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Racism and the mentor-student relationship: Nurse education through a white lens

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SUMMARY

This paper is based on a study of relationships between Internationally Recruited Nurse (IRN) mentors and White[2] students in one nurse education department in England (Scammell, 2010). The aim of the study was to analyse mentorship relationships, focusing on interaction in which perceptions of difference were in play. The research drew upon the principles of qualitative ethnography. Data were collected through focus groups, interviews, participant observation and documentary analysis. The purposive sample included 10 IRNs, 23 nursing students, two lecturers and five placement-based staff development nurses. The data were analysed thematically.

Essentialist constructions of different 'cultures' emerged amongst students speaking of their experiences with IRN mentors. These were used to explain and justify differences in practice and often to portray IRN education as inferior. Difference was viewed as a problem, leading to the reinforcement of boundaries that differentiate 'them' from 'us'. Racism was denied as a source of these views.

The findings suggest that Whiteness as a source of power was influential in the production of racism within everyday nursing practice. Whiteness appeared to be normalised: essentially nurse education is seen through a White lens. Students require deeper sociological understandings to better equip them to recognise and to challenge racism and to acknowledge their own part in its reconstruction.

Introduction

This paper reports on a study of the experiences of Internationally Recruited Nurse (IRN) mentors and White nursing students in the context of practice education (Scammell, 2010). It is asserted that institutional racism permeates the National Health Service (NHS) in the United Kingdom (UK) (Alexander, 1999; Blofeld, 2003). In seeking the elusive understanding of how institutional racism remains a vital force in the NHS, we suggest that the small acts of reiteration of racialised discourses between people in organisations may illuminate how 'unwitting', discriminatory views and practices are perpetuated.

The use of 'unwitting' has particular resonance in the UK context as it is a term used in major reports of investigations of institutional racism (for example within the police service, Macpherson, 1999) to suggest that racism may not have been intended or actions even comprehended as racist. In common with the Carmichael and Hamilton (1967: p5) indication that institutionally racist organisations permit 'respectable people' to 'absolve themselves from blame', this form of absolution requires further investigation. It is with this in mind that we hold some of the 'unwitting' small acts of racism up to the light. Elsewhere (Sue et al., 2007) such acts are termed 'microaggressions'. This too is a very useful concept particularly where racism in face to face encounters is the focus of attention. In this study, reports from IRNs and White nurses are conducted separately and particular discourses in play identified and discussed. It is possible to identify examples of microaggression within some of the narratives and to a more limited extent observe them in direct encounters.

A number of studies (Frankenberg, 1993; Hobgood, 2000; DiAngelo and Allen, 2006) show that Whiteness acts as a source of privilege and power: the insertion of attention to Whiteness may prove useful in the analysis of institutional racism. We are placing an analytical focus on racism rather than on provisional notions of 'cultural difference' as this offers a more robust insight into the context and particular episodes within the data.

Indicative Literature

A small number of studies concern the experience of IRNs working in the UK (Allan and Larsen, 2003; Gerrish and Griffith, 2004; Matiti and Taylor, 2005) and migrant nurses elsewhere, for example Yi and Jezewski (2000). Common issues to emerge relate to communication, work culture, deskilling and discrimination on grounds of perceived race. Racism embodies the notion that one racially defined group is superior or inferior to another. Our understanding of race is that it is a social construction which leads to exclusionary practice (Miles and

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[2] The terms Black and White are given capital letters to indicate their use as proper nouns to describe assumed identities of categories of people.

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Brown, 2003). Different aspects of life, for example clothing, religion or speech, as well as selective physical attributes may become racialised. It is a shifting discourse; racism occurs when earlier discourses of race are used to explain presently perceived differences, although this does not preclude the development of newer narratives of race.

Allan and Larsen (2003) found that IRN participants described racism as silent, covert and difficult to deal with as it was 'in the hearts and minds' of the indigenous population. The insidious nature of racism is also reported in a Canadian study (Hagey et al., 2001) involving immigrant nurses of 'colour'. The analysis revealed processes of marginalisation at work; they were treated differently 'on the ground' despite the policy rhetoric. The study concluded that there is a denial of racism in nursing.

In a major policy review, Alexander (1999) concluded that there was evidence of institutional racism at many levels within the NHS. Lemos and Crane (2000) reported that 57.7% of NHS workers from Black and Minority Ethnic (BME) communities had either experienced or witnessed racial harassment. Significant problems are evident including poor job satisfaction amongst BME nurses and increased intent to leave, inequalities in terms of career progression and concentration of BME staff in less popular nursing specialties and locations (Ball and Pike, 2003). A number of policy initiatives have been developed to address discrimination (Department of Health, 2005), however racism appears persistent. There is a greater focus upon processes and procedures to tackle discrimination including the development of race equality plans, although some argue that their impact on racism is limited (Olumide, 2007).

Discrimination against clients from BME communities producing an array of health inequalities, is also apparent in the UK. A study by Bowler (1993) involving women of South Asian origin revealed highly stereotyped staff views, leading to care that was determined by ethnic group as opposed to need. Similarly a study of the experiences of White nursing staff caring for patients from BME communities (Murphy and Macleod Clark, 1993) demonstrated ethnocentric attitudes to care. Vydelingum (2006) found that whilst nurses responded to 'cultural needs', care remained constructed from the perspective of the dominant White population and patients were expected to fit with this approach.

Multiculturalism is a powerful discourse within nursing in the area of ethnicity and difference. It is a contested concept and relates to essentialist notions of culture (Culley, 2006). Multiculturalism can be conflated with ethnicity. Ethnicity in turn is expressed within the policy literature as an aspect of diversity and is often linked with culture and race. The terms ethnicity, culture and race are often used interchangeably and are infrequently defined, making their meaning rather ambiguous, resulting in unhelpful conceptualisations of 'difference'. Racism can be dismissed through reference to multiculturalism—'we treat everyone the same'. The problem with this approach is that it is underpinned by the assumption that by offering an equal service, everyone can access and use it appropriately and it fails to account for the impact of structural inequalities on social groups and the privileging of one group over another.

White privilege is explored by DiAngelo and Allen (2006) in an observational study of group dialogue about race amongst elementary and secondary school teachers. They found that White participants used the discourse of personal experience to block challenges about the reality of racism—'if I don't feel it, it doesn't exist'. This had the effect of preventing exploration of the impact of inherited historical and social processes, thereby maintaining White privilege. Indeed DiAngelo (2010:p1) argues that individualism is so embedded in dominant society that it functions as 'one of the primary barriers preventing well-meaning (and other) white people from understanding racism.' She outlines eight dynamics of racism that are obscured by this discourse. Of particular relevance is the assumption that success is a facet of individual effort with no acknowledgement that our 'starting position', for example our social group membership, will provide an advantage. This has the impact of casting dominant group members (for example Whites) in a positive light whilst simultaneously casting those groups who have achieved less (people form BME communities) in an unfavourable light. In order for anti-racist education to succeed, Schroeder and DiAngelo (2010: p244) argue that 'nurse educators need to facilitate colleagues and students to identify, name, challenge, and transform the norms, patterns, traditions, structures and institutions that keep white supremacy in place.' This inevitably involves the analysis of the role of institutional power, in this case within nursing, as it impacts on the way power dynamics operate at the micro level, for example between practitioners.

Duffy (2001) agrees that in nurse education, the dominant culture is perceived as the norm. Puzan (2003) argues that White privilege is a significant feature of nursing. Western science is linked with Whiteness and this dominates in nursing curricula. The nursing elite are dominated by Whites, providing little impetus to challenge the expectation that patients conform to White norms of care (Blackford, 2003). Consequently nurse education has been criticised for failing to address the impact of racism in nursing practice (Cortis and Law, 2005). A process of racialisation seems evident, whereby populations are categorised according to their imagined phenotypes and other markers of difference. This leads to essentialist constructions of cultural groups as fixed and sharing a homogenous set of immutable characteristics. Essentialist views of culture are often mapped onto ethnicity, leading to the conflation of the two terms in much professional literature (Gustafson, 2005).

Methods

The study draws upon key principles of qualitative ethnography. Assumptions underpinning this approach include an acknowledgement of multiple standpoints, including that of the researcher. The aim of the study was to explore and interpret constructions of difference within mentorship relationships that involve IRNs and White English nursing students in one nurse education department in England. Four methods of data collection were used: focus groups, semi-structured interviews, participant observation and analysis of documentary sources. Themes were identified in the data and, adopting a social constructionist perspective, recognised discourse discussed.

Central to the research were IRN mentor and White nursing student encounters. The study was designed to capture how institutional processes and activities intersected with nurses' experiences of practice education. The prime focus was on reports of micro social relations (everyday actions, speech and documentation) principally between IRNs and students but recognising these were informed by the macro practices of institutions such as the NHS and nurse education. Key informants were therefore included to capture a wider picture of the community. The resulting 'texts' were analysed alongside relevant documentation.

In the UK, the dominant ethnic group is White British, although the UK is one of the most multicultural societies in Europe. Diasporas of various communities from Commonwealth countries and more recently from central and eastern Europe, mainly in urban areas, are evident. However the study was undertaken in a semi-rural area where there were far higher levels of White British people compared with other parts of the UK. In the two care provider organisations involved in the study, 80.5% and 94% of registered nurses workforce reported their ethnic origin as White British. 96% of undergraduate nursing students and 91% of academic faculty from the health school involved described themselves as White British (Scammell, 2010).

Purposive sampling was used and as themes emerged, theoretical sampling (Denzin and Lincoln, 2005) was adopted to explicate these further. 22 female students and one male student volunteered; all were White British except one Black Zimbabwean. Ten IRNs participated, seven female and three male; six were Asian, three were Black African