of the nurse in British hospitals. This arises partly because OSN tend to be recruited to the bottom grades of nursing in the NHS, where their technical skills are underused.

Relevance to clinical practice. Segmentation within the nursing hierarchy contributes to the conflicting messages and mismatch of expectations experienced by nurses at the ward level, regarding the role of the nurse.

Key words: deskilling, international nurse recruitment, nurses, nursing, segmentation theory

Introduction

This paper considers some of the circumstances surrounding a common experience of newly recruited overseas nurses (OSN) to UK National Health Service (NHS) hospitals,

¹It is acknowledged that 'assimilation' is a sensitive term because of its negative associations with colonialism. In the context of the research the term is used positively to refer to effective accommodation of international nurse recruitment into the nursing labour force or cadre, which is of course already highly segmented. It is not intended to refer to general cultural assimilation.

which relates to them becoming 'deskilled'. Research shows that often, newly recruited OSN are prevented from using the technical skills gained in training outside the UK to the detriment of the NHS and the chagrin of the nurses themselves (Gerrish & Griffith 2004, Smith 2004). Case studies conducted by the author in three northwest England hospital trusts corroborates the finding that deskilling and disempowerment is widely experienced by OSN and sheds light on the reasons why it occurs. It is argued the multiple and cross-cutting conflicts between segments of the UK

nursing profession (Melia 1987) have established a traditional pattern of recruitment, selection and promotion that does not easily accommodate OSN, who tend to have high levels of technical skills and a lack of practical experience of direct care which refers to the provision of patients' hygiene needs when they are unable to perform these activities independently: examples include washing, toileting and feeding.

This paper falls into four sections: section one describes the changes in international recruitments that have occurred since the early 1990s, arguing that since that time OSN tend to be recruited as qualified and trained nurses. This creates one of the basic conditions necessary for deskilling. Section two focuses on the character of the nursing cadre to which OSN are assimilated. It uses Melia's segmentation theory to illustrate the divided nature of nursing as an occupation in the UK, suggesting that it is characterized by strong internal divisions, coupled with weak occupational boundaries. It is argued that, in addition to a conflict over the leadership of nursing, there are further important horizontal divisions in the occupation which have always existed historically in one form or another (Dingwall *et al.* 1988) Currently, a significant division exists between a skilled group of senior qualified nurses (usually at grade E and above) and the subordinate segment of the rank and file, comprising junior qualified nurses (grade D and below) and unqualified health care assistants (HCA) at grades A, B and occasionally at C. OSN are usually recruited to increase the supply of direct carers in the subordinate section of the rank and file of nursing, at least initially, whatever their prior level of training and skill. Here we have the two elements necessary to understand the deskilling of OSN: firstly, recruits are often highly trained; secondly, the nursing system into which they are recruited expects them to occupy a particular and subordinate position.

Having outlined the ideas used in the paper, the following sections demonstrate how the processes of deskilling actually work themselves out in particular hospital settings. Part three presents case study material derived from a study of the experiences of OSN in the three hospital trusts studied in the northwest of England. This is followed by some reflections of the implications of the findings for policy, in section four and is concluded with a summary of the main arguments.

Section one: changes in international nurse recruitment during the 1990s

Migrant labour has a long and chequered history in the UK and the NHS. Large-scale migration of nurses facilitated by government policy began in earnest during the 1950s and

1960s and peaked in the 1970s (Culley & Mayor 2001). These generations of OSN were drawn mainly from Ireland and from English speaking, former British colonies of the commonwealth, in the West Indies, Africa and Asia (Culley *et al.* 2001, p. 135, Buchan 2002, p. 26). They were recruited primarily to train alongside British recruits, which meant that both UK nurses and OSN were trained as nurses under the same system.

Recently, the terms 'international nurse recruitment' (INR) and 'internationally recruited nurses' (IRN) have crept more freely into usage in the literature and general discourse on 'international recruitment' (IR). These terms are used synonymously with OSN recruitment throughout this paper. However, it is noted that terminology is rarely neutral and the re-branding of OSN as IRN may be indicative of a desire by employers and policy-makers alike, to distance themselves from the association of past generations of OSN and their treatment as workers in the health service. Many commentators observe that OSN have traditionally been used as cheap labour disproportionately in the lower grades of nursing and often subjected to racial discrimination from patients and colleagues (Beishon *et al.* 1995, Carter 2003). The tendency to employ OSN initially at the lower grades in nursing as direct carers, where their skills and expertise tend to be underused, is not restricted to the UK context: similar findings are revealed in other European Union (EU) and non-EU countries such as Germany and Spain (Zulauf 2001), Japan (Iredale 2001), Australia (Hawthorne 2001) and North America (Kingma 2006) (see also Smith *et al.* in this issue).

During the 1990s and following the transferral of nurse training to higher education, some important policy changes occurred in the practice of OSN recruitment. Firstly, nurses began to be batch-recruited from a wider range of countries by the NHS and the private sector. Increasingly employers came to rely on commercial recruitment agencies to locate suitable recruits and facilitate the processes of selecting and inducting them into UK hospitals (LaRusso 2003, Buchan *et al.* 2005). Secondly, employers and agents began to recruit candidates in higher numbers as qualified nurses who trained outside Britain. These changes have important implications for nursing as a profession and an occupational group.

Political and Practical Implications of INR

The changes in recruitment practice have resulted in nurses arriving from increasingly diverse cultures and nursing systems. The fact that they are socialized as nurses in different cultural, social, political and economic circumstances has altered their receptivity to ways in which they are

inducted into the nursing cadre in the NHS. This has complicated the prospects for their effective assimilation, which has become less likely than in the previous era, when OSN and 'home' nurses learnt their trade together within the same nursing system.

One notable finding from this research has been the distinctive role specification of nurses in the UK. Here, direct care is institutionalized in hospitals. Attachment to direct care is central to the practice of nursing and valuing it as an intrinsic part of the nursing role is acquired through the socialization processes in nurse training programmes. In countries where direct care is delegated to patients' relatives or non-nurses, attachment to the idea of nurses as direct carers tends to be much less (Witchell & Ouch 2002, p. 11, Smith *et al.* 2006, pp. 42, 91). This difference in the specification of the nurse's role understandably leads to a mismatch of expectations between OSN and home nurses (HN). Because OSN are recruited routinely in NHS hospitals to be direct carers on the lower nursing grades this routinely creates a situation in which deskilling may occur.

Having outlined some contextual background to INR, section two draws on Melia (1987) segmentation ideas, arguing that two crucial horizontal divisions in nursing occur, the first at the senior level of the occupation and a further division at the ward or clinical level.

Section two: segmentation theory

The largest occupational group in hospitals are nurses (and midwives), who account for almost half of the wage bill and consume the largest part of the NHS budget (Thornley 1996). Nurses, as Melia (1987), p. 5) notes, form a very diverse and heterogeneous workforce, with various segments claiming to carry out the work of the nurse. Melia draws on the concept of segmentation and develops it from earlier work by Butcher and Strauss (1961) and Butcher and Stelling (1977). The latter define a segment as members of a sub-group in the profession sharing a similar identity and ideas about nursing as an occupation, the content of the job and its relationship to other parts or 'segments' of the occupation. This paper extends Melia's (1987) original use of segmentation theory to examine tensions that exist within the rank and file segment and applies it to deskilling propensities faced by OSN in the NHS.

In nursing, two main segments are 'service' and 'education' elites. Both segments can be described as playing an important role in providing policy direction and a different 'voice' for the expression of interests of nurses as an occupational group (Melia 1987, pp. 3–5).

The service segment includes 'the new managers', who are line managers from ward managers upwards and 'new professionals' that are an emerging group of senior nurse specialists and consultants, with a high degree of autonomy from line management. The third and largest group in the service segment is the 'rank and file' (Melia 1987, pp. 163–166) who are located in hospital wards and other clinical areas. This group comprises qualified and unqualified nurses, with their own internal division of labour referred to in this paper as an elite and a subordinate level. Both elements of the rank and file in the UK participate in the activity of delivering basic nursing care to patients/clients; but qualified nurses have a wider theory or knowledge base, acquired in their nurse training as student nurses, than HCA.

Employers or managers have to plan continually for and maintain the supply of, nurses in the rank and file, in the context of an aging workforce. Traditionally, the supply of workers has been mainly recruited from young, predominantly female school leavers. However in recent years, this source of labour has decreased in numbers because of a national falling birth rate and also of increased labour market choices and opportunities, particularly for graduate women (Gerrish & Griffith 2004). Supplies of new qualified and unqualified nurses are now being achieved from recruitment of older female workers and a government-led drive to recruit OSN (Department of Health (DoH) 2000) to swell the numbers of the subordinate levels of the rank and file.

Melia (1987), p. 163) describes the education segment of nursing, as comprising the 'academic professionalizers': this group tends to be at the senior levels of nursing and is often university-based. Their work includes teaching undergraduate nurses, academic research, publications and promoting the theory base of nursing. The composition of the occupation's regulatory body, the NMC (Nursing and Midwives Council), has a significant weighting from the academic professionalizers as committee members and from this position they seek to progress a professionalizing agenda. One important policy development stemming from the preceding regulating nursing body has been the introduction of *The Scope of Professional Practice* (United Kingdom Central Council (UKCC) for Nurses, Midwifery & Health Visiting 1992), which was replaced by the new *Code of Professional Conduct* (Nursing and Midwifery Council (NMC) 2002).

Briefly, 'scope' as it is colloquially known, does away in theory with the need for nurses to be certificated for expanding their roles, providing they have received appropriate training and are competent in the particular task or skill.

The academic professionalizers have long been advocates of 'new nursing', which represents an ideological shift from task-oriented, to patient-centred care (Salvage 1992). Their aims have included constructing nursing as an autonomous profession in its own right, separate from the historical dominance of medicine (Witz 1992). Many of these ideas theoretically underpin 'the nursing process' introduced in Britain in the 1970s. This is a diagnostic tool used by nurses in assessing, designing, implementing and evaluating patient care. Two of its functions are to render nursing visible and to provide a scientific base to the provision of nursing care, as a distinct and autonomous practice, independent from medicine (Melia 1987, p. 2, Porter 1998, p. 80). In this sense it is also an occupational closure mechanism as it is used in part to establish nursing's claim to expert and specialist knowledge, a central tenet in the struggle for any occupational group to be accepted as a legitimate profession (Porter 1998, p. 77). Therefore, the academic professionalizers play a key role in reproducing the rhetoric of nursing as a 'full' profession, imbued with values of nursing based on a North American model of providing holistic care. This is an important part of identification for nurses trained in the UK and at the heart of the UK system lies an implicit value that trained nurses carry out basic nursing care. This espoused value, if not always maintained in practice by qualified nursing staff, forms a central element of socialization for UK-trained nurses (Melia 1987).

Between these two elite groups: the academic professionalizers and nurse managers at the senior levels of nursing, there is a division and conflict of interests. While the academic professionalizers want nurses to become autonomous practitioners, free to use their clinical judgement similar to doctors, nurse managers are more concerned with controlling nurses' behaviour and the context in which they carry out the nursing function. Sources of tension between these segments of the profession reside in the scope, content and levels of autonomy that nurses should have in their day-to-day practice. Some of these issues and their impact on the assimilation of OSN into their subordinate roles on wards are demonstrated in the next section drawing on research conducted in three hospital trusts.

Section three: aims, objectives and methods of the study

The data collection carried out over a 12-month period in 2002–2003 examined the processes involved in the assimilation of OSN into NHS hospitals. Two broad questions were designed for this purpose: How does each of the three trust organisations address the issues involved in recruiting,

retaining and supporting the assimilation of OSN into the nursing cadre? How do the OSN and HN accommodate each other professionally and socially at the level of the workplace?

The study was conducted in three NW regional hospital trusts in England and involved OSN from Spain, the Philippines and India. Each of these countries has government agreements with the UK to pursue active batch IR (Buchan *et al.* 2004, p. 2). A case study approach was devised, with the hospital trusts forming a 'unit of analysis' (Yin 1994, p. 21). Multiple research methods were used to collect data for a comprehensive analysis of the trust sites as the organizational contexts where OSN assimilation occurs. Qualitative data included recorded, semi-structured interviews conducted in the workplaces and within the homes of the OSN. Interviews with managers, HN and nurse mentors and periods of observation on the wards were undertaken in the hospitals in all three cases.

Overall, a total of 63 semi-structured interviews were tape-recorded and transcribed in the study. These included 40 interviews with members from seven OSN cohorts across the three trusts, interviews with eight hospital managers and also 15 HN (most of whom were also mentors to OSN). The OSN respondents were selected randomly from the cohort lists and members were approached individually and asked if they would be willing to participate. During the observation periods on the wards contact was made with managers and HN. This led to a 'snowballing' effect, as those approached initially acted as gatekeepers to other participants on a voluntary basis. The aims and objectives of the study were explained verbally to the respondents and supported by a written information sheet. Written consent was obtained, with an assurance of anonymity and the right to withdraw from the research at any time, in accordance with the ethics committee requirements and ethical research guidance.

Interview schedules drawn up were loosely structured around six topics. Previous nursing experience; reasons for coming; recruitment agency, induction and adaptation course experience; mentoring and general support from managers and HN; intentions to stay; and finally, worst and best experience since arrival to England. Although the subject of racism was not on the schedule it arose spontaneously in many of the interviews with the OSN.

The interviews were supplemented with periods of observation on wards, which provided valuable additional data and insight from informal contact with a wider range of hospital personnel, including other nurses, clerks, porters, ward domestics and doctors.

Quantitative methods included analysis of data from internal hospital documentation, government data and

demographic analysis of national census statistics. The plurality of these research methods produced rich source data, which focussed on the experience and organization of the different cohorts of OSN recruited to the trusts. Thematic analysis of the interviews revealed that deskilling emerged strongly in every case.

Results: deskilling

The findings from the three trusts simply identified as Trusts One, Two and Three revealed that each organization required qualified nurses to attend a training course for intravenous (IV) therapy known informally as the 'IV training course'. The course was rarely available to newly qualified nurses at grade D or below and places were tightly controlled by line managers who acted as gatekeepers, as funding for the training was usually part of the ward budget. These technical skills were regarded by many HN as having some prestige attached to them because they were acquired postregistration. Places on training courses of this kind were in high demand and in short supply and the resulting skills were associated with higher-grade nursing roles.

The OSN in the study from the three source countries had all acquired IV skills as part of their preregistration nurse training. However, they were prevented from practicing them until they had proved their competence in the British system, by attending the IV course and passing the competency tests. Much of their adaptation period (averaging three to six months) and beyond was spent carrying out direct patient care with HCA. This, in itself, was a great culture shock on arrival at their new posts, because they had done little of this type of nursing in their countries of training.

A Filipino Nurse in Trust One described his feelings and the difficulties he encountered in the differences between nursing in England and in the Philippines. Prior to his present D grade staff nurse post in this trust, he had worked in an emergency room (ER) where he 'performed many cannulations everyday on adults, children and babies'. Despite this, he did not obtain a place on the trust IV course until 16 months after he arrived in the UK; hence, he was unable to practice these skills throughout this period. His outlook and dilemma as a nurse was expressed as follows:

Here I find nursing very basic, bathing the patient, taking the obs. ... The nurses are waiting for the doctor to say 'that lady needs an IV infusion'. ... In the Philippines ... I would do everything ... I would tell the doctor, 'she has a venflon in' and the doctor will greatly appreciate me'.

In this extract the nurse strongly sees his role as helpful to the doctor; it is a source of pride that he will be perceived by the

medical profession as being helpful and efficient. It is also important to his identification as a nurse that he can carry out technical skills learnt in his training and perfected in his previous job in ER. His frustration is twofold: firstly that he cannot act efficiently in the patient's best interests, carrying out procedures for the doctor and so gain respect through these actions. Secondly, the patient has to wait for care and this could be detrimental to the patient's recovery.

These findings were far from unique; on another occasion a female nurse from the same cohort, when asked what she missed most about nursing in the Philippines replied:

Taking a pride in doing everything for the doctors ... the bloods, ECGs etc.

Less emphasis is placed on the importance of basic nursing care in their accounts of nursing. This is because, in their home nursing system, direct care is associated with lower-grade work. But in England they now have to do a great deal of this for patients, which is frequently hard and repetitive work.

Similar dilemmas of deskilling emerged in Trust Two within the two cohorts of nurses from India studied. The Indian OSN interviewed were also very frustrated and felt demoralized by not being able to use their technical abilities on the wards until they had attended the internal trust IV course. This requirement applied to all new nursing staff coming from outside the organization, from other UK trusts as well as from abroad. However again, there was a long delay before these courses became available to the OSN. One nurse in Trust Two described how she perceived the management rule preventing her from performing venopuncture and cannulation, learnt as a student nurse in India, as feeling as if:

They tied our hands.

Another nurse from this group described how she became so frustrated watching a HN and a junior doctor fail to insert an intravenous cannula into a patient with 'poor veins', that she asked if she could do it. She successfully put the venflon in and the ward sister came to watch. She was anxious that she would be 'told off' for exercising this skill without having the prerequisite internal IV training. The manager praised her but there was still ambiguity about whether she could perform cannulation in the future.

Ambiguity regarding the capacity of OSN to undertake cannulation was a feature in each of the three trusts. A nurse from Spain in Trust Three said:

The ward manager allows me to do cannulations and phlebotomy, having observed me in the beginning, but I have had to fight to be allowed to do these things when she is not on duty.

These accounts demonstrate the confusion and inconsistency that exists in the UK nursing system surrounding nurses' extended roles in relation to IV administration in particular and the arrival of OSN in batch recruitment exercises has brought this uncertainty to the foreground.

The difficulties for staff in interpreting both the service segment rules around training and the academic professionalizers' intentions of empowering nurses through 'scope' and the NMC 'code of conduct' to be autonomous practitioners in areas of competency, were compounded for many of the OSN in the study, by restrictive local employment practices. The debate around role extension for nurses provoked interesting responses from HN, who often had polarized views about the issue; some felt that the trust was deliberately treating OSN like HCA by not recognizing their technical skills acquired abroad.

A mentor, a junior sister in Trust Two, said:

Its appalling the way they are treated as HCA for so long, it must be demeaning for them because they are trained, qualified nurses.

These observations and sentiments about 'the trust's' attitude were echoed by many clinical managers and HN on the subject of the non-recognition of the OSN training and qualifications gained abroad. Other comments from HN and managers on the subject were:

OSN are paid an A grade because [the management] think that they won't know any better (ward manager).

The trust feels that their qualifications are not as good as an English nurse' (staff nurse).

Other views from HN and managers on the issue of extended role skills were more tailored to the service segment managers' intended use of OSN as direct care providers.

I think OSN need to learn the basics first before carrying out cannulations and IV therapies' (mentor).

Senior managers in the service segment of the trust organizations, when questioned about the technical skills of OSN, which are part of the nurse's extended role in the UK nursing system, acknowledged that this was a highly political and contentious area. They suggested that the HN might feel undermined by OSN performing to a perceived higher level than UK nurses. Some HN did feel threatened, or felt that some of these technical duties in the UK context were not part of the nurse's basic role. Many times HN described the OSN as performing like junior or 'mini' doctors, which belied their official description as 'supervised practice nurses'.

This suggests that the evaluation of OSN in their adaptation phase is typically in error as HN and mentors are

expecting something more akin to a UK-trained third-year student, socialized to a higher degree in direct care than are these OSN. Many of the HN and mentors expected that the OSN arrival would make their working lives easier and underestimated the support that they would be required to give during adaptation. These groups were surprised at the technical ability of the OSN. Additionally, it was expected that OSN would be more familiar with giving direct patient care, which was considered a core competence by the HN.

Finally, the ambiguity over IV training and role extension was compounded by a further anomaly. Each of the three trusts was bringing in a new support worker grade, grade C. Recruits to this new grade would be drawn from the ranks of the existing HCA and they would be trained to level three national vocational qualifications (NVQ) to do many of the tasks qualified nurses were prevented from doing routinely, such as IV cannulation, phlebotomy and electrocardiogram (ECG) recordings. This new flexible worker grade would undertake these technical tasks as well as doing elements of direct care, such as bed making and some patient hygiene duties. This situation is indicative of weak occupational boundaries, as many different disciplines now have responsibilities for technical tasks that historically tended to be the preserve of the medical profession.

The inconsistency of the rules for different grades of nurses and other disciplines, carrying out various IV therapies, had not escaped the attention of some nurses in the service. One charge nurse in Trust Three suggested that the UK system of the expanding role of the nurse in the UK was very often 'confused'. He pointed out that:

Phlebotomists are trained to take bloods in one afternoon, so why should nurses have to take a course and to be supervised doing such a task ten times in order to be deemed competent?'

Section four: reflections on policy implications of the findings

It is clear that the extended role in nursing remains a highly contentious area that the national policy UKCC (1992) 'scope document' was intended to resolve. The arrival of increased numbers of OSN in recent years has renewed attention to the problems associated with role extension. Employers, at local level, continue to require accreditation for certain skills that nurses trained in the UK acquire the following basic registration. But many of these technical skills form part of OSN basic training as qualified nurses, yet are not recognized by the UK employers in the service segment. The findings in this research indicate that managers in the NHS often do not recognize nurses' training and

skills acquired outside their individual organizations, or in other countries.

This paper suggests that a contributory reason for inconsistencies in the local interpretation of policy on nurses' extended roles is the existence of tensions between the service and education segments of nursing, concerning control over scope, practice and skill mix in nursing. Provisions for role expansion existed in the UKCC *Scope of Professional Practice*, the intentions of which have now been incorporated in the NMC's (2002) *Code of Conduct*. The aims, to promote nursing as a profession and nurses as autonomous practitioners, have been actively supported by the academic professionalizers in the education segment at policy level (Melia 1987, Dingwall *et al.* 1988). However, it is also clear from the case studies that some managers locally in the service segment are resistant to OSN exercising clinical judgement on such things as IV administration and other role extensions, because they are recruited to the rank and file of nursing primarily as direct caregivers (see also Allen & Larsen 2003, Smith *et al.* 2006).

Evidence in this study suggests a further reason for reluctance to recognize OSN technical abilities. This is that service managers at local level want them to 'fit in' to the nursing team and to the manager's interpretation of the grading structure; being recognized as proficient in various ways and having an expanded role while remaining in the subordinate segment would cause OSN to stand out from their peers. This means in practice ignoring the technical competencies that OSN bring with them to the United Kingdom; in effect, as Gerrish and Griffith (2004), p. 585 observe, OSN are being constrained by 'bureaucratic boundaries'. An obvious policy implication of this finding is that by underutilizing OSN technical abilities, the NHS as an organization are wasting obvious and freely available benefits. Additionally, OSN may find that their technical skills decay through lack of use and they often become frustrated and demoralized by local restrictions on their clinical practice as nurses.

Conclusions

Pressure on employers and policy-makers to address nursing shortages and in particular to replenish direct caregivers in the subordinate levels of the rank and file of nursing have led managers to recruit from migrant labour markets. This is a solution with many precedents in the UK. The renamed IRN continue to be located in the lower end of the nursing hierarchy, just as the preceding generations of OSN also had to begin their nursing careers in the UK at the bottom (Doyal *et al.* 1981, Akinsanya 1988). However, the current practice

of recruiting OSN that are already qualified as trained nurses, has led to more rather than less wasteful recruitment practices and less efficient assimilation into the nursing cadre than might be hoped for.

The deskilling revealed in this study involves a mismatch of expectations between HN and OSN about the scope of practice and nursing. This can be compounded by a sink or swim approach by managers in some trust organizations to the processes involved in INR. This is manifest in the way that nurses at practice level are left to interpret the conflicting and mixed messages regarding nursing autonomy received from both segments of the profession. The deskilling of OSN requires attention at the level of national policy and a change locally to less restrictive employment practices, if a generally improved use of this resource is ever to be realized.

Acknowledgements

The author gratefully acknowledges the financial support of the Economic and Social Research Council. This research was undertaken as part of the doctoral studies by the author.

Author contribution

Manuscript preparation: TO'B.

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