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Exploring the Career Pathways, Professional Integration and Lived Experiences of Regulated Nurses in Ontario, Canada

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Sociology

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EXPLORING THE CAREER PATHWAYS, PROFESSIONAL INTEGRATION AND
LIVED EXPERIENCES OF REGULATED NURSES IN ONTARIO, CANADA

(Thesis format: Integrated Article)

by

Godfred Odei Boateng

Graduate Program in Sociology

A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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Abstract

In the context of an enduring shortage of nurses, this study explores the career pathways and experiences of immigrant and Canadian-born nurses in two Ontario cities utilizing a qualitative research design consisting of 70 in-depth interviews. Differences in career entry and experiences of workplace conflict across immigration status and race are explored.

First, I explore successful immigrants' pathways into the nursing profession and their social and economic integration into the Canadian economy in light of the traditional assimilation and segmented assimilation theories. The study reveals distinct career pathways taken by foreign-born nurses and Canadian born nurses. While Canadian-born nurses have a shorter and a more direct pathway into nursing, foreign-born nurses, especially IENs and Visible minority nurses, face more complex systemic and multidimensional challenges in transitioning into the profession. I conclude from this study that the segmented assimilation theory cannot accurately capture immigrants' experiences in nursing as it does not take into account the conditions of the labour market. Second, I examine nurses' conflicts with patients and family members/friends, the sources of the conflicts, the role of racial status, and the coping mechanisms used. I find that racial status influences the experience of conflicts at the workplace. Visible minority nurses experience verbally aggressive behaviours more frequently relative to White nurses. This, I find impedes their integration in the nursing profession. Third, I examine conflicts amongst nurses and the implications of intra-professional conflict for the nursing profession. The findings show that conflicts centre on workloads and tasks, as well as race and age. The study reveals evidence of White nurses engaging in social closure, sometimes excluding and marginalizing Visible minority nurses. Nonetheless, I find the response of Visible minority nurses' foster professional unity and not division.

This study calls for skilled immigrants seeking nursing integration to be provided with adequate information on the requirements and necessary credentials needed for their professional integration before migration and upon professional entry. Also, the removal of factors that create toxic work environments and reproduce workplace inequality are pertinent in promoting the wellbeing of nurses, their professional integration, and quality healthcare.

Keywords

Career pathways, professional integration, intra-professional conflicts, nursing, racism, IENs, immigrants

Co-Authorship Statement

Dr. Tracey L. Adams contributed to Chapter 5, “‘I think this one has evil in her’: An Exploratory Study of Intra-Professional Conflict amongst Nurses in Two Ontario Cities” as second author. All research, analysis and writing included therein are the work of Godfred Odei Boateng

Acknowledgments

I believe it would not be worth talking about this work without acknowledging various important personalities whose innumerable and immeasurable contributions have brought this project to this end. My very first and most sincere thanks is directed at the Lord Jesus Christ for granting me the grace to see the end of my program, for the gift of an excellent supervisor, for access to research participants whose responses have made this project a success, and for the assignment of mentors whose advice have enabled me finish within time. To my supervisor – Dr. Tracey Lynn Adams – I say *nulli secunda*. Tracey’s unflinching support, critical comments, quick reviews, and excellent appraisals have facilitated the completion of this project. Not only has she added voluminously to my knowledge and skill, but she has consciously and unconsciously taught me to be a good sociologist. The enthusiasm she has for her research has been contagious and motivational for me; I hope to walk in those landmarks she has left behind.

I would also like to acknowledge Dr. Teresa Abada as the second reader of this thesis; I am gratefully indebted to her for her very valuable comments on this thesis. My appreciation goes to the entire faculty at the Sociology department for creating an enabling environment that fertilizes scholarly and critical scholarship. I have benefited a great deal from this. My success in this Ph.D program is also attributed to the wise counsel and motivation of Dr. Isaac Luginaah and Dr. Godwin Arku of the Geography department and also Dr. Erica Lawson of the Department of Women’s Studies and Feminist Research. Their admonishing’s have given birth to a number of publications I have authored. My deepest gratitude goes to the examiners– Dr. Ivy L. Bourgeault (University of Ottawa), Dr. Yolanda Babenko-Mould (Western University), Dr. Jerry White (Western University) and Dr. Teresa Abada (Western University) – whose valuable feedback has greatly improved this thesis. Special thanks go to my colleagues – Jonathan Amoyaw, Cliff Davidson, Esra Ari, Julie Young-Marcellin, Allison Cordoba, Nicole Etherington, Frederick Armah, Mengieng Ung, and Vincent Kuuire – who have been companions, coauthors, and also the strength behind my success.

I gratefully acknowledge the funding sources that have made my Ph.D. work possible. I was funded for the entire four years through Western Graduate Research Scholarship. My data collection will have been hindered without the Graduate Research Award.

I will like to thank all the registered nurses and registered practical nurses of London Health Sciences Centre (LHSC) and the University Health Network (UHN) whose readiness and willingness to share with me their experiences on the job have made this project a success. Special thanks go to the individuals within these institutions who coordinated and promoted the research to enable their coworkers be part of this research study. Your efforts have yielded great fruits. I am also grateful to the administrative staff of the Sociology department, especially, Denise Statham for connecting me to the necessary resources I needed for the past four years.

To my dad, Joseph Odei Boateng and my mum, Juliana Aniagyei, you laid the best foundation I needed to get to this end. Your constant prayers have been a great support to this accomplishment. A dream is made reality today and it is only a sign that the Lord hearkened to your prayers.

To my dearest wife – Mavis Odei Boateng– your patience, your love, your support, your ideas, and your hope for a great future has been the backbone of this enterprise. You provided the needed encouragement in times of despair and the strength to overcome every hurdle. My success is only a fruit of the seed you sow. This work is dedicated to our unborn children: J.W.O. Boateng and Julie-J. Odei Boateng. I trust the good Lord will cause you to surpass this height.

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Chapter 1

1 Introduction

The recruitment and retention of nurses has become a high priority area within the health care sector globally as countries such as Canada, United States and United Kingdom experience an increasing shortage of nurses, an aging population, and an aging workforce (Hall et al., 2009). In Canada, the situation is dire as an estimated workforce shortage of 11,000 nurses in 2007 is expected to reach 60,000 full-time equivalent registered nurses (RNs) by the year 2022 (CNA, 2009; Murphy et al., 2012). Although different policies and solutions have been proposed to address this shortage (Murphy et al., 2009; 2012), it persists. The most current statistics from the Canada Institute for Health Information (2015a) show a decline in the supply of regulated nurses by 0.3 percent over the previous year. The number of nurses not renewing their registration was found to exceed the number entering the profession (CIHI, 2015b). More specifically, the supply of registered nurses (RNs) decreased by 1.0 percent, with a slow growth in the supply of registered practical nurses (RPNs) at 1.4 percent. Low and negative growth has been attributed to nurses' retirement, nurses leaving the profession or migrating to another Canadian jurisdiction or outside of Canada (CIHI, 2015b). The consequences of this shortage have been found to include decreased staff morale, increased job strain, longer hospital wait times, and more patients leaving without being seen, all of which culminates in poor quality health care and impedes workforce sustainability (Sawatzky & Enns, 2012).

One of the ways by which Canada aims to reduce the nursing shortage is through the recruitment of immigrant nurses. However, there is evidence that immigrants face many barriers and difficulties when entering the labour market: many internationally educated nurses (IENs) face difficulties in acquiring the right working documents, registration, upgrading their educational credentials, and passing the licensing exams (Boyd & Schellenberg 2007; Ogilvie et al., 2007; Kawi et al., 2009; Flynn, 2011). This has consequences for the profession, immigrants and their families. Professionally, it limits the number of IENs who successfully integrate into nursing practice. IENs experience delays in hospital employment, loss of income, and low self-esteem. The unsuccessful

applicants may resort to lower skilled and lower paid jobs that subsequently leads to deskilling (Frith, Sewell, & Clark, 2006; Watson-Roberts et al., 2014).

Immigration is not the only solution to labour shortages, however. Research has also focused on nursing retention, identifying the work environments that foster retention and reduce nursing turnover. Better work environments not only improve retention, but they result in higher quality nursing care. One area of concern within nursing is workplace conflict. Nurses face abuse and assault from patients and their families (ONA 2015). They also experience workplace conflicts in their interactions with colleagues and other health care professions. Research investigating workplace conflicts has highlighted several influential factors including nurses' inexperience, inadequate staffing, unsafe design of care units, inadequate patient medication, lower levels of control, and poor organisational support (Shields & Wilkins, 2009; Moylan, Cullinan, & Kimpel, 2014; Rodwell & Demir, 2014). Additionally, hospital restructuring, combined with government legislation, have brought changes that produce stress and strain relations, including the need to keep up with higher standards of work continuously, the increased complexity and demands of current nursing work environments, and budget cuts that affect staffing levels (Martel, 2003; Roscigno et al., 2009; Laschinger et al. 2010; Deery et al., 2011). Negative work environments, workplace bullying and workplace incivility have been associated with negative health and organizational outcomes (Laschinger et al., 2010). They also foster turnover and impede retention.

Although there has been research on the barriers experienced by immigrant nurses, and research identifying the conflicts nurses' face on the job, fewer studies have brought these two issues together, and explored the significance of immigration status and race to Canadian nurses' experiences of workplace conflicts and how these experiences affect their professional integration (see Neiterman & Bourgeault, 2015a). Also, studies that focus on nurses' integration fail to examine workplace factors that shape nursing practice (see Neiterman & Bourgeault, 2015b). Covell et al. (2014) argue for the need for research that examines workplace integration. Further, while research has explored the barriers faced by immigrant nurses, the role of education and race has not been adequately explored. This dissertation seeks to fill these gaps in the literature through a case study of

foreign and Canadian-born nurses working in two Ontario cities. I seek to build on earlier research on the significance of race to nurses' experiences in Canada (Calliste, 1996; Das Gupta, 2009; Flynn, 2011), to gain a more nuanced understanding of immigrant nurses' experiences, especially immigrant Black nurses, relative to their Canadian counterparts.

This study seeks answers to 4 research questions across 3 research papers. The four research questions are as follows: (a) Are the pathways into the nursing profession experienced by foreign-born nurses different from those of Canadian-born nurses? (b) Do experiences of patient abuse vary by immigration status and race? (c) Do experiences of intra-professional conflict amongst nurses vary by immigration status and race? (d) Does the impact of these conflicts, and do nurses' coping strategies, vary by immigration status and race? In exploring answers to these questions, I consider the implications of these conflicts for the nursing profession and its development.

To answer these questions, a qualitative research design was used after been approved by the Western University ethics review board. I employed in-depth interviews with 70 RNs and RPNs from two Ontario cities. The 70 nurses came from multiple hospitals, long-term care facilities, and a public health unit. This number was attained at the point of saturation where the responses of both immigrants and non-immigrants became repetitive and consistent. Question one was answered using narratives from the total sample; however, question two and three were answered using 66 out of the 70 nurses interviewed. In these analyses, the sample was restricted to participants who claimed to be Visible minority immigrants or White Canadians to enable clearer comparisons. Thematic analysis was conducted through systematic review of interview transcripts using MAXQDA software.

This study contributing to a deeper understanding of the factors that shape immigrants' entry and integration into the nursing profession has been organised into six chapters. In Chapter 2, I scope the existing literature to identify current knowledge on and gaps within the literature on skilled immigrants and immigration policy, immigrants and skilled work, professional work and nursing, reaccreditation for foreign trained nurses, the gendered and racialized nature of nursing, and the challenges of immigrants in nursing.

In Chapter 3, “Exploring the Career Pathways of Nurses and their Integration into the Nursing Profession in Ontario, Canada,” I explore successful immigrants’ pathways into the nursing profession and their social and economic integration into the Canadian economy, in light of the traditional assimilation and segmented assimilation theories. I further examine the complications associated with the registration and licensure of Internationally Educated Nurses (IENs) and their initial entry into the nursing profession. Using data from in-depth interviews with 42 immigrant nurses and 28 non-immigrant nurses who work or have worked in direct care, I distinguish the pathways into nursing undertaken by foreign-born and Canadian-born nurses. The study revealed that Canadian-educated nurses (native-born Canadians, and to some extent the foreign-born Canadian trained) had a faster and a shorter route into the nursing profession. Internationally educated nurses had a slower and a much longer route into the profession for a variety of reasons. These included life course factors (age, marital responsibilities, births), challenges with accreditation (incomplete documentation, delays in assessment, non-recognition of foreign credentials, competency gaps, certification, poor language proficiency), and the lack of Canadian work experience. However, I also discovered that once they had fully integrated into the profession, foreign-born nurses and Canadian-born nurses earned middle-class incomes. I conclude from this study that the segmented assimilation theory cannot accurately capture immigrants’ experiences in nursing because it hasn’t taken into account labour market considerations. The nursing shortage and availability of employment facilitates the integration of foreign-born nurses.

In Chapter 4, “Go Back to Your Country: Exploring Nurses’ Conflicts with Patients in Ontario,” I draw on the in-depth interviews to examine nurses’ conflicts with patients and family members/friends, the sources of the conflicts, the role of racial identity, and the coping mechanisms used. I find that racial identity/immigrant status influences the experience of conflicts at the workplace. Visible minority nurses experience more frequent verbally aggressive behaviours relative to White nurses. This, I argue, impedes their integration (career development) in the nursing profession. Although some see nurses in a position of authority over patients, for minority nurses (and others) this authority is not accepted, and patients exert power over them through abusive behaviours.

Chapter 5, “I think this one has evil in her: An Exploratory Study of Intra-Professional Conflict Amongst Nurses in Two Ontario Cities,” examines conflicts amongst nurses and the implications of intra-professional conflict for the nursing profession. Using the in-depth interviews and comparing Visible minority and White nurses, I examine the sources of these conflicts and distinguish between the coping strategies of nurses. The findings show that conflicts centre around workloads and tasks, as well as race and age. There is evidence that White nurses engage in social closure, sometimes excluding and marginalizing Visible minority nurses. Although such divisions have the potential to divide the nursing profession internally, it appears that the response of Visible minority nurses (to work harder and seek out work environments in which they feel more welcome) may foster professional unity.

Chapter 6 provides a conclusion to the dissertation. In this chapter, I briefly discuss the research findings presented in Chapters 3 to 5. I then consider the policy implications of these findings. Based on the results of the study, I provide directions for future research regarding the work of immigrants in the nursing profession

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Chapter 2

2 Literature Review

2.1 Introduction

This chapter provides a review of the literature on immigrants in professions. It provides the basis on which all the three papers following are developed. First, emphasis is placed on the migration of skilled immigrants and the difficulties they encounter in entering and integrating into different professions. I then focus on the nursing profession, looking at the job characteristics (the gendered and racialized nature of the job) and why it is a valuable case study in exploring the career trajectories and work experiences of professionals in Ontario.

2.2 Migration of Skilled Immigrants and Immigration Policies

Globalisation and geo-politics have influenced the nature of international migration such that not only are the most developed countries – including Australia, US, UK and Canada – receiving immigrants from countries with similar economic power, but also there is now, a phenomenal increase in the number of skilled immigrants from Asia and Africa (Iredale, 2005; Kofman & Raghuram, 2006; CIHI, 2009). The current trend of immigration to Canada has brought significant changes creating a more diverse Canadian population. From Confederation in 1867 to the mid 1960's, Canada's immigration policy (open door policy) was tailored specifically to immigrants of European origin. This changed 20 years after the Second World War in the midst of an economic boom. The policy was modified to cater to the specific needs of Canada in the promotion of economic development; immigration was seen as a substitute for declining births among the Canadian born (Boyd, 2013). The new policy introduced by the Liberal government ran on the wheels of a point system for the selection of immigrants based on their education, skills, and resources rather than their racial and ethnic background (Guo, 2009; 2013). This policy facilitated the immigration of skilled labour from Asia, the Caribbean, Latin America, and Africa. The point system has been subsequently revised to

adapt to the changing economic and human capital needs of Canada. For instance, on 28 June 2002 the Canadian Immigration and Refugee Protection Act (IRPA) was implemented allocating a high number of points to education levels which signal skill in the knowledge economy (Kofman & Raghuram, 2006; Liu, 2006).

In January 2015, Citizenship and Immigration Canada (CIC) rolled out a new policy by which skilled immigrants could live and work permanently in Canada. The Express Entry System creates a pool of candidates for immigration to Canada. To get into this pool, skilled foreign nationals are required to meet the criteria for one of the following federal immigration programs – the Federal Skilled Worker Program (FSWP), the Federal Skilled Trades Program (FSTP) or the Canadian Experience Class (CEC) (CIC, 2015). Most professionals enter Canada under the FSWP. In determining an individual's eligibility through the FSWP, applicants need to have worked for at least one year (1560 hours total/30 hours per week) in a skilled job that falls within the National Occupational Classification (NOC). In addition, the applicant needs to be highly educated and fluent in English or French having a Canadian Language Benchmark of seven and above. Further, the applicant needs to show his/her ability to adapt to Canada. Finally, applicants must show proof of funds sufficient to support themselves and their family upon arrival. Applicants are then assessed based on these factors and should get a minimum of 67 out of 100. This benchmark is taken as an indicator of their successful entry and integration into the Canadian labour market (CIC, 2015). All qualified professionals and skilled immigrants with this minimum number of points become eligible to apply under the Express entry system.

CIC (2015) has indicated that under the Express entry system, interested applicants must first fill out an online profile that includes a language test score, the educational credential assessment, and an outline of their experience. Based on this profile, the candidate will be ranked against others in a pool using the express compressive ranking system which takes into account the aggregate points gained from all the factors being assessed. Human capital factors (age, level of education, official language proficiency, and Canadian work experience) are privileged in this system, and constitute a total of 460 points; applicants with spouses or common-law partners depending on their level of

education, official language proficiency, and Canadian work experience can also add a maximum of 40 points. In addition, applicants with transferable skills (education and foreign work experience) are able to add a maximum of 100 points. These factors when satisfied provide the applicants with a total of 600 points. The applicant needs to get an additional 600 points either from being provincially nominated, or from having arranged employment, culminating in a total of 1200 points. It is out of this total that applicants will be ranked against each other. Those with the highest points will be given the nod to apply for permanent residency under a particular program (CIC, 2015b). In assessing this new policy, it is obvious that applicants with high human capital and the requisite work experience are privileged over those without. However, as to whether this translates into employment and integration into their chosen profession upon their arrival is another question. Immigrants arriving in Canada under the skilled worker category come with high hopes of economic success, which are dashed after they discover the job search and hiring process in Canada is different (Walker, 2006)

Organizations such as Employment and Social Development Canada and the Human Resources and Skills Development Canada (HRSDC) recognize the barriers faced by skilled immigrants on arrival. Hence, in 2003, the Foreign Credential Recognition Program (FCRP) was instituted to facilitate the smooth entry and integration of immigrants and other internationally trained workers into the Canadian labour market (Bourgeault, 2007; ESDC, 2014). Bourgeault (2007:98) notes that in March 2005, the “HRSDC [announced funding of] \$545,145 for a Diagnostic for the National Assessment of International Nurse Applicants project by the Canadian Nurses Association.” Boyd (2013:186) also reports that in that same year, “under the Internationally Trained Worker Initiative, an additional \$75 million was provided over 5 years to assist with the assessment and integration of up to 1000 physicians, 800 nurses, and 500 other regulated health professionals.”

Komlodi et al. (2014) have noted the availability of information on the skills requirements for jobs internationally trained health professionals might want to engage in on arrival. However, they note the limitations of this information. New immigrants such as health professionals lack culturally-situated information which will facilitate their

entry into the North American healthcare system. Also, Walker (2006), after reviewing Canadian policy research and initiatives between the year 2000 and 2006, reported a steady growth in labour market integration initiatives for skilled immigrants. However, policies and programs matching skilled immigrants to labour market needs were found to be missing in the strategic plan. The absence of such relevant programs prolongs or delays immigrants' entry into appropriate and relevant jobs that match their skills and competence. Walker suggested the need to address barriers facing immigrants across different occupations and increasing immigrant integration at the workplace. Similarly, the Migrant Integration Policy Index (2015) has suggested the need to increase entrepreneurship and survival rates of immigrant businesses as a route to integration and prosperity.

Generally, research recognizes the challenges skilled immigrants face in their integration into prospective occupations and the concerted efforts the Government of Canada has put in place to ensure that the barriers are ameliorated. In spite of these measures, the extant literature shows that skilled immigrants continue to face daunting challenges and barriers that impede their integration into the Canadian Labour market and the society at large.

2.3 Immigrants and Skilled Work

Various scholars have outlined barriers faced by skilled immigrants in their entry and integration into the labour market. These include skill mismatch, underemployment, non-recognition of foreign credentials, reaccreditation, cultural displacement, and racial discrimination. The following discussion will highlight each of these challenges and how they affect immigrants' integration into the labour market.

2.3.1 Underutilization and Wage Gap

Underutilization of immigrants' skills has been considered a brain waste/abuse which comes at a cost to the individual and Canadian society (Reitz, 2005; Bauder, 2003). Income disparities between foreign-educated immigrants and native-born Canadians with comparable skills have increased over time (Aydemir & Skuterud, 2004; Reitz, 2005; Templeton & Fuller, 2013; Reitz et al., 2014). Reitz (2005) found a \$2.4 billion gap between the two groups as the former were noted to work in occupations that were below

their skill level. Reitz et al. (2014) also found that with the influx of economic class immigrants, the educational levels of recent immigrants were much higher than the Canadian native-born workforce. The proportion of university degrees was three times higher for recent immigrants in 2006 than for the native born population. However, the trend in immigrant employment and earnings has taken a downturn. Specifically, a census analysis of immigrants revealed a decline in access to skilled occupations between 1996 and 2006 (Reitz et al., 2014). This has been attributed to the non-recognition and devaluation of their foreign credentials and underutilization of skills of new immigrants (Girard & Smith, 2013). The devaluation of foreign credentials has particularly affected ethnic and racial minority immigrants (Reitz, 2005). Reitz and colleagues (2014) also found Canadian society loses out from the underutilization of skilled immigrants. They estimate that the “the value (in today’s dollars) of work lost to the Canadian economy grew from about \$4.80 billion annually in 1996 to about \$11.37 billion in 2006” (p. 1).

2.3.2 Low Skilled Jobs

Numerous studies point to the poor earning outcomes of skilled immigrants as a consequence of their concentration in low income jobs. Reitz and colleagues (2014) reported that in 1996, 3.9 percent of immigrants with university education worked in low skill occupations relative to 2.6 percent of their native-born counterparts. By 2001, 6.8 percent of immigrants compared to 2.9 percent of native-born Canadians worked in low skilled occupations. These percentages did fall in 2006, but the gap remained: 4.3 percent of skilled immigrants compared to 1.8% of the educated native-born worked in low skilled jobs. Girard and Smith (2013) also reported that immigrants educated in Asia, Latin America, and the Caribbean were less likely to secure access to a regulated occupation than either the native born or other immigrants. The over-representation of skilled immigrants in entry level, low skilled and low paying jobs is a consequence of job mismatch – differences between the supply of and demand for skills – and a high employer demand for less-skilled labour in trades and other lower level occupations (Zietsma, 2010; Reitz, 2013). These point to the limitations of the human capital theory that suggest that education, on-the-job training, acquisition of skills and experiences naturally lead to increased productivity and individual earnings (Buzdugan & Halli,

2009). In a few cases where education has been found to pay off in terms of employment and wages, Chiswick and Miller (2010) report that the gains made are much higher for immigrants from developed countries than for those from developing countries. On this note, the point system that serves as the basis for selecting the ideal immigrant under the current immigration policy (Federal Skilled Worker Program and Canadian Experience Class) is unable to guarantee successful integration into the labour market.

2.3.3 Non-Recognition of Foreign Credentials and Reaccreditation

Immigrants' foreign credentials and their previous work experience are often unrecognized, leading to immigrants' skills being underutilized (Boyd & Schellenberg, 2007; Houle & Yssaad, 2010). Houle and Yssaad (2010), in their study 'Recognition of newcomers' foreign credentials and work experience' find that newcomers from the United States, the United Kingdom and Western Europe had a higher probability of having their credentials and work experience recognised, compared to those from Asia and Latin America. The training of immigrant professionals from third world countries is deemed deficient, incompatible, and inferior (Guo, 2009). This is particularly true in Canada's regulated professions and occupations.

Adams (2007, 2015) has argued that professions are regulated because there is deemed to be a public safety risk to allowing the lesser-trained to practice. Professional regulation has historically been designed to ensure that professional practitioners are skilled, knowledgeable, and competent. Regulation establishes a uniform standard that all professionals providing services to the public are required to meet. Such policies, however, restrict access to professional practice (Boyd & Schellenberg, 2007; Adams, 2015). There has been concern that professions are creating unreasonable restrictions that prevent qualified people from developing countries from gaining entry to practice. In response, provincial governments, like Ontario's, have passed legislation to ensure Fair Access to Regulated Professions (Ontario, 2006). In Ontario a Fairness Commissioner is charged with ensuring that professions are not unreasonably restrictive when regulating entry-to-practice in the province. When foreign credentials and training are assessed as not equivalent to those standard in Canada or other Western countries, the foreign-educated are asked to complete additional training, and pass professional entry

examinations (Alboim et al., 2005). This process has been found to take a few months to a number of years depending on the type of profession (See Adams, 2007; Bourgeault, 2007), and it is very costly for immigrants both in terms of the expense of the programs and exams, and income lost (Bourgeault & Neiterman, 2013). Immigrants end up engaging in menial, part-time, casual, and other survival jobs to pay their bills and make up for the gaps in their credentials.

In addition to these regulatory barriers, skilled immigrants also face barriers in the labour market as employers prefer to hire people with Canadian education and work experience. The situation is particularly dire for immigrants from third world countries, who appear to face more credential gaps and employment discrimination. Additionally, Guo (2009) links the predominance of skilled immigrants in low-skill occupations to their lack of skills in the official languages of Canada. Generally, the jobs these skilled immigrants end up doing prevents them from honing their career-relevant skills, and those relating to their training in their country of origin (Man, 2004). Hence, without work and further training in their field of specialization, they become deskilled and their situation becomes more precarious over time.

2.3.4 Cultural Displacement

Another key barrier skilled immigrants have to deal with is cultural displacement. Skilled immigrants have to navigate their way through a complex labour market system with little or no social or cultural capital (Creese et al., 2009; Creese & Wiebe, 2009; Newton, Pillay, & Higginbottom, 2012). This affects not only their economic integration but also has a concomitant effect on their social and cultural integration. This key challenge largely stems from communication and language differences or barriers. Language proficiency – right accent, grammar, spelling, style – are necessary for a job search, a successful entry into a profession, acceptance by peers in a profession, successful integration into the profession, and a chance for promotion (Boyd & Schellenberg, 2007; Frieson, 2011; Newton et al., 2012). Further, recent immigrants' lack of knowledge of embedded and underlying cultural assumptions in their professions can affect trust and collegiality at work, and thereby impede their professional integration (Frieson, 2011). Skilled immigrants must acquire language skills, as well as learn cultural norms that

shape practice and interaction with co-workers, employers, and clients. This can be a steep learning curve that can further delay immigrants' entry into the labour market.

2.3.5 Influence of Race

The intersections of race, gender, ethnicity and class have also been found to relegate particularly immigrant women and members of racial minorities to low-skilled jobs and encourage their descent into poverty (Krahn & Lowe, 2002). Cresse and Wiebe (2012) have noted that this trend has worsened over the last two decades as a result of economic and organisational restructuring and 'flexibility' leading to an increase in non-standard work. There is considerable evidence that those of racial and ethnic minority origin are more likely to be discriminated against and their foreign credentials discounted in the Canadian labour market. Alboim, Finnie and Meng (2005) and Esses et al. (2006) argue that in order to understand the economic integration of immigrants into the Canadian labour market it is important to understand the source of their human capital. Immigrants from Asia, Africa, and the Caribbean have their credentials most often discounted. Social characteristics such as racial and national origin, as well as age and gender were found to contribute to the disproportionate discount of the credentials of visible minorities (Reitz et al., 2014). This places racialized groups in a disadvantageous position. Stewart and Dixon (2010) argue that racial minorities also experience racial discrimination, stereotypes, prejudice, structural and interpersonal racism that results in wage and wealth inequalities in the labour market. In examining the wage disparities that exist among men in the United States, Stewart and Dixon found that racial inequality modestly varies by immigrant status. White immigrants fared best in the labour force, followed by Asians, Latinos, and Blacks. Additionally, an analysis of all the census groups by Teelucksingh and Galabuzi (2005) showed that the biggest decline in labour market participation was observed among racialized groups together. Thus, racism further undermines the ability of immigrants to integrate into the Canadian labour market (see Krahn & Lowe, 2002).

2.3.6 Downward Social Mobility

Krahn et al. (2000), Bauder (2003), Grant and Nadin (2007), Cresse and Wiebe (2009), Guo (2013) and many other scholars have reported the downward social and occupational

mobility of racial and ethnic minority immigrants upon their arrival to Canada. Underemployment, engagement in low-skill and low paying jobs, non-recognition of foreign credentials and the need for recertification, cultural displacement, as well as racial discrimination all work together, in direct or indirect ways to create a condition of downward assimilation for recent immigrants. Research suggests that racialized members of the second or third generation face similar difficulties (Reitz & Somerville, 2004; Heath, Rothon, & Kilpi, 2008). Grant and Nadin (2007) after studying 180 skilled immigrants to Canada from Asia and Africa found that most of them were overqualified for the positions they held. They had difficulty obtaining a suitable job in their own profession. Hence, these highly skilled immigrants faced unemployment, underemployment and low incomes below the poverty line. Grant and Nadin (2007) further reported that 77.4 percent of their respondents worked in professions with the highest NOC skill level classification before migration; however, only 40.2 percent were able to find jobs that matched their level of expertise. Additionally, they note that it was professionally trained refugees who had experienced the most downward mobility due to their inability to get suitable work. Similarly, Creese and Wiebe (2009) after studying 61 recent immigrants from sub-Saharan Africa reported three-quarters of the participants experienced downward occupational mobility with the majority engaged in low-skill, low wage, and insecure forms of survival jobs. Professional/occupational mismatch vis-a-vis poor employment and income outcomes can be argued to facilitate this downward social mobility and the plunge into poverty (Guo & DeVoretz, 2006; Guo, 2009).

2.3.7 Segmented Assimilation Theory

Segmented assimilation theory provides an explanation for the downward social mobility experienced by immigrants who are members of visible minorities. According to segmented assimilation theory, assimilation is not possible for all. Rather, racial hierarchies and limited economic opportunities are barriers that hinder integration, at least for some groups (Portes & Zhou, 1993; Zhou, 1999). Portes and Zhou (1993) argue that immigrants' race and economic positions intersect to create three distinct incorporation pathways across immigrant generations: path 1 – traditional assimilation into the White middle class; path 2 – selective integration when immigrants of color

retain ethnic ties and culture to facilitate upward socioeconomic mobility (Portes & Zhou, 1993; Portes & Rumbaut, 2001); path 3 – downward assimilation into a racialized minority with limited economic opportunities (Portes & Zhou, 1993; Bloemraad et al., 2008). Portes and Rumbaut (2001) further explain that the path taken by first generation immigrants is fuelled by their human capital, their mode of incorporation into the host society and their family structure; this in turn differentiates them from the path their children (2nd generation) take. The evidence provided in the literature above is most related to the third stream of the segmented assimilation theory. Buffeted by the forces of systemic and racial discrimination, non-recognition of credentials, and cultural displacement, many skilled professionals have only limited access to the labour market. These conditions then facilitate their downward descent to lower skilled and lower income jobs. However, it should be noted that there are few (e.g. the Chinese) who through the interaction of cultural attributes and social structural factors achieve upward mobility (see Zhou & Xiong, 2005; Zhou & Kim, 2006)

2.3.8 Split Labour Market Theory

The arguments of Segmented Assimilation Theory find some correspondence with Bonacich's (1972) Split Labour Market theory, which seeks to explain why people from different ethnic backgrounds may be paid differently for substantially similar work. As the literature on immigrants' labour market outcomes shows, immigrant labour is routinely undervalued, and Visible minority immigrants are paid less than others. Skilled labour has successfully mobilized to protect their incomes by cutting off minorities' access to opportunities and higher wages (Buzdugan & Halli, 2009). In order to enhance their own position relative to their capitalist employers, ethnic majority workers implement exclusionary measures to protect their incomes and access to jobs, relegating minority workers to positions with lower incomes and fewer opportunities for advancement.

Racial identity then divides the working class into better-paid (White) and poorly-paid (Visible minority) members (Allahar, 2010; Bonacich, 1972). This division is a source of conflict within the working class. Under the current labour market conditions, a large concentration of cheap labour is seen as a means of undercutting the existing labour force

and enforcing docility. The presence of a 'reserve army of labour' made up of members of visible minorities, ensures that White workers will conform. The demand for cheaper labour has the potential to undermine the highly paid.

Historically workers have organized into professions and unions that have sought to protect the employment opportunities and incomes of majority workers, by excluding minority workers. Exclusions have been made on the basis of race and ethnicity, training and education, and citizenship. Such exclusions increase the ability of White workers to bargain with their employers, at the expense of minority workers (Bonacich, 1972). These exclusions can relegate minority workers and immigrants to dirty, dangerous and demanding jobs.

Agnes Calliste (1987) provides an excellent example of the operation of split labour markets in Canada in her study of "Sleeping Car Porters in Canada." She shows how Canadian and American-born Black workers were relegated to the position of sleeping car porter on Canadian railways, and denied opportunities for promotion and better wages, despite their high levels of human capital and skill. The rail workers' unions supported, and indeed fought for, these discriminatory practices. Calliste (1987) argues that the employment of Blacks was partly a product of labour shortage and was also a means by which the company could displace troublesome and potentially expensive labour. Calliste (1987) posits that the railway companies collaborated with the White-worker dominated unions to displace Blacks from higher paying jobs.

Split Labour Market Theory is a helpful addition to Segmented Assimilation Theory, as it draws attention to the capitalist labour market context and actual processes through which members of visible minorities are marginalized. In combination, the theories shed light on the experiences of Visible minority immigrants to Canada. Both theories identify the pathways through which immigrants are marginalized in the Canadian economy, and the racism, business practices, and activities of dominant workers that combine to effect this marginalization.

The relevance of these theories is demonstrated by the extensive sociological literature that identifies the downward assimilation and marginalization experienced by skilled

immigrants (Pendakur & Pendakur, 2000; Picot, 2004; Grant & Nadin, 2007). Racialized immigrants and women appear to have the worst labour market outcomes. Nonetheless, the literature on downward assimilation has predominantly focused on immigrants in general; case studies of immigrants in specific occupations and professions are increasing in number, but this is still an understudied area. Thus, we know little about how these processes play out across professions, and whether there is heterogeneity amongst professions, and immigrants' experiences of them. This begs the question – is downward economic mobility common to immigrants in all professions or occupations? What are the profession-specific challenges immigrants face as they attempt to integrate into the profession? It is in this context that the following discussions will centre on the nursing profession and why it is a valuable case study for understanding immigrants' entry and integration into the labour market.

2.4 Nursing as a Valuable Case Study

To explain why the nursing profession is a valuable case study for exploring the career pathways and lived experiences of immigrants, I will first provide a brief history of the profession in Canada, and outline its status as a regulated profession in Ontario. Thereafter, I will examine the gendered and racialized nature of the profession, and finally, narrow in on immigrants in the nursing profession with emphasis on the challenges they face, and the impact of these challenges on immigrant nurses.

2.4.1 A Brief History of Nursing in Canada

Nursing emerged in Canada during the Victorian era – a time of idealism, philanthropy, and social change. During this time, the roles of women were socially being reconstructed, and opportunities for women were on the rise. Nursing both adapted to, and challenged, Victorian ideals of respectability and middle-class femininity. It violated prevailing notions of femininity by its very nature as an occupation for women, outside the home, which required respectable women to be in close physical contact with people outside their intimate circle (McPherson, 1996). At the same time, it was an occupation which celebrated and incorporated Victorian notions of women as self-less, caring, and devoted to others (Bramadat & Chalmers, 1989; Flynn, 2011). In the 19th century,

conditions in hospitals were appalling; hospital administrators, following guidelines from Florence Nightingale, sought to reform hospitals by placing well-trained, middle-class white women in positions where they could provide care to patients. This elite position was not only a function of class and gender, but also of the social relations of race, ethnicity, and nativity (Bramadat & Chalmers, 1989; McPherson, 1996)

Bramadat and Chalmers (1989) identify three distinct models or phases of nursing education: the Nightingale model, a hospital-based apprenticeship model, and a professional model. The Nightingale model was prominent in the UK, but never really took root in Canada.

McPherson (1996) reports that in the late nineteenth century, with the increase in hospitals, hospital-based nursing expanded. Hospitals could not afford many trained nurses, however, and they relied heavily on the labour of nurses-in-training. Under the hospital-based apprenticeship model, nursing students would combine lectures with work on the hospital wards. The first formal nursing program based on the hospital apprenticeship model was established in 1874 at the General and Marine hospital in St. Catharine's, Ontario (McPherson, 1996). Nurses would obtain practical experience of nursing at the hospitals, and upon graduation would predominantly work as private duty nurses in patients' homes. Educational recommendations of Florence Nightingale were used to facilitate the use of nurses as a source of cheap labour for hospitals. In these hospitals, student nurses were under the authority of a small number of trained nurses, and medical doctors (Coburn 1974; McPherson, 1996). Private employment brought more autonomy, but it was precarious and low paid. During the Depression, the situation was particularly dire for nurses. The demand for private nursing declined as people were not able to afford their services. This made nurses see hospital employment as more attractive (Coburn 1974; Bramadat & Chalmers, 1989).

Although the hospital-based apprenticeship model lasted well into the twentieth century, by the 1920s, nursing education and the job itself began to change. Nursing regulation, and registration for formally trained nurses, began in Ontario in the early 1920s. It took three to four more decades before the regulatory body, the College of Nurses of Ontario,

was established. (Adams & Bourgeault, 2004). Nursing education advanced as well in this era. Up until the Second World War, the Canadian Nurses Association provided a curriculum guide which enabled hospital schools to maintain their autonomy from post-secondary institutions.

By the 1960s, the health care system expanded greatly, with government support, leading to greater diversification of nurses' roles and functions. Nursing education moved away from hospitals and into community colleges, and later universities. The first nursing degree program was started at the University of British Columbia in 1920 (Coburn, 1974). Nursing itself became more scientific and specialized, especially in critical and neonatal care (McPherson, 1996). The fight against sexism and the drive for professionalization further led to improvement in educational standards and the development of a distinct body of knowledge on nursing with a unique framework of practice (Coburn, 1974; Bramadat & Chalmers, 1989; Adams & Bourgeault, 2004). The pursuit of professionalization has made nursing within every province and territory a regulated profession that upholds stringent standards and practice which distinguish trained nurses from the untrained and fosters nurses' autonomy. Today there are 154,047 regulated nurses in Ontario composed of 111,287 RNs (including 2,362 NPs) and 42,760 RPNs (CNO, 2015).

2.4.2 Professional Work and Nursing

Nursing is a regulated profession in Canada, and its status as a regulated profession shapes not only the nature of nursing work, but also entry to practice. There is a substantial literature on professions. Briefly, this literature explains that professions are a special type of occupation, characterised by certain traits such as specialized knowledge, the presence of a professional association, advanced training and education, a service orientation, and a code of ethics (Adams & Welsh, 2007). Professions are also characterized by some degree of power. Freidson (1970) and Johnson (1972) argue that professions can be distinguished from other occupations by their ability to control their occupation, their work, and the labour of those who work with them. This power is achieved through processes of social closure, and by a profession's relationship with the state (Adams, 2010). Through social closure processes professionals cut off access to

privileges and opportunities to non-professionals. State sanction of these restrictions (limiting entry to practice to those who are trained at accredited institutions, for example) makes them effective. Regulated professions are governed by legislation that grants them specific regulatory and practice privileges on the condition that professional bodies act in a manner that will protect the public and the consumer (Adams, 2010). After an appraisal of the different definitions given to professions, Adams (2010: 66) defines them as ‘organized occupations with status whose relations with the state, the public, and other professional groups are structured and regulated.’”

Nursing was first regulated in Ontario in the early 1920s. The first legislation simply established a register for nurses, so that people could distinguish the trained from the untrained. Trained and registered nurses, could claim the title “registered nurse.” Medical doctors in Ontario were opposed to nurses being granted more substantial professional privileges. Nursing did not become fully self-regulating profession in Ontario until legislative change in the 1950s and 1960s; in 1961 nurses regulatory body, the College of Nurses of Ontario, was legally established. While male-dominated professions like medicine and dentistry were able to obtain a number of regulatory privileges, and legislation that limited who could practice in their fields, the female-dominated profession of nursing faced more resistance from legislators (and medical doctors) when it requested similar privileges. It wasn’t until the legislative reform of the final decades of the twentieth century, that nursing’s professional status came closer to that of the male-dominated health professions.

The practice of nursing has long been ‘open’. That is under early nursing legislation, anyone could work as a nurse, but only the trained and credentialed could call themselves “registered nurses.” The profession was historically dominated by White, middle-class women who could afford the formal training. As nursing practice became more closed over time, only those who obtained nursing education from an accredited institution and completed all of the formal entry requirements could practice in the province. Those without these qualifications, including the foreign-trained, must obtain them before they are allowed to practice in Canada. As Adams (2015) has argued the rationale is that practice by the unregistered could put the public at risk.

Entry to practice restrictions provide an inherent barrier to practice. No-one who has not obtained education at an accredited institution can practice. Research has shown that these restrictions affect some groups more than others. The poor may not be able to afford post-secondary education, and may not have the cultural capital to succeed in school. Immigrants are particularly affected. While some foreign schools are deemed equivalent to Canadian educational institutions, others are not – particular those located in non-Western countries. This creates many problems for immigrants as documented above. Specific to nursing, Ogilvie and colleagues (2007) identified the licensure challenges of IENs in Alberta including (1) the lack of clarity regarding the licensure process, (2) ethnic/racial discrimination, (3) the length of time for assessment and remediation, (4) ambiguity with regards to educational equivalencies, comparable nursing education and clinical experience, (5) increased costs associated with upgrading, and (6) the lack transparency, consistency, and equity in the determination of readiness to practice. Ogilvie et al (2007) recommended the following policy initiatives in overcoming such barriers. They suggested the need for the government to invest in IENs licensure process which will expedite their professional entry, the absorption of costs incurred through government subsidies, the use of web-based refresher programs, the creation of appropriate-level language proficiency courses for professional practice, and the accessibility to competence assessment and remedial programs. It seems likely that Ogilvie et al.'s (2007) findings are generalizable to other Canadian provinces, notably Ontario, which has the highest number of IENs in Canada (Kolawole, 2009).

Apart from accreditation and certification challenges that need to be surmounted, visible minorities and foreign educated professionals have to deal with the gendered and racialized nature of the nursing profession.

2.4.3 Gendered and Racialized Nature of Nursing

Nursing is a strongly female-dominated profession. Men's participation in nursing increased from 5.6 percent (13,985) in 2005 to 7.4 percent (20,674) in 2014 (CIHI). Research suggests it is also a strongly gendered and racialized profession. The employment pattern and duties associated with nursing profession were based on gendered and racialized ideologies that were pervasive in the late nineteenth and early

twentieth centuries. The reigning ideology of domestic work and Eurocentric beliefs defined nursing as work for middle-class White women (Flynn 2011; Coburn 1974; McPherson 1996).

The nursing profession was regarded as a feminine ideal: it honoured nurturing and self-sacrifice. Nightingale is reported to have insisted that women of the upper and middle classes could make a respectable career out of being a mother to the destitute. She indicated that nursing was an extension of the domestic (home) work (Coburn, 1974). Nursing was regarded as the epitome of a woman's nurturing, serving role – it was not to be regarded as an occupation like others; “the attitude that women's work in the home was her primary duty, was reflected in hospital regulations, as well as the pressures of public attitudes, prohibiting women from remaining in the profession after marriage” (Coburn, 1974:156). Women at the time were socialized to respect male doctors. They were to show wifely obedience to the doctors (e.g. they were to stand whenever a doctor was present; have traits like quietness, gentleness, patience, endurance) and motherly self-devotion to the patient (Coburn, 1974, Carpenter, 1993; Calliste, 1996; Adams & Bourgeault, 2004). The work and identity of nurses was characterised as caring while that of the doctor was curing. With this dichotomy, the latter was seen to require compensation within a capitalist framework while the former was likened to unpaid labour. Consequently, nurses received lower wages for their labour since their work was only seen to be supplementary to the primary duties of a woman to her family (Reverby, 1987; Coburn, 1974; Melchoir, 2004). This gendered ideology has prevailed over time and still persists. Even after gaining autonomy through professionalization, nurses are still institutionally subordinate to physicians as the final authority when it comes to patient care. They cannot give diagnoses (Melchoir, 2004; Adams & Bourgeault, 2004). To some extent, today's direct care nurses, like their early twentieth century antecedents, “assist with initial medical treatment, execute subsequent tasks, and monitor patients progress, while physicians retain control over the conceptualization of medical knowledge and practice” (McPherson, 1996:16). This asymmetrical relationship maintains the gendered hierarchy within the healthcare system in Canada.

The position of Black female nurses within this gendered hierarchy was historically worsened by racial ideology. People who were not Anglo-Saxon were considered to be socially inferior. Flynn (2011) argues that until the late 1940s, Black women were excluded from nurses' training because nurses wanted to keep their elite position which hinged on Eurocentric and middle-class standards. Racial and ethnic minority women had to perform according to a culturally established set of behaviours, appearances, mannerisms and other cues that matched the image of a middle class White woman to be accepted as real nurses. Even when they sought training in the United States and returned, they had difficulty getting a job (Calliste, 1996). The thought of a Black woman in nursing did not fit the ascribed status or image of a nurse. McPherson (1996: 17) reported that "in the eyes of hospital administrators and nursing leaders, Canadian women of non-European heritage could not be relied on to reflect the morality of health at the bedside, to meet the standard of gentility demanded by elite patients, or to negotiate the tricky sexual terrain of patient care." Being brilliant alone was not enough for the job; brilliance had to be complemented with the right image and attitude (Flynn, 2011). Black women faced opposition with serious implications when they failed to perform the role of the proper student nurse. Their position in the job hierarchy affected the compensation they received relative to their White counterparts. Glenn (1992) argues that job hierarchy and differentials in pay were based on real differences in skills and responsibility. However, she notes that the division between skilled and unskilled jobs highlights the racial division of labour; i.e. differences existing between nurses and nurse's aides are typically racial. With technological advancement, nurses began engaging in more technical tasks, such as taking temperature, pulse, and respiration, administering drugs, intravenous drips and bandaging wounds. These tasks were performed by RNs who were mostly White, while the less technological aspects of patient care were given to practical nurses and nursing aides who were mostly Blacks (McPherson, 1996; Flynn, 2011). Consequently, the intersection of race, gender, and class in the Canadian society can be seen to have defined nurses' occupational status and work roles.

Although a lot of inroads have been made in the nursing profession, the characterization of the nursing profession as hierarchical, gendered, racialized and class based continues even today.

2.4.4 Immigrants in Nursing (Challenges and Consequences)

Immigrant health care providers, “particularly those of colour, experience both implicit and explicit forms of racism in terms of barriers to access in practising their profession and status of position” (Bourgeault, 2010:54). Calliste (1996) argues that Black nurses’ admission into Canada as permanent immigrants was based on racialized conditions. They were to have qualifications that exceeded those of their White counterparts. This reproduced the subordination of Black nurses’ within a gendered and racialized profession. Even after they obtain entry, foreign-trained nurses have additional challenges, finding the professional environment unwelcoming and complex (Komlodi, Caidi & Abrao, 2014). The result, according to Calliste (1996) is racial segregation in the occupation as Visible minority nurses are relegated to positions as nursing aides/ personal support workers or as licensed practical nurses (see Glenn, 1992). When they work as RN’s, nurses of colour are marginalised and treated as the ‘other’. Even with their qualifications and skills, they are perceived to be less competent, less skilled and less disciplined than their White counterparts. Additionally, because they occupy the lowest positions in the nursing hierarchy, in times of hospital restructuring they are the first to be laid off, demoted or dismissed often with the excuse of incompetence.

Calliste (1996) and Das Gupta (2009) have outlined the different patterns of racism faced by Visible minority nurses. These include targeting, scapegoating, excessive monitoring, marginalization, infantilization, underemployment and denial of promotion, co-optation and selective alliances, bias in work allocation, and discipline for minor or non-existent problems. These patterns of everyday racism faced by immigrant nurses create toxic work environments that consequentially hinder their integration (upward mobility) into the nursing profession.

2.5 Purpose of the study

Generally, the extant literature as examined – either theoretically or empirically – paints a bleak picture for most skilled immigrants especially those from third world countries. The findings suggest that almost all immigrants, and especially Blacks, experience downward social and economic mobility upon their arrival. However, it is unclear from

the existing literature whether second and third generation immigrants of colour experience the same challenges as the first. The literature also lumps together the experiences of immigrants in all professions, thereby suggesting that the challenges and outcomes faced by immigrants in their entry and integration into the different professions are the same. The literature fails to acknowledge the heterogeneity and uniqueness of each profession. Further, there are a few studies that show the influence of race as a source of conflict at the workplace that concomitantly deprives visible minorities of opportunities for integration. When this has been examined, it is mostly within Visible minority groups without a comparison to other ethnic and racialized groups. Further, most of the studies reviewed lump the experiences of immigrants together, without differentiating between 1st generation immigrants or 1.5/2nd generation immigrants and their source countries.

Using the nursing profession as a valuable case study, this study seeks to illuminate our understanding and provide answers to the gaps highlighted in the extant literature by exploring the career pathways and lived experiences of immigrants in two Ontario cities. This will be done in three distinct papers. The first paper, will examine the different career pathways, challenges, and professional integration of both Canadian born and foreign born RNs and RPNs working in Ontario. It will highlight the factors that shape the entry of immigrants into the nursing profession while comparing them to the native-born. The second will explore nurses' experiences of abuse and discrimination by patients and their families with emphasis on racial status. It will explore the impact of this abuse, and how nurses cope with it; with a focus on how experiences differ for White and Visible minority nurses. The third paper will examine intra-professional (nurse to nurse) conflicts and its implications for professions and their development. It will examine the sources of these conflicts, how nurses cope with these conflicts, and the implication of these conflicts on professional unity.

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Chapter 3

3 Exploring the Career Pathways of Nurses and their Integration into the Nursing Profession in Ontario, Canada

3.1 Introduction

In their study of Canada's nursing shortage, Murphy et al. (2009) claim that the shortage of registered nurses who provide direct, clinical care to Canadians will increase from nearly 11,000 full-time nurses in 2007 to almost 60,000 full-time nurses in 2022. Current statistics from the Canada Institute for Health Information (2015a) show a decline in the supply of regulated nurses by 0.3 percent over the previous year. The number of nurses not renewing their registration was found to exceed the number entering the profession (CIHI, 2015b). More specifically, the supply of registered nurses (RNs) decreased by 1.0 percent, with a slow growth in the supply of registered practical nurses (RPNs) at 1.4 percent. In order to counter this looming shortage, they recommend strategies to reduce absenteeism, increase enrolment in RN education programs, and steps to reduce attrition in nursing education programs. Although not a strategy recommended by Murphy and colleagues, others have advocated that the entry of skilled immigrants can address shortages in health care professions like nursing (Zietsma, 2010). Canada's immigration policy aims to recruit skilled immigrants, regardless of their country of origin, to ensure that immigration brings significant social, cultural and economic benefits to Canadian society. Nonetheless research has revealed that the path of skilled immigrants into regulated professions is not an easy one (Basran & Zong, 1998; Boyd & Schellenberg, 2007)

In Canada 8.6 per cent of Registered Nurses (RN) employed in 2012, graduated from an international nursing program (CIHI, 2011; CFNU, 2012). Many other Internationally Educated Nurses (IENs) seek entry, but fail to complete all of the provincial entry requirements (Bauman et al., 2006). Among the barriers identified by Bauman and colleagues are delays and difficulty in registration, obtaining educational upgrading, gaining language competence, and passing the licensing exams. Others agree that the

entry and integration into nursing for immigrants is cumbersome (Flynn, 2011; Ogilvie et al., 2007; Kawi & Xu., 2009). Studies of immigrants in other professions identify similar challenges with the accreditation process, in addition to occupational mismatch, discounting of credentials, non-recognition of foreign education and experience, social closure practices of professional organisations, discrimination, and structural and interpersonal racism (Li, 2003; Buzdugan & Halli, 2009; Chiswick & Miller, 2010; Stewart & Dixon, 2010). As Boyd and Schellenberg (2007: 2) argue, “while highly educated immigrants are recruited on the basis of their potential professional contributions to Canadian society, the re-accreditation requirements they must meet often act as barriers to the full utilization of their skills.” Consequently, the career paths taken by immigrants may be marred by institutional/systemic challenges, life course events, and racial discrimination (Batnitzky & McDowell, 2011; Moyce et al., 2015) leading to a downward socioeconomic mobility.

This study seeks additional insights into the career pathways and challenges faced by immigrant nurses in Ontario, through a case study of the career pathways and professional integration of both Canadian born and foreign-born RNs and RPNs working in two Ontario cities. It reveals that the pathways pursued by those born and/or raised in Canada, and those raised elsewhere are markedly different. Immigrant nurses experience many barriers and challenges that hinder their ability to pursue a career in nursing. Barriers are particularly acute respecting education, accreditation, and landing one’s first job. Those immigrants who are able to overcome these hurdles, however, are able to integrate successfully into the nursing profession, and enjoy the benefits promised by the profession.

3.2 Theoretical Framework

Traditional assimilationist theories of immigration depict a linear process by which immigrants give up past languages, identities, cultural practices, and loyalties to assimilate into their new society (Gordon, 1964; Alba & Nee, 2003). However, over the last six decades, many scholars have questioned this depiction of immigrant integration (Rumbaut, 1997; Zhou, 1997; Alba & Nee, 2003; Xie & Greenman, 2005). New immigrants to Canada and the United States are quite distinct from earlier cohorts in two

ways. First, there has been a shift in new immigrants' countries of origin towards Latin America, Asia, and more recently Africa. These immigrants become racial/ethnic minorities in their new countries, and have been less able to integrate into the White middle class. Second, research argues that new immigrants have more diverse socioeconomic backgrounds compared to earlier immigrants (Portes & Zhou, 1993); hence, they will start out on different 'rungs' of the class system. Further, economic change – specifically the decline of manufacturing – has also been seen as limiting opportunities for immigrant integration (Portes & Zhou, 1993; Massey, 1995). Although the distinctiveness of new immigrants may have been overstated (Alba & Nee, 1997; Perlmann & Waldinger, 1997, Xie & Greenman, 2005), it seems clear that these immigrants have not experienced the linear assimilation into the White middle class spoken of in earlier theories.

In response, new theoretical approaches have been developed, including theories of segmented assimilation and reactive ethnicities (Rumbaut 1997; Zhou 1997). Assimilation is here defined as the achievement of equal footing in the host society's primary groups and social institutions. According to segmented assimilation theory, assimilation is not possible for all. Rather, racial hierarchies and limited economic opportunities shape barriers and hinder integration, at least for some groups (Portes & Zhou, 1993; Zhou, 1999). Portes and Zhou (1993) argue that immigrants' race and economic positions intersect to create three distinct incorporation pathways across immigrant generations: Path 1 – traditional assimilation into the White middle class; Path 2 – selective integration when immigrants of color retain ethnic ties and culture to facilitate upward socioeconomic mobility (Portes & Zhou, 1993; Portes & Rumbaut, 2001); Path 3 – downward assimilation into a racialized minority with limited economic opportunities (Portes & Zhou, 1993; Xie & Greenman, 2005; Bloemraad et al., 2008). Portes and Rumbaut (2001) further explain that the path taken by first generation immigrants is fuelled by their human capital, their mode of incorporation into the host society and their family structure; this in turn differentiates them from the path their children (2nd generation) take.

There is a fair amount of empirical support for this theory in studies of immigrant's experiences in Canada. Immigrants have higher unemployment rates and lower employment rates than their Canadian-born counterparts (Statistics Canada, 2015), especially when they are members of visible minorities (Tran 2004). Those with foreign-degrees earn less than those with Canadian degrees (Statistics Canada, 2015, Li, 2001; Reitz, 2007). Immigrants face employment discrimination, and have difficulty finding good jobs in their fields without Canadian job experience (Bauder, 2003; Li, 2003; Buzdugan & Halli, 2009). Immigrants are also over-represented in non-standard jobs (Fuller & Vosko, 2008). Evidence suggests that recent cohorts of immigrants have trouble integrating into the Canadian economy, and that immigrants who are members of visible minorities have a particularly difficult time. Immigrants seeking entrance to professions also experience the discounting of their credentials, difficulty in transferring occupational skills, problems with language proficiency (Green & Green, 1999; Boyd & Schedullenberg, 2007; Houle & Yssaad, 2010). Limited social networks in addition to limited support from ethnic community social structures can also limit their ability to find work, and thereby broadly impede their integration into Canadian society (Fernandez-Kelly, 1995; Zhou & Kim, 2006).

Do these overall patterns hold for individual occupations? Studies suggest that they do. For instance, research shows that migrants tend to fall to the bottom of the hierarchy of care work suggesting a downward assimilation into poverty (Hondeganeu-Sotelo, 2007; Picot et al., 2008). In accordance with segmented assimilation theory, Visible minority immigrants cluster at the low end of the occupational distribution. For instance, a 2015 report found that African Canadian immigrants were over-represented at the low end of health services jobs in London Ontario with 31.9 per cent of the women employed in health services or work as Personal Support Workers (PSW), although 33.5% of them had foreign university diplomas and degrees (Woldemicael et al., 2015).

Nevertheless, there is not yet an extensive literature on immigrant nurses in Canada. Research has identified some barriers associated with the accreditation process in nursing (Bauman et al., 2006; Oglivie, 2007). The entry-to-practice requirements for nursing in Ontario are detailed in the next section.

3.3 Nursing Registration in Ontario, Canada

To practice as a registered nurse (RN) or Registered Practical Nurse (RPN) in Ontario, Canada, candidates must be registered with the College of Nurses of Ontario (CNO). Registrants must meet the following requirements. They must have successfully completed an accredited nursing education program (RN or RPN). They must have recent practical work experience: most Ontario applicants automatically meet this requirement by completing a nursing program approved by the college within the past three years. Candidates must also have passed the CNO registration examinations for the type of nursing they want to practise. In addition they have to pass either the RN or RPN Jurisprudence Examination. To enter practice, nurses must demonstrate proficiency in either English or French. Further, they must be a Canadian Citizen, a permanent resident of Canada, or hold authorization under the Immigration and Refugee Protection Act (Canada) to engage in the practice of nursing in Ontario. Before registering one must also truthfully state whether one has ever been found guilty of an offence, or been refused registration. Finally, they must declare whether they suffer from any physical or mental condition or disorder that could affect their ability to practice nursing in a safe manner (CNO, 2014a,b,f).

These requirements are the same for everyone, but they create many challenges for Internationally Educated Nurses seeking to practice in Canada. For instance, IENs may have difficulty getting their education assessed or recognized as equivalent. Further challenges are associated with a recent addition to nursing registration requirements. In 2013, the CNO established an objective structured clinical examination (OSCE) to test applicants' real-life nursing practice experience and assess their knowledge, skill and judgment in a setting as close as possible to real-life clinical experience; a multiple choice exam (40 questions) was added to the assessment (CNO, 2014c,d,e,f). They may also need to write TOEFL for the assessment of their language competency. Comparatively, IEN's have additional procedures they need to follow relative to their Canadian educated counterparts.

How do these requirements disadvantage immigrants seeking entry to nursing and what is the impact on their careers? In accordance with segmented assimilation theory, are

immigrants (1st, 1.5, 2nd generation), especially members of visible minorities, less able to integrate into professional careers? Are they channeled into the lowest-paying, least attractive nursing jobs? Or do they have opportunities for integration? This study explores the experiences of immigrant nurses, examining their pathways into their careers, and how these differ from the pathways of Canadian –born nurses.

3.4 Methodology

A qualitative research design was used to explore the career pathways of nurses and their experiences in Canada. The research was approved by a university ethics review board. Brinkmann (2014: 278) explains that qualitative interviewing is “the most objective method of inquiry when one is interested in qualitative features of human experience, talk and interaction because qualitative interviews are uniquely capable of grasping these features and thus of being adequate to their subject matters (which is one definition of objectivity)”. This study employed one-on-one, semi-structured, in-depth interviews using open-ended questions and intense probes to gain insight into nurses’ experiences, and also to illuminate the complexity and nuances surrounding the career pathways of immigrant and non-immigrant nurses, and their ability to integrate into the nursing profession.

3.4.1 Study Participants

Purposive sampling was used in the selection of a sample of direct care nurses working in two Ontario cities. In view of this, hospitals, nursing homes, private care agencies, and organizations that aid in the smooth transition of foreign trained nurses (such as Care Centre for Internationally Educated Nurses) were visited and informed about the study. Interested nurses were requested to contact me through email or the contact number on the posters. Further, passive snow ball sampling was used to locate both immigrant and non-immigrant nurses. This method was chosen to identify nurses in direct care, as well as those who had ever worked in direct care. Participants were very thoughtful about recommending other nurses to me. Interviews were conducted with a largely heterogeneous sample of registered nurses and licensed practical nurses engaged in direct care nursing. Most of the interviews were conducted at the hospitals and the homes of the

nurses with a few conducted at community libraries. Recruitment was conducted in both a mid-size and a large (more ethnically diverse) Ontario city. A total of 70 RNs and RPNs were interviewed: 42 nurses were immigrants and 28 were non-immigrant. This number was attained at the point of saturation where no new information or themes were observed in the data. Of the 70, 32 were White (Caucasian) and 38 were members of a Visible minority originating from sixteen different countries¹. Fifty-five of the participants were Canadian Educated while 15 were Internationally Educated. A full description of the sample is given in the results section.

3.4.2 Interviews

The interviews varied in length from forty minutes to two hours forty minutes. In the former, the respondents were mostly working at night in the hospitals and were interviewed before their work, during their breaks, or after their working time; also, most of the respondents in this category were non-immigrants who had been educated in Canada. Consequently, they had less to say about the challenges they faced on entering the nursing profession. Longer interviews were more common with immigrant respondents who described at length the complex issues and numerous challenges they experienced while seeking entry into nursing. This notwithstanding, the interviews were guided by a list of questions framed within key themes which gave some consistency to each of the interviews. The answers provided by each respondent at the onset of the interview influenced the order that was followed in interviewing the person. This is in accordance to DeVault's (1990) notion that the researcher and participant make meaning together.

¹ The usage of visible minority in this study is tailored to the 2009 standard classification of Statistics Canada and also the Federal Employment Equity Act. This category includes persons who are non-Caucasian in race or non-White in colour and who do not report being Aboriginal. This category includes Chinese, South Asians, Blacks, Filipino, Latin American, Southeast Asians, Arab, West Asian, Korean, and Japanese. Examples of visible minorities: Blacks (Black Africans, West Indians, Caribbean), Indo-Pakistani (Bangladesh, East Indian, Pakistan, Sri Lankan), West Asian and Arab (Afghani, Armenian, Egyptian, Iranian, Iraqi, Jordanian, Lebanese, etc), Others (Latin Americans, Indonesian or Pacific Islanders). Please refer to <http://www.statcan.gc.ca/concepts/definitions/minority01-minorite01a-eng.htm>

The interviews began with general questions on what motivated the respondents to enter nursing. They were then asked more specific questions on the educational routes they had taken to nursing, their career histories, the time it took for them to get jobs after graduation, the challenges they encountered in getting into the profession and a description of their current jobs. Both Internationally Educated Nurses (IENs) and Canadian Educated Nurses (CEN) were questioned on their experiences of the obstacles and supports they had encountered in pursuing this profession. Further, probes (such as ‘can you provide me with details’, ‘can you explain further’, ‘describe clearly to me’) were used to investigate in-depth the experiences of nurses for clarity of responses, for interpretations, and to garner interactive opportunities with the respondent in establishing a sense of rapport and also to reduce the risk of social desirability bias (Lousie Barriball & While, 1994; Doody & Noonan, 2013; Brinkmann, 2014).

There were instances where respondents were not forthcoming in describing the challenges they had faced. However, less of this was seen with immigrants as they saw me as a fellow immigrant interested in the work they did and hoped my study would make it easier for subsequent immigrants to navigate their way into the profession with greater ease.

All the interviews but two were audio-taped with the consent of the nurses. For the two who refused to be recorded, I took notes. Detailed notes were also taken during the interview process to ensure the context of responses made was captured.

3.4.3 Data Analysis

The transcription and analysis of the narratives followed a systematic approach using software to ensure rigor and to enable a rapid identification of major strands and patterns emerging from the interview (Seale & Silverman, 1997; Crozier, 2004; Fernandez-Kelly & Konczal, 2005). In the transcription process, the audio recording was played slowly and repeated often using “Express Scribe Transcription Software” to ensure the transcription accurately reflects the respondents’ views and statements. Using the MAXQDA software, the transcripts were systematically coded to develop themes. The first level of coding was done using the semi-structured interview schedule which was

already structured in themes. This was followed by a second level of coding (sub-codes) which was done in situ of the first coding to categorise similar and different views on a particular theme. The third level of coding incorporated themes that were newly derived from the study. The identification of themes followed a particular criterion: (1) frequency (themes with the largest number of mentions were considered important), (2) universality (how predominant the same theme was across different research participants), (3) differentiation (relative importance of different themes in different groups), and (4) emphasis (emphatic speech or emotional speech) (see Baxter & Eyles, 1997). By using various commands within the retrieved segments of the software, I was able to produce cross-tabulations of narratives on different themes for immigrants and non-immigrant nurses. For instance, with the help of the software I was able to derive narratives of participants who were internationally educated and faced challenges in making an entry into the profession. A few research participants (4) were contacted again to review the themes to determine if they accurately reflected their experience. They had no queries of the themes; rather they added more details for clarification (Lincoln & Guba, 1985). The narratives are presented in the following section. Below, pseudonyms are used to protect the identity of my respondents.

Table 1: Description of Participant Characteristics from Interviews (N=70)

Participant Characteristics	Sample Size (N)	Percent/ Mean	Participant Characteristics	Sample Size (N)	Percent/ Mean
Sex			Ethnicity		
Male	7	10	Canadian	30	42.86
Female	63	90	British	1	1.43
Race			Dutch	1	1.43
White (Caucasian)	32	45.71	Ghana	14	20
Visible minority	38	54.29	Nigeria	4	5.71
Immigration Status			Sierra Leone	1	1.43
Immigrant	42	60	India	3	4.29
Non-immigrant	28	40	China	2	2.86
Generation of Immigrant			Filipina/o	2	2.86
Non-immigrant	28	40	Iran	1	1.43
1st Gen. Immigrant	30	42.86	Persian	1	1.43
1.5 Gen. Immigrant	5	7.14	Korea	1	1.43
2nd Gen. Immigrant	7	10	Hispanic	1	1.43

Place of Work			Malta	1	1.43
Hospital	57	81.43	Caribbean	2	2.86
LTC/Nursing Home	9	12.86	Barbados	2	2.86
Hospice	1	1.43	Serbia	1	1.43
Public Health Unit	3	4.29	Trinidad	1	1.43
Place of Educ/Training			Zimbabwe	1	1.43
Canadian Educated	55	78.57	Area of Work		
Internationally Educ.	15	21.43	Sub-Acute Medicine	12	17.14
Current Position at Work			Long Term Care	10	14.29
Staff Nurse/Bed side Nursing Management	58	82.86	Palliative/Geriatrics	3	4.29
Nursing Educator	7	10	General Surgery/Surgical	9	12.86
Supervisor	1	1.43	Neurosciences/surgery	5	7.14
Employment Status			Orthopaedic Surgery	6	8.57
Full-time	4	5.71	Intensive Care Unit	3	4.29
Part-time	58	82.86	Neurology	2	2.86
Casual	9	12.86	Operating Room	2	2.86
Retired	1	1.43	Paediatrics	2	2.86
Period of Work			Psychiatry/Mental Unit	3	4.29
Age	70	10.65(11.02)	Nursing Resource Team	3	4.29
Age Grouped			Oncology	1	1.43
20-29	22	31.43	Emergency	1	1.43
30-39	19	27.14	Cardiac	1	1.43
40-49	13	18.57	Community Nurse	2	2.86
50-59	9	12.86	Management	2	2.86
60 +	7	10	Education	2	2.86
Age Started Working			Convalescent unit	1	1.43
Working	70	27.61(7.38)	Religion		
Marital Status			None	16	22.86
Married	37	52.86	Christian(practising)	35	50
Single	19	27.14	Christian(Non-practising)	12	17.14
Separated/Divorce	6	8.57	Muslims	3	4.29
Common Law	8	11.43	Jewish	1	1.43
Number of Children			Others (Baha'i, Hindu, Buddhism)	3	4.29
Children	70	1.27 (1.40)			

Data Source: Data for this study were collected from different Healthcare facilities in two Ontario cities from June 2014 to November 2014.

3.5 Results

The Foreign-born and Canadian-born have significantly different trajectories into nursing. In this section, I document these distinct pathways, highlighting the variations experienced by the Canadian-born, internationally educated nurse immigrants, and those immigrants who undertake nursing training in Canada. First, though, I provide an overview of the study participants.

Table 1 provides an overview of the characteristics of the 70 nurses who voluntarily participated in the study. Consistent with the distribution of males and females in the nursing profession in Canada, 7 out of the 70 were males with 63(90%) being females. The sample was evenly split: 35 (50%) of the participants were immigrants, and 35 were Canadian-born. Given that the literature suggests that members of the 2nd generation may experience labour market difficulties, while those who immigrate when young (members of the 1.5 generation) may have fewer difficulties than those who immigrate when older, I separated out these two categories in the following analyses. Five participants were members of the 1.5 generation, while 7 were 2nd generation immigrants. Similar, to the distribution of regulated nurses to the hospitals and nursing homes in Canada, 57 nurses worked at the hospital, 10 worked at the Long Term Care/Nursing home, while 3 worked at the Public Health Unit. Again, in line with Canadian nursing educational trends, 55 out of the 70 nurses were Canadian Educated and 15 were internationally educated. With respect to work status, 58 nurses out of the 70 worked full-time, 9 worked part-time, 2 were retired, and 1 worked on a casual basis. On average, the nurses had worked for a period of 10.65 years. The mean age for the participants was 38.26 years. The average age at which participants started working was 27.61 years. The average number of children born to the participants was 1.27. The ethnic background of the participants was wide ranging, 30 of them claimed Canadian origin (White); however, the rest were of the following origins: British, Dutch, Ghana, Nigeria, Sierra Leone, India, China, Philippines, Iran, Korea, Hispanic, Malta, Caribbean, Barbados, Serbia, Trinidad and Zimbabwe. The participants worked in several areas within the hospitals and Long Term Care (LTC); this included sub-acute medicine, geriatrics/palliative, general surgery/surgical, neuroscience/neurosurgery, orthopedic surgery, Intensive Care unit,

neurology, operating room, pediatrics, psychiatry/mental unit, Nursing Resource Team, Oncology, Emergency, Cardiac, community, convalescent unit, education and in management

3.5.1 Career Pathways into Nursing

Foreign-born nurses and Canadian-born nurses recounted distinctly different pathways into nursing practice. These paths are illustrated in Figures 1 and 2. As Figure 1 shows, the path for foreign-born nurses is much longer and more complex, than the pathway for Canadian-born nurses depicted in Figure 2. Nevertheless, it is notable that the paths of study participants eventually converged towards integration into nursing as either a Registered Practical Nurse (RPN) or a Registered Nurse (RN). The diagrams were developed from participants' responses to two key questions: Are you able to give me a brief history of your education into nursing? Kindly provide me with your career history into nursing? Below, the experiences of foreign-born and Canadian-born respondents are recounted separately.

Figure 1: Career Pathways of Foreign-Born Nurses in Ontario

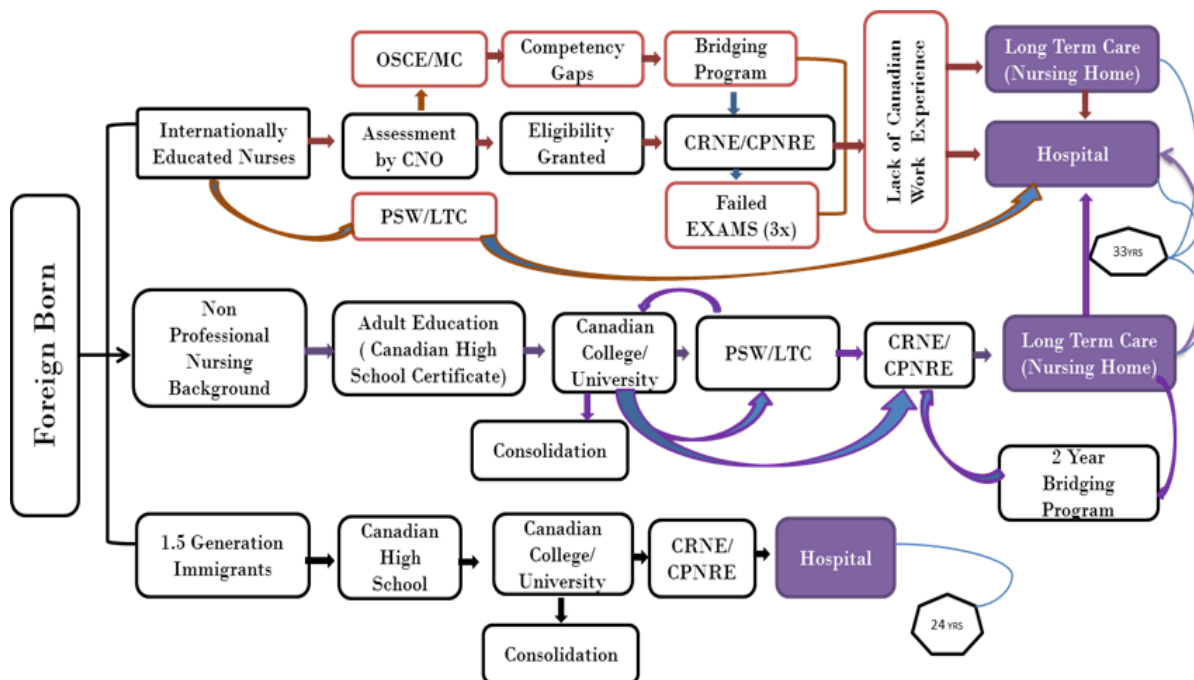
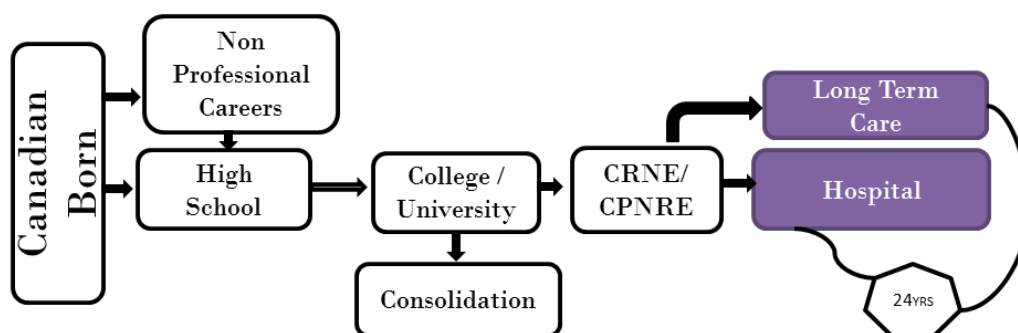


Figure 2: Career Pathway of Canadian-Born Nurses in Ontario



3.5.1.1 Canadian-Born Nurses

As Figure 2 shows, the path for the 35 Canadian-born (native Canadians and second generation immigrants) into nursing was a straight-forward one. From high school, the Canadian born went straight to Ontario colleges or universities where they completed a nursing education program. Upon completion they wrote the registration exams and either worked as RNs or RPNs in the Hospitals or LTCs. They acquired work experience during the last year of their schooling, working in the hospitals for their “consolidation.” Many obtained full-time jobs at the same hospitals in which they obtained their work experience. The average age at entry into the profession for those who followed this path was 24 years. This path was the same for 2nd generation immigrants in spite of their ethnicity or race.

Virtually none of the respondents reported substantial difficulties with this path. Out of the 35 participants, only one wrote the registration exams a second time. In this sample, most (32 out of 35) pursued a degree program and became Registered Nurses (RNs). Out of the 35, 6 of the participants had previously pursued a degree in a different program (usually health sciences) before moving into a nursing program. After graduating from high school, it took an average of four and half years to get into the nursing program, four years to finish the degree program in nursing, and just a few months to obtain employment in their field. The quotes below illustrate the directness of the educational and career pathways taken by this group:

I have relatively a straight pathway. I went straight from high school to University. I got my Bachelor of Sciences in Nursing for the 4 years... My integrative practicum in fourth year was in clinical neurosciences in [a] Hospital. I applied for a job half way through my practicum and I was

accepted and I have been working there for the past three years. [CEN, Female, RN, 3 years, Neurosciences]

I went to high school and graduated. I went to ---- university for the Bachelor of Science in Nursing. With that, I qualified to write the exams. Wrote that, worked in a hospital, floating in the medical surgical area. I saw the opportunity to work in the OR... then I took the peri-operative course. So now I am qualified to work in the OR and I work there now. [CEN, Female, RN, 2 years, Operating Room]

So I went to ---- high school which is also known for academics. They offer a lot of the basic courses. Everything is more like accelerated. In high school I took all the mandatory courses. I didn't even realise I was taking them. They made it easier to go into nursing. From there I went to the [university and pursued a collaborative program] for four years. After that I graduated and started working. [CEN, Female, RN, 3years, Orthopaedic Surgery, 2nd Gen-Black]

Most of the nurses in this group, worked in different areas of hospitals where they earned good remuneration and benefits. This groups' smooth transition reveals the significance of having been educated in the Canadian school system.

The significance of Canadian education can further be seen by a consideration of the experiences of members of the 1.5 generation -- that is, those who came to Canada at a young age. The third path of Figure 1 shows, members of this group had similar experiences to the non-immigrants. The five participants in this category were members of visible minorities. All five went from high school to university, and into a hospital job, like their Canadian-born counterparts. They reported no challenges with university, the registration exams or employment, despite their ethnic minority status. The average age at which they started work was 24 years; the same for the non-immigrants

They have the main school and they have a classroom just for the transitional students, i.e. new immigrant students coming in. They thought the language was a problem. We spoke English, it was mostly for cultural integration. After maybe a year or two, I was out of that program and I went into main stream elementary...I went through High school and then I went to ---- college which was one of the best schools to go for nursing at the time. I graduated 2.5 years later. I wrote the exams, passed the exams, worked for a while. I worked in different areas. [CEN, Female, RN, 29years, Neuroscience, 1.5 Gen – Black-Jamaica]

...I completed middle school grade 8 in Canada after I left Ghana at the age of 14. I went on to high school here and then completed grade 12, graduated with the high school diploma, then I went into my first degree which was in communications. It was a three year program. After I graduated with a bachelor in communications, I went on to pursue nursing, which is a four year bachelor of science in nursing degree leading up to the profession. After the nursing degree, I wrote the CRNE to be certified in order to practice in Canada... I started practicing as a registered nurse. [CEN, Male, RN, 3 years, Psychiatry, 1.5 Gen]

Overall, regardless of Visible minority status, those who had completed high school in Canada had a smooth and relatively short transition into nursing practice. The experience of foreign-born nurses was significantly different.

3.5.1.2 Foreign-Born Nurses

Foreign-born nurses, with the exception of the 1.5 generation immigrants, faced significantly different, and more complex and interrupted, transitions into nursing careers. Two distinct pathways are evident. The first path, at the top of Figure 1, is the path pursued by internationally educated nurses, which as the figure shows, was particularly complex. The second was the path pursued by immigrants who were educated in another field and decided to undertake nursing after arriving in Canada, and often, after having difficulty obtaining a job in the field in which they had prior training. These paths will be discussed separately.

3.5.1.2.1 Internationally Educated Nurses (IENs)

The first path in figure one, with dark orange arrows, represents the pathway of Internationally Educated Nurses. IENs on arrival reported they were assessed on their credentials and for those who came in after January 2013, they had to complete the Objective Structured Clinical Examination (OSCE). When they passed, they were eligible to write the registration exams (CRNE/CPNRE), which allowed them to practice as registered nurses or registered practical nurses in Canada. Even after passing they reported barriers in obtaining employment and entering practice. This resulted in most of them finding work in Long Term Care facilities to obtain work experience, before moving to the hospitals. Those who had gaps in their credentials after being assessed were made to take bridging programs in order to be eligible to write the registration exams. Those who failed the exams on the third try were made to go back for further education before returning to write the exams again. IENs on arrival worked as PSWs in Long Term Care facilities until they acquired the necessary qualification to allow them work as RPNs or RNs in either the hospitals or LTC facilities. The barriers and delays associated with this path resulted in a later age at entry: they finally starting practice as RNs or RPNs at an average age of 33 years.

IENs experienced many delays and difficulties gaining access to nursing, and their lack of Canadian work experience, difficulties with language competency, and limited social contacts further hindered their career pathways.

3.5.1.2.1.1 Delays

IENs identified six different types of delays, affecting their career trajectories. First, some experienced delays associated with the gathering of all the information required by the College of Nurses of Ontario (CNO) for assessment. These delays come from the university or college or the healthcare facility where the IEN studied or worked before moving to Canada. While for a few participants the delay was only a few months, for others it took up to two years, to acquire all of the documentation required. Abigail explains her situation:

I registered with the College of Nurses here in 2004. I was asked to produce my registration details from Ghana which included my transcripts from Ghana Nurses and Mid-wife Council. I had to gather all this information to the college before they will give me the chance to write their exams here to get the license. Ghana did not bring the credentials on time. I was here until 2005. By the time I got the transcript there were a number of changes in the system. So I could not write the exams, I had to do refresher courses. I did refresher courses: some in ---- college, some courses at [another school]. I finished in 2007. It took 3 years for me to finish with my refresher courses. After that, they registered me in the college to write the exams. I wrote the exams and by the grace of God I passed [IEN, Female, RPN, 7 years, LTC]

There were a few nurses who before or upon arrival, got their credentials assessed because they had fore knowledge of what was required and were made eligible to write the registration exams either without any conditions or on condition that they take a bridging program. Once they passed, they moved on straight into practice. Such was the story of Keziah. She explains that

“In 2008 [I called] CNO and I told them I am a nurse, and I will like to be a nurse in Canada. What should I do before coming? They sent me a form and a package and asked for some documents from the nursing station in Iran, my workplace and my University from which I graduated. Whiles back home my documents were assessed and I was given the permission to write the exams as an RN in general class. But they also offered me to do some bridging program here that is totally free. It helps you to be familiar with the system. I took that, it was almost six or seven months in college. I got that certificate in the bridging program. After that I passed my exams and then I got my License [IEN, Female, RN, 4 years, sub-acute medicine]

Keziah had social contacts who helped her learn what was required, and enabled her to minimize the delays. The friends she had in Canada directed her to the CNO. On arrival, she had to do a bridging program for seven months. While in school, she also worked as a PSW. On completion, she wrote the CRNE and passed. She is now a Registered Nurse working in a reputable hospital.

The second form of delay is associated with assessment. There were participants who experienced few delays because their nursing education was deemed equivalent to

Canadian training. These included nurses who were trained from the United Kingdom, the United States, the West Indies, and from the Philippines. On the other hand, a few of the IENs had to wait for almost a year to get their credentials assessed and the report sent back to them. In the interim, the only opportunity they had to work was to be employed as PSWs. Some made this choice to help them pay their school fees and also to pay for their living expenses. Having to work, as well as prepare for the exams also prolonged the preparation period. With the recent introduction of the OSCE and the multiple choice exams, IENs commented that it was going to be difficult for subsequent nurses not to have gaps.

When I came here, one of the difficulties I found, they will not readily offer me my license until I got a work visa. The government would not give me a work visa until I got a license from the College of Nurses. I found they worked against each other. In the meantime, the university had offered me a job and I kept putting it off. I couldn't get a license and I could not get a work permit. In the end, somebody from professional practice here called the College of Nurses and helped me through the hurdles, and they were able to facilitate the smooth receipt of the license. I am not able to tell which came first, the work visa or the License. [IEN, Male, RN, 15years, Cardiac]

I was recruited from Britain by a nursing agency to address a shortage of nurses from the rural areas in Canada. When I arrived in Canada (Alberta), I had to do another program to get my licence. This lasted for two years. However, I wanted to work in a ---- hospital so I migrated to [this city]. But I wasn't picked. I had experience working in all the different units but they thought the experience I had was not enough. Consequently, I started working for a nursing home. This is how I started working with the elderly [IEN, Female, RPN, 23years, LTC].

When IENs are deemed to have competency gaps, they have to enrol in a bridging program in order to be eligible to write the registration exams. This may also take between one to three years to complete as we find in the narrative of Abigail above. For a few of the IENs, after assessment they were only eligible to write exams for a lower level of practice. A case in point is found in the narrative of Uche, a male registered nurse from Nigeria: *"I was a registered nurse in Nigeria, licensed but after the assessment here with the college, they gave me RPN which is registered practical nurse. I had to sit for the exams...and I passed. Then the college licensed me to start practising as an RPN."* To practice as a registered nurse (RN), he needs to enrol in a bridging program before he can take the RN exams; this he hopes to do in the near future. This process prolongs the path to integration.

The third delay is associated with nurses who have to write TOEFL in order to be eligible to write the exams. This was also found to take 1-2 years. If it is not done on time, the nurse might have to start the process all over again since the time given to write the

exams is fixed at 3 years from the time the nurse arrives in the country. For those who studied in a foreign language, having to learn everything afresh in a new language was more difficult. Nora, a Registered nurse from Malta, explains that

I found it hard that I had to go back to high school. Uhm...the program is so tough and sometimes English people don't understand what the professor is saying, imagine those with English as their second language. It is much tougher. I had to learn everything new. Like diseases, I know them in my language; it is not the same for other Canadian students because they have been brought up hearing those words. Even at work, sometimes it is hard to understand certain terms. [CEN, Female, RN, 1.25years, Neurology]

A fourth delay was reported by those who did not have the right immigration papers to work. These workers needed their employers to apply for a Labour Market Impact Assessment (formerly Labour Market Opinion) to allow them to obtain the required work permit, or needed to obtain their permanent residency status. IENs find it difficult to obtain the labour market impact assessment as many employers are unwilling to apply: as one IEN stated, *“they are not going to hire somebody if they have to do paper work.”* In the case of Robert, a registered nurse, now working in LTC, it took three applications by his employer before he was approved.

Fifth, nurses reported delays and difficulties in passing the nursing exams. Lacking knowledge of the Canadian Health Care system and work practices, they were at a disadvantage. Some of the IENs (7 out of 15) explained they needed to attend refresher programs before making the attempt. Emily, a registered nurse from India indicated that *“Most of the questions are ethics related. You don't think about it but it is ethics related. You should know the ethics and you should know the culture. You need to know what goes on in Canada otherwise you can't answer the questions.”* In the case of Fatmattah, a registered nurse currently working in a Paediatric unit, after failing the exams the first time, she explains that

I thought I needed some Canadian experience just to see how to do the Canadian exams. I applied everywhere and I wasn't getting any job. Eventually, I got a job in the nursing home in ----- as an assistant. This helped me a lot. From there I knew how the Canadian system is, how it is different and how it would affect my exams. Then after six months, I [registered for] my exams and I got through”.

For others, such as Bono, a male registered nurse from Nigeria, they ended up joining the CARE Centre for Internationally Educated Nurses. Bono explains that

“On my own, I went to join the Care 4 nurses project. It is like the refresher program organised by some people for Internationally Educated Nurses. I joined that for maybe 3 or 4 months to have an idea of what nursing in Canada is all about. Throughout that time I was also studying to write the exams. So I did and I passed. I started work in here in July 2002”.

Sixth, a few of the IENs also complained of delays in getting their license. Abiba, now a General Surgery nurse indicated that *“after the exams, I had to wait 10 or 11 months to get my license. I passed but somehow the processing part delayed. It didn’t really get through. From the day that I wrote the exams to the day I got my license, it took 10 or 11 months. After I got my license, I got a job within a month.”* For those who were waiting for their license to start practising as RNs, they worked as PSWs or with temporary licenses in the LTCs which provided them with the right experience for them to work in the Hospitals once their licenses were ready.

As these nurses’ stories reveal, there are many delays associated with becoming registered to practice. Nurses usually cannot afford to spend years obtaining the education and credentials they need without working, so many take on other jobs as PSWs or in related fields. While working in these fields gave them valuable Canadian experience, having to work while retraining or waiting for approval, further delayed their entry into nursing.

3.5.1.2.1.2 Canadian Work Experience

After passing the exams, the IENs had difficulty entering nursing practice, especially in their desired fields and locations, without Canadian work experience. Cassey a registered nurse from Iran explains:

How am I going to get experience if nobody hires me? I did so many interviews, I went to workshops in Toronto, I drafted my resume. I talked to one of the recruiters she told me ‘oh first we usually hire our own nurses, then our own nursing students, if we have anything left we will consider you’. I said Whao!!! It is so mean. Yeah, that was my story. I said people who come here, they think the problem is getting the license; the problem is that after, getting a job is problematic

The IENs explained that the hospitals were ready to employ nurses who did their consolidation/placement in the hospitals (implying preference for Canadian education), which was not an option for IENs but for only those who had been educated in Canada. Those who did their consolidation in the hospitals were found to have the experience of working on the floor and have knowledge of the rules governing the floor, which was also a disadvantage for the IENs. This was made more evident by an IEN who had to take

a bridging program and hence, was fortunate to have the opportunity to do her consolidation in a particular Long Term Care facility. Upon completion, although she applied to other hospitals, it was only the LTC facility that offered her a job.

Many IENs who wanted to work in hospitals, began in LTCs to obtain work experience. Out of the fifteen (15) IENs interviewed in this study, 12 of them had to start working in LTC. Only three went straight to the hospitals; most of those who started at the LTCs were later able to transition to a hospital job. This has been labelled by the IENs as the “continental offer.” Sarah, who came in as an IEN and currently works in a hospital Orthopaedic unit, explains that *“I worked for three years in India before I came to Canada. I started working in the nursing home. I worked in the nursing home for 17 years. In between there, I applied to [the hospital], I got a job here. I have been working here since 2008”*. Massa and Florence also explain that:

I got one interview here. I worked 7 months and I went off to Long term care. I got a position as PSW; I worked there for 5 months. In between I got my license. And I tried to work there as RN. I did not have any joy there. I quit that job after 10 days as RN and applied here [hospital]. I had an interview and that is it. [IEN, Massa, 6 years, Palliative, India]

Before I got the license...I worked as a PSW in the nursing home for 3 years. When I got my papers, they employed me as RN... [IEN, Florence, 19 years, Convalescent unit, Ghana]

IEN's reported other barriers including issues with language, and difficulty in locating jobs without social contacts. Nevertheless, everyone in my study eventually found work in nursing. It was a difficult and long process, however. The average age at which IENs started working in either the hospitals or Long Term Care was 33 years. Although the study recorded a minimum of 23 years and a maximum of 53 years, those who started working at the average age and above were mostly members of visible minorities, while those who started working below the average age were mostly Whites.

The main barriers to IENs were experienced prior to receiving their license. All of the IEN participants obtained work within a year after being licensed as an RN or RPN, in a hospital or in a long-term care facility. Some found work immediately, while others had to wait for some months. Nevertheless, their pathway into nursing was long, and for many arduous.

3.5.1.2.2 Immigrants with Non-Professional Background in Nursing

The second path outlined in Figure 1, signified by the purple arrows, represents the pathways taken by immigrants with no professional nursing background prior to immigrating to Canada. Many of these individuals originally tried to find work in the fields in which they were trained, but ran into difficulty. In the participants' own words,

Back home I did business accounting um...when I first moved here my aunty was already a nurse and she discouraged me from doing business accounting because there will be no jobs for me. I didn't know very much about the nursing profession to be honest [CEN, Female, RN, 3 years, Sub-acute Medicine]

Back home I was not a nurse, I was an accountant. When I came to Canada in 2002 I tried to get my CAG, I got level 1 and then I think level 3. But it was very expensive... I could not get a job as an accountant. The most I could get was an accounts clerk. With that kind of money I can't take [care of myself and go back to school]. After about 3 years of trying [to get] into the accounting field I just gave up and decided to go into nursing. I decided to do nursing because there are a lot more jobs available for nurses. [CEN, Female, 6years, Geriatrics, 1st Gen]

Some of these participants had friends or relatives in nursing who encouraged them to switch careers. Others simply identified nursing as a more promising path for an immigrant in Canada. Nursing was seen to open good job opportunities, and provide a good income.

These nurses were trained in Canada, but to access nursing training programs they had to possess a Canadian high school certificate, or equivalent. Those without it or who had gaps in their high school credentials were made to go back and take requisite courses in English, Math and Science. This allowed them entrance into the college to pursue a nursing program. Most, however, did not pursue a degree program directly; they enrolled in a Personal Support Worker (PSW) program which lasted between 6 months for full-time to 12 months for part-time. This was influenced by a number of factors such as the lack of funds, family responsibilities, and acquisition of permanent residency status in Canada. Hence, on graduation, they worked as PSWs in LTCs to raise funds for further schooling and to support their families. In the course of time, they went back to school to pursue either the degree program or diploma program in nursing which allowed them to work as RNs or RPNs in the hospitals or LTC. Those who chose the RPN due to age, family responsibilities, and financial constraints, upon graduation went back to work in the LTCs and those who were lucky, in the hospitals as Registered Practical Nurses.

However, those whose ultimate goal was to obtain the RN certificate, upon working for a while went back to do a two year bridging program that allowed them to practice as Registered Nurses. This also enabled them to work in the hospital which was considered to be the optimal place of work for immigrants.

While these pathways into nursing were often quite a bit smoother than their IEN counterparts, the pathways were long and interrupted ones. Mabel's path is somewhat typical:

...I graduated in 2005 from ----, after a five month program [in PSW]...uhm...which my High school credentials were good enough to do. After that I worked for about five to six years as a PSW. I worked for 2 years in the community and five or six years in LTC after I moved to [city a]. I decided to go back to school for the RN program...I applied two times to ---- University to a collaborative [university – college] program ... The first time, I did not get through; they said my credentials were not complete. The second time I applied with several follow-ups; they told me I had to get extra credits in Maths, English, Chemistry and Biology. So I went back to [an adult education centre] for a year and took seven credits of high school education. Grade 11 and grade 12; with that they also made me write a letter, because I was a mature student and had a baby at the time. It was just a week before school opened that I got a call indicating I had been accepted into ---- University to do the four year program [CEN, RN, 3 years, Sub-acute Medicine]

Many participants pursued nursing education in steps due to challenges with family responsibilities, kids, and financial constraints, as they had to pay their way through. They used their high school certificate to do the PSW program in college and worked for a while before going back to College to do the RN program. Apart from the requirements of the university for her to pursue nursing, Mabel's experience also illustrates the role family responsibilities play in delaying immigrants' efforts to enter into the program. Life course events such as pregnancy and delivery prevented her from pursuing the nursing program immediately; this is rarely the case for the Canadian-born nurses, since they tend to enter the profession at a young age. A similar scenario is exemplified in the narrative of Adisa, a native of Nigeria:

The path to nursing for me is quite different from all others. I remember coming from Nigeria, I had to go to ---- where I did the adult education. My uncle wanted me [to do] nursing. I went to -- -- for three months. Did a course in English; at the end of that I went to college to do the pre-health science. I did the pre-health science for 8 months, then I applied to the nursing program at -- -- university and --- college; you are allowed to apply to both of them. You choose where ever you want to go to. I chose the university for my four years. I went to school [in] 2009, I was done in 2013. [CEN, Female, 1 year, Neurology]

The interrupted pathways into nursing of these immigrant nurses reveals the strategies, immigrants pursue to become economically integrated. They balanced working full time

and being a full-time student, in addition to taking care of children. In the case of Shinai, I also find the bridging of gendered roles as she had to work to help support her household, and to save enough money to pay for her schooling. The complex career paths pursued by these nurses resulted in them entering practice at an average age of 33 years. It is not surprising, then, that immigrants find themselves been supervised by nurses of similar ages when they enter practice.

3.5.2 Career Integration

A look at the career pathways of immigrant and non-immigrant nurses is incomplete without a consideration of their career status. Foreign-born nurses were more likely than their Canadian-born counterparts to work at long-term care facilities, a work environment my respondents depicted as less attractive than work in the hospitals. White participants were also more likely to be in positions of authority.

Despite these differences, the nurses I spoke with reported good incomes and job opportunities. Foreign-born nurses appeared to earn the same income as their Canadian-born counterparts. Most of the participants estimated an average income of \$54,873.6 per annum for new graduates upon entry into the profession based on a reported hourly pay of \$28.58 (40 hours/week) for full-time Registered Nurses. This figure was reported to increase to an average amount of \$80,640 per annum for full-time Registered Nurses in direct care after working for 20 years. Registered Practical Nurses (RPNs) had varied incomes; those who worked at the hospital made more money than those who worked at the LTC. RPNs on entry made an average of \$44,160 per annum based on hourly pay of \$23.00 for those who worked at the hospital. This amount was reported to be \$2-\$3.00 lower for those who worked in the LTCs. The hourly pay has seen an increase more recently. Registered nurses upon entry made on average \$31 per hour, RPNs who worked at the hospitals made average \$26 while those who worked at the LTC made \$23. The amounts reported by the participants suggest that after working for an average of 10 years, both Registered Nurses and Registered Practical Nurses fall within middle to lower middle-class categories, making the nursing profession one which is most envied and respected by immigrants.

At least 30 of the immigrants indicated that through the nursing profession they have been able to support their families, acquire both fixed and variable assets (e.g. houses, cars, etc) either by themselves or together with their husbands, own small businesses, and/or are able to send remittances back home. The following narratives express the gains made from nursing when nurses were asked to comment on their satisfaction with nursing.

To be honest, it has given me so many opportunities not just in terms of jobs but in terms of my life. Because of nursing, I have been living independently from my parents; I haven't asked money from my parents since I was 19 years old. If anything I have given my parents like some help too. And I am very proud to say that because of my job, I give my sister money...she is in University too and instead of my parents giving her pocket money I give her pocket money. That's because of my job and because of nursing, I was able to go on two trips this summer...I went to the Bahamas, I went to Disney...because of nursing I was able to move from city a to city b, own a house ...and because of nursing I have met so many people too and so I will do it all over again. [CEN, Female, 2.33 years, Neuroscience, 1st Gen., Filipina]

I was depending on my mother, now I don't depend on her, I rather support her. Working as a nurse has given me independence. It helped me buy a house; I am able to buy anything I want. Do things without asking for help from my mother. I have been able to send money home to my grandparents and my cousins who are still in school. Because of my job, I was able to sponsor my husband to Canada. It really helped to speed up the process because of the amount I make in my job and its stability. It only took 6 months for me to do all the processes. [CEN, Female, 3 years, Surgical unit, 1.5 Gen., Ghanaian]

Personally, it has opened my intellect and my ways of knowing regarding the health care system...With the knowledge I have acquired you always have a job....besides acquiring two cars, a house which was my choice, for me the money I make goes to savings. I can look forward to a better future for my family. I can enrol my kids in various activities [such as hockey, soccer, and swimming] regardless of the cost. I am living a stress free life financially. I am not living pay check to pay check...I am able to contribute to the Canadian system; I am not dependent on government assistance. I also know of lots of nurses that are not dependent on the government [CEN, Female, RN, 3 years, Sub-acute Medicine, 1st Gen., Black]

There are several things that one could look at. 1. In terms of job mobility, it is difficult not to notice an opportunity whereas in other professions you may have slight difficulty jumping from one job to the other. 2. You are able to compete so far as you have your [license] because you had similar training here in Canada. 3. In meeting your needs, the pay is not bad. You are able to without much difficulty meet your needs; the pay is not bad compared to other professions...the nursing job offers me opportunity to go into the medical program...you get easy acceptability into the medical program.[IEN, Male, RN, 6 years, LTC, 1st Gen., Nigerian]

The opportunities as expressed in the nurses' narratives are phenomenal; however, the extent to which participants optimized the opportunities was influenced by their age of entry, life course events, satisfaction with present position, and personal aspirations. Of these factors, age of entry and life course events emerged as key factors that limited how much IENs and foreign-born Canadian Educated Nurses maximized the opportunities relative to Canadian-born nurses.

3.6 Discussion and Conclusion

This study examined how the present nursing shortage and high turnover within the nursing profession affect immigrant nurses' paths and their integration into Canadian society. More specifically, the study investigated how factors such as immigration status, race, country of origin, and education influenced the transition and integration of immigrants into the nursing profession. This was done by comparing the educational and career paths taken by foreign-born and Canadian-born, and internationally educated and Canadian educated nurses. The study highlighted the challenges and facilitating factors that influenced immigrants' integration into the nursing profession. Key among the findings made in this study, are the distinct pathways that exist for Internationally Educated Nurses (IENs), foreign-born Canadian Educated Nurses, and Canadian-born nurses in their integration into the profession. While Canadian-born nurses had a shorter and a more direct path into nursing, foreign-born nurses had a longer and a complex path into the profession. This notwithstanding, I argue that although immigrants, especially IENs and Visible minority nurses do face complex, systemic, and multidimensional challenges in making a transition into the profession, those who overcome these hurdles appear to integrate into the nursing profession and become economically assimilated into the Canadian society.

Both the segmented assimilation theory of Portes and Zhou (1993) and the reformulated assimilation theory of Alba and Nee (2001) posit that racial discrimination will make it much more difficult for those defined as non-White to achieve upward mobility in a racially stratified economy. In this study, regardless of race or ethnicity, there is evidence of economic assimilation. First, the participants' incomes were similar to the income levels of White middle-class native Canadians. Second, occupational mobility into the nursing profession was converted into financial and residential gain and a path to social and cultural integration (Massey, 1985; Bloemraad et al., 2008; Mendez, 2008). For instance, through the nursing profession the immigrants were able to purchase houses, cars, make financial investments, engage in leisure activities (take vacations), and enroll their children in extracurricular activities regardless of the cost. Third, the study revealed that immigrants who integrated into the nursing profession were not dependent on

governmental assistance, which has previously been associated with immigrants especially members of visible minorities (Gilens, 1995; Winter, 2008). Arguably, the downward assimilation reiterated in lots of research on immigrants' especially Visible minorities has been partial (Silberman et al., 2006; Picot et al., 2008). Through the nursing profession – working as a Registered Nurse or Registered Practical Nurse in a hospital job –first generation visible minority immigrants and their children are able to assimilate into White middle class without having to wait for the next generation. There are some immigrants who do struggle in the short term due to the experience of delays; however, in the medium and long-term they do assimilate into the middle class.

Also, the findings in this study suggest no differences between 1.5, second generation, and other Canadian-born once they acquired their Canadian education. This underscores the nursing profession as offering an occupational pathway that allows the wages of native born to be at par with the wages of immigrants (ethnic minorities). Where there are even delays, immigrants especially IENs do catch up.

Additionally, the findings of this study provide little support to the theory of selective acculturation (Portes & Rumbault, 2001), where immigrants use strong social support networks as protection against discrimination and for assistance in navigating the educational system and labour market to achieve upward assimilation. Although coethnic networks had a significant role to play in supporting immigrants navigate the educational system and the labour market (Berkman et al., 2000), networks provided less support against discrimination before their integration into the profession. The key factor that propelled immigrants into the nursing profession was the acquisition of Canadian education in nursing. Regardless of an individual's ethnic background, once they acquired the professional education in nursing, they got employed within a year, enjoying the promised benefits that come with their career. This reinforces the relevance of human capital in the acculturation process of immigrants.

The findings suggest that nursing may be different from many other professions, with a promise of success for immigrants. It seems likely that labour market conditions such as high turnover rates, attrition, and nursing shortage create job opportunities. While

employers may have a preference for White Canadian workers, as queuing theory argues (Reskin & Roos, 1990; Kaufman, 2002), when there are insufficient numbers, employers move further down the queue to employ other qualified workers regardless of their race or immigration status. While there is still evidence that labour queues exist (as minorities are over-represented in PSW work, and nursing in long-term care), those who obtain the necessary qualifications appear to have opportunities for advancement and access to good nursing jobs. Research into immigrant integration into other professions and occupations should consider the role of labour shortages and labour market conditions further.

This notwithstanding, integration into the nursing profession did not come without challenges. Immigrants, especially IENs had to scale the challenges of accreditation, delays and difficulties in registration, upgrading their educational credentials, gaining language and cultural competence, and integrating directly into a hospital job. These challenges are consistent with the findings of Bauman et al (2006), indicating that after almost 10 years of redirecting policies to enable the smooth integration of IENs into the nursing profession, IENs continue to face barriers to registration, accreditation, and employment which delay to a greater extent their integration into the nursing profession. Of course, the nurses I spoke with had navigated these barriers successfully – a bias inherent in the study sample. Nevertheless, this study found that there are some supports in place to help IENs, such as the CARE Centre for Internationally Educated nurses. Such organizations help to minimize nurses' challenges, reducing their schooling, and increasing their odds of passing the registration exams and getting a hospital job within a year of enrolment. Other provinces and professions might implement a similar program to mitigate the challenges experienced by immigrants to Canada. The presence of a variety of work settings to enable IENs to acquire Canadian job experience was also important in this study, IENs quite often found work in Long Term Care facilities, before eventually finding hospital work. This made their previous human capital relevant in the process of integration; IENs could easily retrain and navigate the labour market unlike other professionals (see Boyd & Schelleberg, 2007). Out of the 15 IENs who participated in this study, 12 of them had to start from the LTC before moving to the hospitals. Acquiring the Canadian work experience at the LTC made it much easier for IENs to transition to hospital jobs.

It is also worth emphasizing that the experiences and integration of foreign-born nurses in this study were for most part influenced by life course factors. These factors highlight key tenets of the life course perspective; such as the principle of timing; i.e. “the developmental antecedents and consequences of life transitions, events, and behavioural patterns vary according to their timing in a person’s life” (Elder et al., 2013: 12). First, the age at which immigrants arrived in Canada influenced where they started. Those who came at a young age (1.5 generation) ended up integrating into the profession at the same age (24 years) as the Canadian born – inclusive of 2nd generation immigrants. However, those who arrived at a later age (above age 20) faced a number of barriers resulting in their integration into the profession at an average age of 33 years. Second, the educational qualifications immigrants had upon arrival influenced the competency gaps they had to fill upon assessment and whether they had to start from high school or the University. Most of them had to upgrade to an Ontario Senior Secondary diploma before moving on to college or the University to pursue a nursing program. Married participants had to work to support their husbands while in school. This most often prolonged the years it took for participants to complete the schooling requirement for the nursing program. In addition, pregnancy and births interjected the schooling years shaping their integration into the nursing profession. Consequently, younger immigrants regardless of their ethnic or racial background experience a faster and a more direct integration into the nursing profession in Canada. Theoretically, I find that this study provides compelling evidence in support of Treas’ (2014) proposition for a synergy of life course theories and immigrant incorporation theories in exploring immigrants’ integration. This is most significant as the segmented assimilation theory has been found in this study as inadequate in explaining the integration process of immigrants in professions such as nursing.

Lastly, the findings of this study challenge stereotypes that immigrants are lazy, slow, unambitious and responsible for the economic disadvantages they face (Calliste, 1996). Rather my participants were a tenacious group who worked diligently to achieve upward mobility in their careers. When faced with poor labour market conditions and limited opportunities, many switched careers, preventing a downward assimilation into poverty, and instead achieving upward mobility into the middle class.

There are limitations associated with this study which suggest further avenues for future research. Given that the sample used in this study was not randomly collected, it is difficult to make any form of generalizations. Future research might have to consider a quantitative approach with a random sample to enable generalization. Also, a longitudinal study of immigrants from their arrival to their integration into the profession may help establish a cause and effect relationship. Additionally, future studies may examine a comparison of career paths taken by immigrants into different professions. This will highlight which professions work best for immigrants and which ones offer little opportunity for their economic assimilation into the Canadian society. Finally, as integration into the profession does not end with employment and income earned, it would be valuable to unearth some of the challenges immigrants have to navigate as they progress through the profession.

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Chapter 4

4 “Go Back to Your Country”: Exploring Nurses Conflicts with Patients in Ontario

4.1 Introduction

Nurse retention is essential if we are to sustain the health workforce and ensure quality health care (Murphy et al., 2009). However, there is considerable turnover in nursing, and this has been linked with poor working environments and workplace conflict (McGilton et al. 2014; Laschinger & Fida., 2014). Nurses work in highly stressful environments and are vulnerable to abuse from patients on the job (Shields & Wilkins, 2009; ONA, 2015). There is concern that assaults against nurses are increasing (ONA, 2015). Research on this topic of nursing abuse has not been extensive, however. Existing studies tend to focus on the correlates and extent of physical assaults, but have not examined the issue qualitatively to identify the nature of the abuse, and how immigrant nurses cope. Further, studies have examined how abuse varies by work experience, organizational conditions, and gender, but have largely ignored the potential significance of race and ethnicity to patient-nurse conflict. This study fills a gap in the literature by exploring how Visible minority² status shapes nurses' experiences of patient abuse on the job.

Nurses are professional workers who – although they provide services to their patients – are also typically seen to hold authority of them. For example, Carpenter (1993), following others, argues that patient care follows a ‘patriarchal’ model where doctors are

² The usage of visible minority in this study is tailored to the 2009 standard classification of Statistics Canada and also the Federal Employment Equity Act. This category includes persons who are non-Caucasian in race or non-White in colour and who do not report being Aboriginal. This category includes Chinese, South Asians, Blacks, Filipino, Latin American, Southeast Asians, Arab, West Asian, Korean, and Japanese. Examples of visible minorities: Blacks (Black Africans, West Indians, Caribbean), Indo-Pakistani (Bangladesh, East Indian, Pakistan, Sri Lankan), West Asian and Arab (Afghani, Armenian, Egyptian, Iranian, Iraqi, Jordanian, Lebanese, etc), Others (Latin Americans, Indonesian or Pacific Islanders). The visible minority in this study consist of immigrants, both first and second generation. Please refer to <http://www.statcan.gc.ca/concepts/definitions/minority01-minorite01a-eng.htm>

cast as fathers, and nurses as wives and mothers. Patients are like children – at least until they get well again (Carpenter, 1993). Under such a model, nurses are seen as subordinate to some health workers, but in a position of authority over patients (see Coburn, 1974; Calliste, 1996). Research on service workers more broadly, though, has emphasized that clients and customers can exert power and control over workers. In an environment where the customer is always right, the employee can be in a vulnerable position. Failing to satisfy a customer, even if an employee is otherwise following company rules, can result in a reprimand or even dismissal (Williams, 2003; Macdonald & Sirianni, 1996). Legislation like the “Patients’ Bill of Rights” may put nurses in a similar position where they must work continuously to make the customer happy, or risk complaints to the College of Nurses or hospital leadership. This may place nurses in a vulnerable position vis-à-vis their patients. The situation may be particularly difficult for those nurses with Visible minority status. Racial inequality may further undermine the authority of Visible minority nurses, and leave them vulnerable to abuse on the job.

Through a study of 66 nurses in two Ontario cities – one large and one mid-size – this study explores nurses’ experiences of abuse and discrimination by patients and their families. Further it explores the impact of this abuse, and how nurses cope with it. Ultimately, I argue that nurses are structurally in a vulnerable position vis-à-vis their patients, and that this vulnerability is exacerbated for minority nurses. Broader social inequalities combine with patients’ rights to facilitate the abuse of minority (and other) nurses.

4.2 Workplace Conflict

Many different terms have been used to capture various kinds of negative interactions on the job, including aggressive, uncivil, inappropriate, threatening, antagonistic and demeaning behaviours at the workplace. These terms include workplace incivilities, interpersonal deviance, employee deviance, oppressed group behaviour, counterproductive work behaviours, withdrawal behaviours, aggressive and sexual behaviours (Penney & Spector, 2005; Watson, 2008; Bruk-Lee, 2008; Raver, 2008; Roberts et al., 2009). In this study, I use the term ‘conflict’ interchangeably with abuse and incivilities, to capture negative behaviours by patients and their families.

Conflicts occur in the context of societal, occupational and organizational structures. According to Watson (2008), workplace conflicts can be distinguished at two levels; first, conflict at the level of interest, which is the difference between employers/supervisors and employees over desired outcomes. For example, the differences in management and employee interests on the distribution of resources or ways of completing a task (Bruk-Lee, 2008:96). The second points to conflict at the level of behaviour. This comes about when parties seeking different outcomes either express their differences through gestures such as acting destructively or cooperating in a sullen or grudging manner. It can also emerge from personality clashes or emotionally charged interactions with others (Bruk-Lee, 2008:96). Both levels/sources of conflicts are consistent with Roscigno et al.'s (2009) typology of conflicts into vertical and horizontal interest conflicts. Vertical interest conflicts do arise through vertical authority interactions/relations at the workplace, mostly between a superior i.e. employer/supervisor and the employee. The horizontal interest conflicts emerge out of horizontal interactions that occur mostly between coworkers or between workers and customers/clients. One may question, however, the extent to which conflict between workers and their customers / clients are truly horizontal. In some contexts workers may have authority over their clients, yet in others, the power relationship may be reversed, as the literature on service workers reveals (Fuller & Smith, 1996; Macdonald & Sirianni, 1996).

4.2.1 Workplace Aggressive Behavior

According Neuman and Baron (1998: 395) workplace aggression refers to “efforts by individuals to harm others with whom they work, or have worked, or the organisations in which they are presently, or were previously employed.” Aggressive behaviours include behaviours that are physical, active and direct (Penney, 2008). This behaviour can be categorised into verbal/covert and physical/overt. The verbal/covert forms of aggressive behaviour may consist of expressions of hostility (e.g. negative gestures, staring looks, ostracisms, verbal sexual harassment, acting in condescending manner, bullying, and delivering negative performance appraisals) and obstructions (retaliatory behaviour, intentional work slowdowns). The overt form of aggressive behaviour consists of both mild and extreme acts of aggression. For example: physical assault/attacks, threats of

physical violence, sexual assault/ harassment, and sabotage (Neuman & Baron, 1998; Deery et al., 2011).

4.2.2 Workplace Incivility

Workplace incivility refers to “behaviours that people experience at work that are rude and discourteous, and that generally go against norms for mutual respect and dignity” (Penney, 2008:896). This includes, among other things, violent interactions, being criticized or scolded for an act that was never done, having one’s credibility undermined in front of others, spreading rumours, gossiping, bickering, back stabbing, and shaming; these behaviours create both physical and emotional injuries (Roberts et al., 2009; Roscigno et al., 2009). Penney and Spector (2005) note that incivility is a harmful behaviour that is not necessarily intentional or malicious; it can however be dismissed or denied by the offender. Incivility can also encompass reactionary attitudes or behaviours of individuals who are targets of uncivil behaviour (Penney & Spector, 2005; Deery et al., 2011). Numerous studies have shown that one form of incivility could lead to another form, creating a spiral and in the end a chaotic work environment (Andersson & Pearson, 1999; Deery et al., 2011). The consequences of such incivilities threaten not only the sustainability of nurses in the profession, but also the quality of care provided.

4.3 Interpersonal Conflicts in Nursing

Apart from coworkers, nurses have been found to be bullied and oppressed by doctors and those in managerial positions, reflecting the vertical power relations that exist in the nursing profession (Porter, 1991; Zelek & Phillips, 2003; Almost, 2006; Sirota, 2007; O’Brien et al., 2009; Churchman & Doherty, 2010). However, the nurse-patient and the nurse-family conflict have received less attention by researchers (see Covell et al., 2014).

The few studies that have examined the nurse-patient/family member conflicts have identified bullying, verbal abuse, emotional abuse, sexual harassment, and physical violence as the main forms of conflicts experienced by nurses (Spector et al., 2014). The sources of this conflict have been tied to nurses’ inexperience, inadequate staffing, unsafe design of care units, inadequate patient medication, lower levels of control, and poor organisational support (Shields & Wilkins, 2009; Moylan, Cullinan, & Kimpel, 2014;

Rodwell & Demir, 2014). Most of these conflicts were found to be perpetrated by the elderly or by male patients (Speroni et al., 2014). Similar to patients, family members or visitors were found to abuse nurses verbally and physically through yelling, swearing/cursing, grabbing, scratching or kicking. Most of the conflicts experienced by nurses in this context were verbal rather than physical (Speroni et al., 2014; Spector et al., 2014).

The consequences of nurses' abuse by patients and family members include emotional stress, negative affectivity, injuries, and PTSD. This had the tendency to increase absenteeism, decrease job satisfaction, lower productivity and organizational effectiveness (Hartley et al., 2012). However, these studies are largely quantitative, lacking depth, 'thick description', and detailed explanation of the conflicts (Geertz, 1973; Hesse-Biber & Leavy, 2004). Secondly, they fail to examine the effect of racial identity and immigration status on this form of conflict (Laschinger et al., 2010; Laschinger & Grau, 2012).

Recent change may have altered nurse-patient relations significantly. Hospital restructuring, combined with government legislation, have brought changes that produce stress and strain relations, including the need to keep up with higher standards of work continuously, the increased complexity and demands of current nursing work environments, and budget cuts that affect staffing levels (Martel, 2003; Roscigno et al., 2009; Laschinger et al. 2010; Deery et al., 2011). Add on to these changes, Bill C-261 and Bill 22 – Patients' Bill of Rights. This legislation provides every resident of Canada and Ontario (respectively) with certain rights as a user of the public health care system. These include the right to give or refuse consent to the provision of health care services; the right to all information necessary to make fully informed health care choices including information about who will provide particular services and about the qualifications of those providers; the right to be dealt with by health care service providers with courtesy and respect, in a manner that recognizes individual dignity and privacy and promotes individual autonomy, in a manner that recognizes and responds to individual needs and preferences, including those based on ethnic, spiritual, linguistic, familial, and cultural factors; the right to participate in any assessment of personal care

requirements and in the development of plans for care, and the right to make complaints, raise concerns and recommend changes without fear of interference, coercion, discrimination or reprisal (Martel, 2003:2-3). This legislation, then, gives patients the right to challenge nurses, question their qualifications, and complain about the services provided. This may contribute to an environment where patients create conflict or behave in an uncivil manner with their care providers.

The purpose of this study is to explore the nurse-patient/family conflict experienced by nurses in two Ontario cities, and their coping strategies, with a focus on how experiences of patient abuse vary by immigration status and race. Although there is some evidence that suggests that ethnic and racial minorities may likely experience a lot more conflicts than their White counterparts (Calliste, 1996; Das Gupta, 2009; Derry et al., 2011; Flynn, 2011), relatively few studies compare the conflict experienced by visible minorities and White Canadians. Identifying the different sources of conflicts for the two groups can lead to comprehensive policies that meet the varied needs of nurses in the workforce. Further it is important to understand how nurses cope with these conflicts and how workplaces have endeavoured to minimize them, in order to provide a safe working environment for nurses. As we will see, however, Visible minority nurses are particularly vulnerable to abuse and incivilities from patients. The research questions driving this study are as follows:

1. Does racial status shape nurse-patient/family member conflict on the job?
2. What factors contribute to the experience of nurse-patient conflicts?
3. What are the effects of these conflicts for nurses' wellbeing and integration, and how do nurses cope with these conflicts?

4.4 Methodology

This paper is part of a bigger research study on the career pathways and lived experiences of nurses in Canada. In this study, a qualitative research design was used to explore the experiences of visible minorities and White Canadians, and specifically the conflicts they face in the practice of nursing. The research was approved by a university ethics review

board. This study employed one-on-one, semi-structured, in-depth interviews using open-ended questions and intense probes to gain insight into nurses' experiences of conflicts with patients and family members, to illuminate the nuances around its effects, how they coped with, and resolved conflicts in the practice and in the process of integrating into the nursing profession.

4.4.1 Study Participants

Purposive sampling was used to recruit direct care nurses working in two Ontario cities. The following organizations aided in the collection of data: hospitals, nursing homes, private care agencies, and the Care Centre for Internationally Educated Nurses. Interested nurses were requested to contact me through email or the contact number on the posters. Further, passive snowball sampling was used to locate both White and Visible minority nurses. This method was chosen to identify nurses in direct care, as well as those who had ever worked in direct care. Participants were very thoughtful about recommending other nurses to me. Interviews were conducted with a largely heterogeneous sample of registered nurses and registered practical nurses engaged in direct care nursing. Most of the interviews were conducted at the hospitals and the homes of the nurses, with a few conducted at community libraries. A total of 66 RNs and RPNs were interviewed for the study. This number was attained at the point of saturation where the responses of both immigrants and non-immigrants became repetitive and consistent. A detailed description of the participants is given in the results section.

4.4.2 Interviews

The interviews varied in length from forty minutes to two hours forty minutes. In the former, the respondents were mostly working at night in the hospitals and were interviewed before their work, during their breaks, or after their working time; also, most of the respondents in this category were White Canadians who had been educated in Canada. Longer interviews were more common with Visible minority respondents. The interviews were guided by a list of questions framed within key themes which gave some consistency to each of the interviews. The answers provided by each respondent at the onset of the interview influenced the order that was followed in interviewing the person.

This was done to ensure that the researcher and the participant made meaning together (DeVault, 1990).

Participants were asked if they had experienced any form of conflict on the job. They were then asked more specific questions on the specific forms of conflict they had experienced, the effect it had on them, how they were able to cope with it, and how some of the conflicts were resolved. Both visible minorities and White Canadians were questioned on how they dealt with discrimination when it came up as a source of conflict. Further, probes (such as ‘can you provide me with details’, ‘can you explain further’, ‘describe clearly to me’) were used to investigate in-depth the experiences of nurses for clarity of responses, for interpretations, and to garner interactive opportunities with the respondent in establishing a sense of rapport and also to reduce the risk of social desirability bias (Louise Barriball & While, 1994; Doody & Noonan, 2013; Brinkmann, 2014). This paper focuses exclusively on nurses’ reports of conflicts with patients and their families.

There were instances where respondents were not forthcoming in describing the conflicts they had experienced. However, less of this was seen with immigrants as they saw me as a fellow immigrant interested in the work they did and hoped my study would make it easier for subsequent immigrants to overcome challenges of conflicts in the profession. All the interviews but two were audio-taped with the consent of the nurses. For the two who refused to be recorded, I took notes.

4.4.3 Data Analysis

The transcription and analysis of the narratives followed a systematic approach using software to ensure rigor and to enable a rapid identification of major strands and patterns emerging from the interview (Seale & Silverman, 1997; Fernandez-Kelly & Konczal, 2005). In the transcription process, the audio recording was played slowly and repeated often using “Express Scribe Transcription Software” to ensure the transcription accurately reflects the respondents’ views and statements. Using the MAXQDA software, the transcripts were systematically coded to develop themes. The first level of coding was done using the semi-structured interview schedule which was already structured in

themes. This was followed by a second level of coding (sub-codes) which was done in situ of the first coding to categorize similar and different views on a particular theme. The third level of coding incorporated themes that were newly derived from the study. The identification of themes followed a particular criterion: (1) frequency (themes with the largest number of mentions were considered important), (2) universality (how predominant the same theme was across different research participants), (3) differentiation (relative importance of different themes in different groups), and (4) emphasis (emphatic speech or emotional speech) (see Baxter & Eyles, 1997). By using various commands within the retrieved segments of the software, I was able to produce cross-tabulations of narratives on different themes for visible minorities and White Canadian nurses. For instance, with the help of the software I was able to derive narratives of participants who were visible minorities and faced either aggressive behaviour or incivilities from their patients. The analysis was conducted in a way to make a distinction between the sources and the different forms of conflicts faced by both visible minorities and White Canadians, how they coped with the conflicts, and the means of resolving the conflicts. A few research participants (4) were contacted again to review if the themes accurately reflected their experiences. They had no queries of the themes; rather they added more details for clarification (Lincoln & Guba, 1985). The narratives are presented in the following section. Below, pseudonyms are used to protect the identity of my respondents.

4.5 Results

The results underscore the prevalence of conflicts in the nursing profession, as all participants (66) in this study indicated they had experienced at least one form of conflict recently during practice. However, members of visible minorities were found to report more verbal aggression than were White participants. This section highlights the nuances and complexities associated with conflict experiences of visible minorities and White Canadians, the effects on their work and well-being, the coping strategies they use in the process, and how they resolve these conflicts. First, I provide an overview of the

characteristics of the 66³ nurses who voluntarily participated in the study and are the specifically chosen for this aspect of the study.

Consistent with the distribution of males and females in the nursing profession in Canada, 6 out of the 66 were males and 60 were females. Most of the reports of conflicts were from the females. Out of the total number of participants interviewed, 28 of them were White while 38 were members of visible minorities. Of the Visible minority nurses, 29 of them were 1st generation immigrants, 5 were 1.5 generation (arrived in Canada at an average age of 12 years) and 4 were 2nd generation immigrants (Canadian born). Similar, to the employment distribution of regulated nurses in Canada, 54 nurses worked in hospitals, 9 worked at Long Term Care/Nursing home facilities, while 3 worked at a Public Health Unit. Again, in line with Canadian nursing educational trends, 52 out of the 66 nurses were Canadian Educated and 14 were internationally educated. With respect to work status, 54 nurses out of the 66 worked full-time, 9 worked part-time, 2 were retired, and 1 worked on a casual basis.

On average, the nurses had worked for a period of 10.65 years. The mean age for the participants was 38.26 years. The average age at which participants started working was 27.61 years. The average number of children born to the participants was 1.27. The ethnic background of the participants was wide ranging, 28 of them claimed to be of Canadian origin (White); the rest claimed the following countries of origin: Ghana, Nigeria, Sierra Leone, India, China, Philippines, Iran, Korea, Hispanic, Malta, Caribbean, Barbados, Serbia, Trinidad and Zimbabwe. Of the latter, 5 of them claimed to have dual identities (2nd generation immigrants). The participants worked in several areas within the hospitals and Long Term Care (LTC); this included sub-acute medicine, geriatrics/palliative, general surgery/surgical, neuroscience/neurosurgery, orthopedic surgery, Intensive Care unit, neurology, operating room, pediatrics, psychiatry/mental

³ The original total sample included 70 participants; however, for this particular study I sought to place emphasis on participants who claimed to be visible minorities and White Canadians. Four of the participants excluded from this study were Whites from the US, UK, and Denmark.

unit, Nursing Resource Team, Oncology, Emergency, Cardiac, community, convalescent unit, education and in management.

The next section will examine the different forms of conflicts nurses experience with patients/family members. The themes that emerged were categorized into physical assault, verbal aggression, and sexual harassment.

4.5.1 Physical Assault

Excessive aggression in the form of physical assault of nurses was found to be very common especially from patients suffering from dementia and Alzheimer's; in addition, patients who were coming out of anesthesia were also found to be violent. A total of 17 nurses reported been physically assaulted by the patients. These forms of assaults were seen by nurses to be part of the hazards that accompanied the profession. Nonetheless, a number of the participants reported receiving bruises or other injuries as a result of the physical assaults. The following narratives illustrate this:

Normally on this floor specifically we have a lot of elderly patients who have Alzheimer's uhm...or just have postoperative delirium or a form of dementia. A lot of the times they don't know because they are confused and they don't realise that they are being physically abusive or verbally abusive. In their confused state they can kick, punch, bite, scratch, yell, and curse [Female, CEN, RN, 3.5 Years, Orthopaedic surgery, White]

I had a patient who was confused and my colleague and I were trying to give him a bath and he started swinging his arms. Next thing we know, he was really jumping out of the bed and he had all these invasive lines. It took like six nurses to hold him down while somebody called the code white. It took six of us plus two security men to actually keep the man calm. This is somebody who was really really confused. So you wouldn't hold it against him. It is the hazards of the job. Knowing what to do when it happens is important [Female, CEN, RN, 1 year, Neurosurgery, Black]

Physical assault was also found to be escalated by miscommunication and misunderstanding.

From patients, I got hit by the phone, I definitely feel like it escalated with our communication; I feel she didn't understand what we talked about and her response was to come physical. I felt I was in the wrong place at the wrong time [Female, CEN, RN, 7.5 years, Psychiatry, white Canadian]

In the nursing home we had a lady, if the PSWs needed to bathe a roommate, three people had to go in, because this woman just beat the crab out of one of the PSWs with her cane. She was bruised all down one side, she had broken thumb. She was this little old lady, but she will just wail. So two PSWs will get the roommate ready to bed, usually the nurse will go in and hold the lady back so she could not charge at them. It was an Alzheimer's unit, a dementia patient. They are terrified, they don't know who you are, you are invading their room, you are trying to do very intimate things with them. They don't like it. Sometimes the best approach is to get out of their way and try again later [Female, CEN, RPN, 3 Years, Psychiatry unit, White]

The narratives underscore the abusive actions perpetrated by patients, which point to the dangers these frontline nurses face constantly at work. Comparing the narratives presented by visible minorities and white Canadians, I found that a nurses' ethnic or racial origin played no role in influencing the physical assault; however, these assaults were very common with RPNs (5 out of 9 RPNs), who for the most part in this study were members of visible minorities and nurses who worked in particular departments within the health care system. This included the psychiatry unit, orthopaedic surgery, and neurosciences.

4.5.2 Verbal Aggression

Verbal aggression in the form of hostilities and abuse were meted out to nurses from both patients who were confused and those who were not. Most of the verbal hostilities were made by conscious patients who were not mentally challenged. This came in the form of threats of reporting or harming the nurses, challenging nurses' competence, excessive family demands, yelling with swear words, raising their voices, racial abuse/discrimination, and use of derogatory words. Although both whites and visible minorities had similar experiences, the latter experienced more of these verbal assaults from White patients.

4.5.2.1 Threats of Reporting to Higher authority or causing harm

Participants revealed threats of reporting to superiors, the College of Nurses, or threats of harm when dealing with either patients or their relatives:

I had a patient who for months targeted me; he never hit me, he will follow me to a room and corner me and he will tell me all the different ways he will have me murdered and say this is going to happen, that is going to happen...and he just stopped. [Female, CEN, RPN, 3 years, Psychiatry, White]

I have had patients who are not confused, never physically violent but I have had a handful of time where patients barking orders at you, swearing at you, yelling and raising their voices at you, threatening you. They will be threatening 'I am going to report you because you didn't give me the juice I wanted'. Again not confused just apparently...or I am going to report you because you are speaking too loud and I am trying to sleep. Just stuff like that. I will say it is more of the verbal abuse as a person [Female, CEN, RN, 3.5 years, Orthopaedic Surgery, White]

The narratives show how nurses ended up being abused emotionally since they could not fight back and had no power to withhold care from patients since this violates patients' rights. This gave most patients and relatives undue advantage over the nurses.

4.5.2.2 Challenge of Competence

Members of visible minorities, much more than their White counterparts, reported having patients challenge or question their qualifications. This was particularly true of Black nurses. The Visible minority nurses (at least 15 out of 38) felt they were scrutinized much more than White Canadians when providing care, and several reported being confused for a PSW or cleaner.

Most of the time when you enter into the room they think you are PSW; they don't know that you are a nurse...The moment you start giving medication and needles and things like that they kind of switch because even though you have told them I am your husband's nurse or your daughter's nurse, sometimes it does not register in their brain that you are a nurse and you are supposed to do some complicated procedures. When they see you do some complicated procedures, they question, is she a PSW trying to do this thing so they always try to grab your badge to look at your name and to see the designation on your badge. You get that all the time from the families. [Female, CEN, RN, 6 years, Geriatrics, Black – Sierra Leone]

I have had some instances where people don't know you are their nurse; I come across as their cleaner. For instance, I went to a patient's room and the patient was like you better clean this stuff before the nurses come to do their assessment. I clean the table, I put the things away and I came in and I said I am your nurse. The whole day, it was embarrassing for them. I played along with it... I just wanted them to know you can't judge people by their skin colour. I have seen some family members who come and they see you and they don't think you should be the nurse [Female, CEN, RN, 5 years, sub-acute medicine, Zimbabwe]

Patients question their actions, and doubt their competence. The nurses feel they are under intense scrutiny:

Most have to do with intimidation; you may have someone who is sick...they are not swearing...they ask you about every single thing. If someone does something different from you, they will ask why is this like that and they sometimes develop some education about certain things. And they want you to do it this way or that...it is very intimidating...you know I don't want this thing to happen again...it has happened before and that kind of attitude. I will respond and say I will do my best. When you go to that room you make sure your T's are crossed, your I's are dotted. I think [that kind of intimidation] is worse than the F word [Female, CEN, RN, 29 years, Neurosurgery, Jamaican]

These Visible minority nurses face the challenge of having to prove themselves over and over again to patients. Their reports show that patients associate them with lower class jobs even though they might be wearing a badge that shows their designation as qualified nurses.

4.5.3 Family Demands and Abuse

Another theme that emerged was excessive demands by both patients and family members or relatives. The narrative of Sandra reveals how dissatisfaction with the information given to family members of patients and the source of the information could increase family members' demands and exacerbate verbal assault with the possibility of causing mayhem in the hospital. Sandra explains this in the actions of two family members:

After they had come up to the desk and screamed at the two other nurses that they needed to see a doctor immediately. They were making outrageous demands...They went down and spoke with another nurse in a very rude and demanding ways. I brought a PSW with me as a witness to make sure I covered myself. They went into the room,[one of the family members] immediately, verbally she attacked me and called me every name in the book; she called me a horrible nurse. She wanted to talk to a doctor, and everything I said was not going to make any difference. I just told her that you need to stop yelling; I said I will call security if you continue to act this way. It is not appropriate. She again continued to yell and they left. [Female, CEN, RPN, 4 years, Sub Acute Medicine, White]

In this narrative, family members were keen on seeing the doctor. The doctor's view is seen to be more valuable and accurate to the family members than the nurse's, even when the information the nurses provide might have come from the doctor. There are other instances where the demands of family members arise out of their misunderstanding of the disease process and their desire to see their loved ones cured quickly. Celine intimated that:

I face family members who don't quite understand the limitations that their loved ones are in which is a very common problem. They insist that their mum or their dad should get up, they need to be moved around more...they call upon the nurses and they force them to get them up or ambulate them even though it is difficult and they are not ready. Specially, for patients that are post-opp. In that situation I very clearly explain to the family member exactly what their surgery was, what part of their bodies was affected and why they are unable to do certain tasks. Sometimes, it doesn't work; sometimes they still refuse to listen [Female, CEN, RN, 2.33 years, Neurosurgery, Filipina]

When faced with such abuse, nurses are in a difficult position. They cannot simply refuse to care for an abusive patient, or avoid an abusive family. Thus, the abuse may continue and even escalate. Hannah, who has been working in a geriatrics unit for the last six years, provided the following account:

If you can't serve me get the hell out of Canada...go back to where you came from... They know that if I say I am not going to tolerate this from you, even if I leave that room it is my duty to come back. When you come back... they will say 'why are you here... get the f--- out of my room'. I told you to get out". But as a nurse you cannot just get out. Repeatedly, you will see patients doing that and saying that [Female, CEN, RN, 6 years, Geriatrics, Black]

Nurses' ability to end the abuse can be limited, because of their responsibility to provide care no matter what.

4.5.4 Racial Discrimination

With regards to discrimination, it was quite uncommon for Whites to be discriminated against by patients. A number of the White participants (20 out of 28) mentioned they never experienced any form of discrimination in the course of performing their work. The few White nurses who reported discrimination felt that patients questioned their expertise due to their young appearance. However, discrimination was very prevalent with the visible minorities, especially Blacks. Visible minority nurses reported racial slurs, disrespect, and rejection by patients for perceived incompetence. Black nurses, especially, reported having their skills downgraded and being verbally assaulted.

Aminata explains that:

I remember one woman calling me an Orangutan...then I was a student and the nurse I worked with, my preceptor was a White lady. She was like, you must be seeing things. The patient was like no, I am not seeing anything...the Orangutan is actually standing next to you. Guess what, she is a very good Orangutan because she is taking good care of me [Female, CEN, 1 year, Neurosurgery, Black]

Another way by which racial minorities were discriminated against was by having patients refuse their treatment, or conversely, seek it out for status reasons.

Some people go to an extent of saying 'I don't want this nurse to take care of me because she is Black'. Other people want the Black nurse to take care of them because they see them as their slave. Back in the day, they could tell them do this and do that. Some patients, not demented patients, [very sound] patients have actually gone on to call a Black nurse Jemima...which is not a good word for Black person...[In the past, Jemima represent a slave or maid]. This patient went on all day to calling the nurse Jemima. [Female, CEN, RN, 7 years, Sub Acute medicine, Black]

They will say "I don't want you, go get a real nurse." Colour wise I have had some rude remarks. One patient will say "hey Black girl come and give me a massage" and stuff like that [Female, CEN, RPN, 8 years, Oncology, Black]

This attitude was found to be prevalent among the elderly. Also, nurses' accents were sometimes a cause for patient complaint. Patients were reported to desire care from nurses who spoke like them and they made derogatory comments to Visible minority nurses with accents. Haneul explained that:

It was like my first month I think. I was helping him at the bedside and then he was complaining a lot. He had this attitude towards me and I was trying to help him. He said to me "you don't understand English." Then I said pardon, and he repeated it again. I told him I am here to help you, so please don't be mean to me. It really hurt my feeling. I keep my calm and did my thing and left the room. Tears [were] coming out of my eyes because he was so rude to me. He will be

like do this, do this, do this....I was like ok. He was like bring another nurse. He is also an educated guy too. He is a retired teacher, so I was really shocked [Female, IEN, RN, 3 years, General Surgical, Korean]

Racial discrimination was not only common to first generation immigrants; even those who are Canadian born and have the appropriate accent still feel discriminated against and disrespected because of their race. The following narratives illustrate this:

Racism exists with the elderly...it is in their soul...the Black girls have a hard time holding on to their jobs. However, they all have to make a living [Female, CEN, RPN, 3 years, Orthopaedic surgery, Black, 2nd Gen].

It is to all nurses, but as a coloured nurse you get it a little more. All nurses will complain of this kind of disrespect but as a coloured nurse it goes to one degree further [Female, CEN, RN, 6 years, Geriatrics, Black]

Overall, Visible minority nurses reported considerable abuse and discrimination. Nurses were degraded and abused because of the colour of their skin colour, rejected because of language barriers/accents and/or due to a perceived lack of competence. They were stereotyped because they were seen to be of a lower class, and disrespected because of their race.

4.5.5 Sexual Harassment

Sexual harassment was rarely mentioned by study participants; yet a few of the nurses (6 out of the 66) recounted their experience of sexual harassment by the patients.

Comparatively, more Visible minority nurses experienced sexual harassment relative to their White counterparts. Out of the 6 who reported sexual harassment, 5 of them were visible minorities. These acts include the use of inappropriate and sexist terms, inappropriate touching, and sexual innuendos. This was most common with male patients against female nurses. The narratives below illustrate this:

Somebody tried to hug me, I said jokingly 'no hug please' or 'I will give you a high 5'. Somebody said 'come here, I give you a hug', then I said 'high 5 will be enough'. I just give them a high 5. I don't say 'no thank you'. I don't want to embarrass them too even though they are being silly. And then some rude guy was kissing [in appropriate body language], giving me a hug 'I said no thank you'. I smiled and walked away. [Female, IEN, RN, 3years, General surgery, Korean]

You have one guy who will sexually approach you... he will describe you and say you Black girls your body parts is like...those kind of things. It is not that I want to have you... in a relationship... but because you are Black.. [Female, CEN, RN, 6 years, Geriatrics, Black]

4.6 Effect of Conflicts

The conflicts experienced by the nurses had negative consequences on their physical, mental, and emotional health. Some nurses reported emotional exhaustion while others identified burnout, unwillingness to come to work, or even intentions of leaving their work area or the profession. Nurses tended to excuse patients not in their right mind, but were hurt by those who were verbally abusive and knew what they were doing. Apart from it causing physical and emotional injuries to the nurse, conflict sometimes had a negative effect on other patients, and created losses for the organization. The effects of the conflicts were varied for the nurses. Amara, a registered nurse, who has been working in the sub-acute medicine unit for the last five years, reported that:

I think that the mental and the emotional come together. With the person yelling at you, and swearing at you, sometimes it is [emotionally] draining; you go home and you wonder, was it me, was it my approach? Sometimes it is not what you have done, but just the way they are. Sometimes, you don't even sleep well because you thinking about such things that happened in the day [Female, CEN, RN, Black]

The consistency of verbal assault meted out against nurses caused emotional injuries and also made the nurses doubt their competency on certain occasions. For others this led to absenteeism and a loss of morale. Gayle explained that:

When somebody is verbally abusive to you and that happens like once a week...No matter what anybody says...you get discouraged, you get frustrated with the job, you don't like your job. You don't want to come in. Sometimes when they call me and say 'Nurse can you cover this shift?'...the first thing I will ask is where am I working? Is it this floor or that floor? If I have had about 3 or 4 shifts...I am not going to kill myself for that particular floor. I will say no I am busy. [Female, CEN, RN, 6 years, Geriatrics, Black]

In other cases, the effect were physically traumatising, nurses ended up with physical injuries, experienced post-traumatic stress disorders, and musculoskeletal injuries, which led to time away from work, and sometimes even permanent disabilities. A case in point is found in the narrative of Cindy. She reported that:

[My colleagues] heard this patient screaming in his room, went down to see what was wrong. When they opened the door, he attacked them. The two women are off for PTSD from the assault. One is in Physiotherapy for ongoing neck injuries and shoulder injuries and she is getting counselling. The male staff that was involved in the assault came back to work because WSIB was so invasive and pressing, he said it was just easier to come back to work. He had a concussion and kidney damage because he was punched in the back so many times [Female, CEN, RPN, 3 Years, Psychiatry unit, White]

In taking days off for workplace injuries, the staff available work short which results in increased work load and further leads to high stress which has a tendency to create a tense environment (which can foster more conflict). In other extreme cases, conflicts at the workplace have an impact on the quality of care given to other patients. One nurse during the interview asked rhetorically “*what kind of care do you want me to give to the next patient after the previous one has injured me emotionally? I may end up giving them either an overdose of what they require or may forget to follow a particular protocol of treatment.*” Consequently, workplace conflicts do not only affect nurses negatively but have unintended consequences on both the patient’s wellbeing and the organisation’s productivity.

4.7 General Coping Strategies

Most of the nurses reported that these conflicts were frequent and an occupational hazard. Consequently, they developed diverse coping mechanisms in order to deal with these conflicts when they occur. When they were the target of physical abuse, nurses called hospital security. The nurses (more than 50%) reported patients complied once the security personnel arrived. Alice explains that:

There is one recently, where a patient was alcoholic and he was withdrawing from alcohol. He was fine and all of a sudden he just flipped. He got quite aggressive with a nursing staff, tried to be physically abusive and we had to call security. It always kind of ... whenever security [is called], these big guys [who] try [to] kick, hit and punch comply when the security guys come around [Female, CEN, RN, 2.5 years, General surgery, White]

Another coping mechanism nurses used was to switch with nurses who had a better working relationship with the patient. In the words of Beatrice:

If you have got a patient who for some reason takes a disliking to you and if they are very confused and work really well with one nurse and there is something about another nurse that sets them off. A lot of co-workers will look into switching to help out if they are the co-workers who can work easily with it. [Female, CEN, RN, 3 years, Neurosciences, White]

Apart from switching to other nurses, the patient might be put under a five point restraint. However, nurses will have to seek the consent of family members in order to do this. Where this consent is not given, they have to still provide care to this patient. This makes the work more dangerous.

Further, nurses coped by either debriefing with their co-workers whom they found to understand their situation better, or vented to their family members or close friends upon arriving at home. However, while on duty they made sure they worked in pairs especially with patients who had been flagged to be uncivil. The following narrative illustrates this:

Co-workers play a big role in that. You kind of become a little family...I could go home and tell, not specifics about what happened, or names or I could give them a scenario and somebody who isn't a nurse they might comfort you. I will say your co-workers, you kind of debrief with them. We have gotten a clinical educator on the floor. She is very good in going into the debrief and having fun on your days off and doing things for yourself [Female, CEN, RN, 3.5 years, Orthopaedic surgery, White]

One of the ways nurses coped with these conflicts was for them to follow the protocols the hospital had developed for dealing with such cases. As they could not fight back or withdraw care from the patients, they resorted to getting more help from their colleagues and devoting more time to mitigating such situations. This also gave them access to a witness should the situation escalate. Nicole explained that:

Our College of Nurses standards does not allow you; you cannot just decide not to treat a patient because you don't get along with them, because they are confused and verbally abusive. You still obviously have to get your nursing care complete. The only way that you deal with it is you get more help when they happen. You can't approach a situation alone for your own safety. We follow the violent protocol, make sure you have colleagues in there with us; maybe devote a lot more time to that patient because it may take a much longer time [Female, CEN, RPN, 2years, Orthopaedic surgery, White]

Another coping mechanism used by the nurses is to talk to the patients or family members about their behaviour. This was reported to ease the stress these family members were going through. Kate explained that *"If the patient is confused then you can't do anything but once they are sound the leadership will go and speak to a patient about their behaviour"* [Female, CEN, RN, 8 years, LTC]. In other instances, family members are also provided with enough information about the disease process of their loved one.

I understand the current situation but this is not the way you are going to deal with the situation; you and I need to be on the same page...you need to take some time back, reflect on what is going on and reflect on it. The dad stood there and observed the conversation. He never said anything, but he kept on nodding his head when I was having the conversation with her. He was affirming what I was saying, this is not the way you deal with that situation. The kid was dying and I knew where she was coming from but that's not the way to address it. She did some reflection and she came to apologise [Male, CEN, RN, 23 years, ICU, Barbados]

Access to thorough information and education about the disease process had a way of calming down patients and family members to an extent.

4.8 Coping Strategies of Visible Minorities

Members of visible minorities followed these strategies and others. For instance, seeking the support of colleagues was particularly important for members of visible minorities who sought out Visible minority colleagues for help and advice. A significant number of Visible minority nurses drew strength from their religious beliefs. Ten (out of 38) saw their work as nurses as a service to God. Consequently, they engaged in some religious activities to de-stress. Below are the narratives of Rachel and Ademola.

You know, [I am] constantly being drained of emotions. As a nurse you just need to realise that this job takes a lot from you emotionally and that you need to replenish your emotional tank repeatedly by being involved in your children's lives and in church. I also have God and I talk a lot to Him, who helps me. I also look at my nursing as an extension of what God is doing through me for the world. I have that perspective so whatever challenge I encounter, I see it as my ministry [Rachel, CEN, RN, 6 years, Geriatrics, Black]

I come here prayerfully because I realize [this is] my purpose. In this aspect, I am like ...Lord what will you have me do...help me to be sympathetic and compassionate. I come in and it works all the time. When I leave I know my patients are Ok [Ademola, CEN, RN, 29 years, Neurosurgery, Black]

Another approach used by the Visible minority nurses is to be excellent at what they do. They reported trying to do extra work in order to gain the confidence and respect of their patients. They endeavour to provide appropriate information to patients and their family members, and ensure the services they provide have no defects, with the hope that excellence will prevent any form of discrimination. Pearla explained that:

I have to really make up for it with my skill and with my knowledge. So when patients ask me questions, I always try my best to answer as much as I can. When I care for patients, I am always very thorough with my care and diligent just so that they don't feel they are unsafe because I am a young nurse [Female, CEN, RN, 2.3 years, Neuroscience, Filipina]

For some of the nurses instead of becoming angry at the patients, they chose to play along their racial bias. Hannah explains:

I play around with it. Sometimes the people will say 'oh... I am sorry I didn't know you were the nurse, I thought you were the cleaner;' then I will say 'why did you think I was the cleaner?' Then they will say 'oh no no...because everybody else wears the same uniform.' That's the excuse I get, but I think I know exactly what they were referring to [Female, CEN, RN, 5 years, Sub-acute med, Black]

All of these strategies put the emphasis on the individual worker, but there are institutional supports in place that can provide supports for nurses dealing with abuse and conflict on the job.

4.9 Institutional Support

Some hospitals discharge or dismiss patients for abusive behaviour. This mode of resolving conflicts was reported more often by participants from the bigger city. Evelyn and Adelaide explained that:

I have had the experience at Hospital A, where a doctor will discharge and dismiss a patient and refuse to give care to them if they do not treat the nurses with respect. They get their warning, the nurse will speak to them, the doctor will speak to them. If they do not comply with that, then the doctor will say 'I will not care for you, you will be discharged.' Whereas here management will speak to them and it doesn't make a difference, the doctors are meant to speak to them. They don't deny them care even though we are under the same umbrella.... [Female, CEN, RPN, 4 years, Sub Acute Medicine, White]

A gentleman was drug seeking and he wanted so straight drugs and was trying to buy them off the other client and one of the Black nurses, she intervened and had caught him and brought him up to the psychiatrist and he called her the n-word and he was discharge because he was being derogatory towards the nurse. Also because his behaviour was violating the hospital policy by wanting to buy drugs [Female, CEN, RN, 7.5 years, Psychiatry unit, White]

Nurses also reported instances where abusive patients were charged by the police for assault after they had been discharged from the hospital.

Further, some hospitals had posters and signs indicating to both patients and relatives that verbal abuse would not be tolerated. In addition, participants who worked in the larger city benefitted from policies on abuse and codes of conduct that were read out to patients and family members on arrival. Patients who were verbally or physically aggressive were flagged or tagged in the system. Hence, nurses and any facility that worked with them had fore knowledge of their behaviour. This was not the same for those I interviewed in the mid-size city

There is a code of conduct on the floor that needs to be followed. If you don't follow it you can be kicked out. Just making sure they understand what the rules are and abide by [them]. If they refused they get thrown out of the hospital. Regardless of how bad their situation is. Just for them to know there are consequences for your actions. You cannot just come in and misbehave and get away with it. We are here to help but there is a code of conduct you have to follow [Male, CEN, RN, 3 years, Psychiatry].

My last shift, I had a patient like that and I normally get a patient like that once every few months or more. With them you know you can't get so personal with them. We warn other nurses about them. We have violent patient forms and we have security too. There is a lot at risk on this floor. [Female, CEN, 3.5 years, Orthopaedic surgery]

Nurses also applied scripted procedures for dealing with conflicts and creating a culture of safety. However, there is a limit to their effectiveness. Beyond this, nurses adhered to personal initiatives.

Lastly, some of the nurses, especially the visible minorities, reported not enough had been done to deal with conflicts at the workplace. They argued that the College of Nurses of Ontario (CNO)'s mandate was more to the public which negatively affected how nurses' complaints were handled. For others, although they filed their incidence report or AEMS report with management, they never saw any action being taken. Further, they also felt management supported patients and their families and sometimes cared little about the nurses. However, there were a few who reported that they had managers willing to support them

4.10 Discussion and Conclusions

According to Flynn (2011: 149), "Nursing is a site where intentionally or not, the values of white supremacy are discursively and materially practiced, expressed, upheld, and validated." Racial inequality is reproduced on the hospital floor as patients, and their families, abuse minority nurses verbally and physically. This racial dimension to nursing abuse has received scant attention in Canada, but it is significant. Racial inequality, combined with the service ethic privileging the customer, and the patients' bill of rights, foster abuse of nurses on the job. Visible minority nurses were more likely to have their qualifications challenged, their services denied, and to be sexually harassed than their White counterparts (see also Deery et al., 2011; Neiterman & Bourgeault, 2015).

According to the nurses interviewed, patients and family members prefer White nurses to Visible minority nurses, which invokes racial hierarchy where Whites are perceived as superior and competent, and Visible minority nurses as inferior and less competent.

Among the minority groups, Black nurses appear to have experienced the most verbal and physical abuse, followed by Indians, Filipinos, and Koreans. Also, second generation immigrants of Visible minority origin were no different in their experiences. Although it was easier for them to make an entry into the profession, they faced similar abuse from patients and family members. Racist imagery and discourse (orangutan, Jemima) is invoked to delegitimize nurses, deny their claims to expertise, and attempt to undermine

their authority (Anderson 1976; Membe, 2001; Acker, 2006; Flynn, 2011). For instance, by saying 'I don't want you...go find a real nurse' the patient devalues the competence of the Visible minority nurse, invoking notions of cultural particularity, and placing a higher value on White nurses (Gill, 2001). Such discrimination mirrors the oppression associated with the political and social identity of visible minorities in the larger society (see Moya, 2002). It points to the means by which racialized nurses are controlled and made to comply with the inequality culture at the workplace (Acker, 2006).

Nevertheless, the effects of these verbal assaults and incivilities were almost the same for Visible minority and White Canadian nurses. The main effects experienced by the nurses included emotional injuries and absenteeism. Nurses also experienced physical injuries on the job. Patient and family abuse threatened the quality of care given to patients, and it has implications for absenteeism and turnover. It is worth noting that some nurses felt more supported by the hospitals that employed them. In the more cosmopolitan city, rules and procedures to protect nurses from patient abuse were drawn on. Physically or verbally abusive patients, as well as those who did not follow the code of conduct in the healthcare facilities were dismissed or faced the rigors of the law upon discharge from the hospital. However, this was not common to all nursing institutions. It was in the mid-sized city that nurses appeared more vulnerable. Here, especially, there is more that can be done by hospitals and other institutions to protect their workers from abuse. The universalization of policies that restrain patients and family members from being abusive to nurses within all health care institutions, especially LTCs in Ontario will scale down the incidence of workplace conflicts.

It is possible that the patient bill of rights, and general 'cult of the customer' in a service society, exacerbates the problems identified by nurses in this study. Nurses may not be in a position of authority over patients as Carpenter (1993) claims. The patient bill of rights justifies patients' questioning of nurses' credentials, and encourages them to report nurses to the regulatory college if they feel they have been mistreated. Patients' clearly take these rights too far, threatening to report nurses for trivial matters such as juice delivery, and questioning the credentials of minority nurses. Nurses' workplaces need to do more to protect their employees from mean-spirited or malicious complaints, and from racism,

and physical and verbal abuse. Hospitals without clear practices and procedures in place should learn from those who do. If patients have the right to challenge nurses, nurses have the right to a safe working environment free of abuse, and to have their abusers face repercussions for their actions.

This study also documented the informal ways through which nurses coped with the conflicts they experienced. Nurses resorted to switching work roles with coworkers who could work better with their patients, debriefed mainly with coworkers and supervisors when emotionally exhausted, consciously overlooked the behaviours of patients with mental disorders, and confronted sound-minded patients for their misbehaviours (Gillespie et al., 2010; Ziersch et al., 2011). Visible minority nurses had some distinct coping strategies. For example, they confided in other members of racial and ethnic minorities, revealing the importance of social networks for care workers (Berkman et al., 2000). These social networks provided social support, exerted social influence, and facilitated interpersonal bonding for the care workers (Berkman et al., 2000). Hence, social networking can be considered as key in promoting the integration of Visible minority nurses into the nursing profession.

Again, Visible minority nurses were also found to resort to religious activities (prayers, church attendance, etc) to de-stress. This makes the creation of prayer rooms within health care facilities important in promoting the well-being of workers. In addition, Visible minority members focused on providing excellent services for patients with the hope of tramping any form of discrimination. Patients in this setting become regulators of quality care, ensuring the professional status quo is adhered to.

Lastly, in the face of increasing workforce diversity and population diversity, it is important that nurses, both natives and immigrants are socialized and equipped with cultural competence skills in order to relate appropriately with patients and family members in general. The issue of racism can be addressed at the point of education. Additionally, instead of removing nurses from areas where they seem to be the target of racial abuse, management should endeavour to approach the issue and not excuse such

behaviour as it serves as a precedent for other uncivil behaviours against Visible minority nurses.

While the findings in this study cannot be generalised to the entire nursing workforce in Canada, they do have implications for reducing conflicts in health care facilities, and improving the experiences of nurses. More effective policies may protect nurses – especially Visible minority nurses – from abuse. It is my recommendation that future studies focus on comparing the experiences of Visible minority members in different professions within the service sector. This will provide immigrants with the requisite information on which career pathway to pursue as they seek to integrate into the Canadian society. Also, an experimental study that rewards patients/family members with civil behaviour and penalises uncivil behaviour will allow health administrators to implement policies that safeguard the wellbeing of employees.

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Chapter 5

5 “I think this one has evil in her”: An Exploratory Study of Intra-Professional Conflict amongst Nurses in Two Ontario Cities

5.1 Introduction

Over the last several decades research has explored inter-professional conflict at work and in the public arena. Studies show that professionals in related and over-lapping fields conflict over who does what at work (Abbott, 1988; Norris, 2001; Hartley, 2002; Timmermans, 2002). Scholars have explored not only how such conflicts affect professional workers and their work, but also the implications of these conflicts for professional status, autonomy, and professional rewards (Adams, 2004, Stevens et al., 2000, 2007). With the growing emphasis on team-work in health care – and the growing complexity of health care teams which increasingly include a wide variety of care providers – scholars have also identified how to facilitate inter-professional co-operation and minimize conflicts on the job through communication, goal-setting, valuing the knowledge different members bring to the team, and organizational supports (Adams et al., 2014; Brown et al., 2011; Suter et al., 2009). The focus in all of these studies, however, has been overwhelmingly on inter-professional conflict. Very little attention has been paid to conflict amongst members of the same profession, or intra-professional conflict, and its implications for professions and their development.

At least twenty-five years ago, professions scholars began to predict that conflict within professions was likely to increase over time. For instance, Freidson (1994) argued that professions were becoming much less homogeneous than in the past, with more hierarchical divisions and specializations that divided practitioners of the same occupation from each other. He predicted that professions in the future may be less unified, and that internal divisions might be a source of conflict and tension. The divisions identified by Freidson were primarily structural. He questioned whether professionals with more or less authority would start to see their interests diverge, or whether professionals who worked in some sub-fields would identify more with each

other, than others in their profession. More recent research highlights other types of divisions. Notably, Noordegraaf (2013) identifies internal division amongst professional practitioners around gender and age; for example, younger professionals may have different visions of professional work, work-life balance, and professional commitment than older professionals. Such differences may foster intra-professional conflicts. In countries like Canada which have been experiencing substantial levels of immigration from members of visible minorities, conflicts around race, immigration status, and culture may also emerge.

This paper explores intra-professional conflicts among nurses in Ontario, and how these experiences vary by race and immigration status. The nursing profession has become more diversified over time. It is not only characterized by divisions in skill and training (nursing practitioners, registered nurses, registered practical nurses), but also by race and ethnicity with the influx of Visible minority nurses, many of whom are foreign-born, if not foreign-trained. Decades of hospital restructuring have increased nurses' workloads, but also led to a redistribution of job tasks as some lower-skill work that nurses used to perform has been passed on to personal support workers, and other auxiliary workers (McPherson, 1996; Deery et al., 2011). Through qualitative interviews with 66 nurses in two Ontario cities, we explore nurses' experiences of conflict on the job. We examine whether conflict occurs around expertise and tasks (who does what, when, and how), and to what extent age, gender, and race are sources of conflict for nurses. We also explore how nurses deal with conflict when it occurs, and consider the implications of conflict for professional unity. We find that while conflicts are evident, it is the more vulnerable and racially marginalized nurses that are more likely to report experiencing it. They respond by skill upgrading and greater personal effort – activities which, in the long run, potentially foster professional unity.

5.1.1 Inter- and Intra- Professional Conflicts

Andrew Abbott (1988) has shown how conflicts between professional groups over jurisdiction, or scopes of practice, fundamentally shape professional development. He argues that professional groups attempt to claim jurisdictions and defend their turf from infringements by other groups. In their battles over jurisdiction, professions appeal to

different audiences, most notably the workplace, the public, and the state. Thus, battles over jurisdiction take place at multiple levels: through conflicts at the workplace, state lobbying for expanded and protected scopes of practice, and appeals to clients and customers to market their services (Abbott 1988: 59-69). It is conflict at the workplace that particularly interests us in this paper. Professional groups may conflict over which professionals get to perform certain tasks, and/or who gets to make decisions about which tasks are done, how, and by whom (Adams, 2004; Norris 2001; Timmermans, 2002; Stevens et al. 2000, 2007). In the health care field, there are many professions and occupations. While state regulation at least partially prescribes who can do what, there are many job tasks that several professional groups are authorized to perform. In such cases, precisely who does what may be a matter of workplace or institution policy, informal arrangements, or agreements amongst health care team members.

Conflicts over jurisdiction are also typically contests over authority and status (Abbott, 1988; Timmermans, 2002; Adams, 2004). Higher status groups try to cut off access to rewards and opportunities to others through processes of social closure (Murphy, 1988; Witz, 1992). More subordinate groups seek to expand their jurisdiction to enhance their authority and status, sometimes using social closure strategies themselves (Witz, 1992). Historically, status lines were drawn not only around criteria such as education and credentials, but also gender and race (Glenn 1992; Witz 1992).

Although less studied, the literature on professions has identified the presence of intra-professional divisions. Internal homogeneity has long been a goal professional groups have strived to attain (Larson, 2013), but internal divisions are always present, and there is evidence they may be increasing (Abbott, 1991; Noordegraaf, 2013). Vertical stratification has increased within professions along with the expansion of professional employment within bureaucratic structures, and horizontal segmentation increases with specialization (Abbott, 1991; Freidson, 1994). In the 1980s, Freidson (1994) predicted that professions could splinter internally, and as a result, “the level of conflict will intensify” as segments within professions develop “different perspectives, interests, and demands” (145). Professionals with authority, and those who perform highly skilled or innovative tasks, may find they have less in common with segments of their profession

performing more routine work. Internal divisions and fragmentation encourages the development of different or competing interests, and ultimately could foster conflict and undermine professional unity (Abbott, 1991; Freidson, 1994; Noordegraaf, 2013).

Research has also highlighted internal divisions in professions due to increased diversity. In Canada, women have entered many formerly male-dominated professions in large numbers (Adams, 2010b), while men have made smaller inroads into female-dominated professions like nursing. Further, as Canadian society has become more ethnically and racially diverse, so has the professional workforce (although not in proportion: Teelucksingh & Galabuzi, 2005). Professions are internally segregated by gender (Hinze, 1999; Noordegraaf, 2013), and men's and women's relative positions could foster fragmentation and potential conflict. Age is also a potentially divisive force: "younger professionals might have different professional ideals and different preferences regarding work-life balance" (Noordegraaf 2013: 11; Widger et al., 2007). Such divisions might affect divisions of labour, and could engender inter-generational conflict on the job. Moreover, research has identified the significance of racial differences within professions and the presence of discrimination and prejudice that could further foster intra-professional conflict (Das Gupta, 2009).

In combination, this research suggests that conflicts within professions may centre on tasks and authority, or occur along the lines of gender, age and race/ethnicity. Further, such conflicts may undermine professional unity. However, there has been little research that has looked at the content and extent of intra-professional conflict, or examined its implications for professional unity. It is helpful, then, to turn to the literature on workplace incivilities.

5.1.2 Workplace Incivilities

Workplace conflict can occur whenever two colleagues disagree about a work-related issue. Thus, conflict can be ubiquitous on the job. However, many such minor workplace conflicts are easily resolved and do not become a divisive or destructive feature of the work environment. In contrast, workplace incivilities are behaviours that are encountered at work that have "implications for safety, integrity and dignity" (Roscigno et al., 2009:

748). These behaviours include “demeaning, abusive, derogatory, threatening, and violent interactions, but also more passive ostracizing exclusions that create emotional injuries and a sense of injustice” (Ibid; see also St-Pierre, 2012; Roberts et al., 2009); all of these behaviors violate social norms about what is “civil” behavior. Incivilities and conflicts can occur between individuals in a vertical power arrangement, or horizontally. Nevertheless, the impact of incivilities is worse when the perpetrators have more social, economic, or organizational power (Penney, 2008). Workplace incivilities may stem from “interest conflicts” (such as those emerging differences within professions documented above), and could be linked with processes of social closure (Roscigno et al., 2009: 749-750). That is, “workplace actors can and often do ignore or invoke formal organizational procedures and rules in order to target or benefit individuals or groups as part of larger social closure projects based on, for example, class, status, gender or race” (Roscigno et al., 2009: 751).

Research on workplace incivilities shows that organizational chaos increases co-worker infighting (Roscigno et al., 2009). Conflict is more common in stressful work environments, and where workers have experienced organizational restructuring, budget cuts, low staffing levels, job insecurity, and increased workloads (Roscigno et al., 2009; Deery et al., 2011). Minority workers are more vulnerable to incivilities, especially from people in positions of authority over them (Roscigno et al., 2009). Workers with skill and seniority are less vulnerable to workplace conflict (Ibid).

5.1.3 Conflicts in Nursing

Nurses may experience many types of conflict on the job. Research has focused particularly on conflicts with medical and other professionals (Hillhouse and Adler 1997; Samuel et al., 2005; McNeil, Mitchell & Parker, 2013), and conflicts and abuse from patients (Sheilds & Wilkins, 2009; Boateng, 2015; McNamara, 2012). Nonetheless, nursing research has touched upon the presence and deleterious effects of conflict amongst nurses. Nurses work in stressful environments, under considerable pressure. Negative working conditions have been exacerbated by continual hospital restructuring, turnover, organizational pressures to do more with less, and increased workloads (Deery et al., 2011). Shields and Wilkins (2006) found that 12 % of Canadian nurses reported

experiencing emotional abuse from co-workers in 2005. Other studies have identified the presence of nurse-to-nurse conflict as well. McGilton et al. (2014) after a study of 41 licensed nurses in seven nursing homes in Ontario, Canada found that the emotional distress brought on by workplace conflicts tipped the balance toward an intention to leave their current job. Laschinger and Grau (2014) also found bullying at the workplace as a significant predictor of burnout which also led to nursing turnover intentions after studying new graduate nurses over a period of 12 months. Blackstock et al. (2014) found informal alliances and misuse of organizational processes increased horizontal bullying among Canadian registered nurses, which in turn increased turnover intentions. In sum, nurse-to-nurse conflict occurs, and its impacts include emotional exhaustion (Hesketh et al., 2003), labour turnover (Brinkert, 2010; Laschinger et al., 2010), increased stress, and poorer patient outcomes (Hillhouse & Adler, 1997; Brinkert, 2010).

Research on conflict in nursing supports the literature on divisions in professions, and workplace incivilities, identifying training, race and ethnicity, and generation as significant. Registered Nurses (RN's) have more training, a wider scope of practice, and more autonomy than Registered Practical Nurses (RPN's). Gordon and colleagues (2013) found that RPNs felt that RNs disrespected and devalued their nursing knowledge, making them feel alienated from the RN community. Such fragmentation across these nursing segments could foster conflict. Research has also identified divisions in nursing by age and generation. Younger nurses have reported being bullied by older nurses (Vessey et al., 2009; Kelly & Ahern, 2009). Moreover, Ylitörmänen et al. (2015) in their study of 113 Finnish RNs, found that RNs who had more than 10 years' work experience in their current unit were less willing to ignore disagreements than their less experienced counterparts.

Research has also identified significant divisions and conflicts within nursing by race and immigration status. Penny (2008) contends that an increase in the diversity of the work force is associated with a concomitant increase in workplace conflicts associated with differences in cultural norms and expectations. Das Gupta (2009) after studying 593 nurses in Ontario reported that Black and other Visible minority nurses experienced marginalization and infantilization by their co-workers. Minority nurses face

discrimination and feelings of ‘otherness’ (Flynn, 2011). Deery et al. (2011) found that more ethnic minority nurses (18.2%) in the UK reported verbal harassment from colleagues, than did their White counterparts.

Thus, there is some evidence that Canadian nurses – both foreign born and Canadian born – experience nurse-to-nurse conflict on the job, and that areas identified in the sociology of professions, and workplace incivilities literature – job tasks and training, age, race and ethnicity – may be significant in shaping this conflict. Little research, however, has explored the nature and locus of these conflicts, qualitatively. Further, while studies have focused on the impact of nurse-to-nurse conflicts for nursing turnover and patient outcomes, we are not aware of any research that examines how nurses cope with these conflicts, and the impact of these conflicts on professional unity. Our research questions are as follows:

- 1) Do nurses report conflicts with other nurses on the job? And if so, what are the sources of these conflicts?
- 2) How do nurses cope with these conflicts?
- 3) What are the implications of these conflicts for professional unity and workplace experiences?

5.2 Methodology

This paper is part of a broader research study of the career pathways and lived experiences of foreign-born and Canadian-born nurses in Canada. In this study, a qualitative research design was used to explore the experiences of Visible minority and White nurses, including the conflicts they experience in practice. The research was approved by a university ethics review board. Purposive sampling was used to recruit direct care nurses working in two Ontario cities, one large and one mid-sized. Posters were posted and contacts made at the following organizations: hospitals, nursing homes, private care agencies, and the Care Centre for Internationally Educated Nurses. Interested nurses were requested to contact the researchers through email or the contact number on

the posters. Further, passive snow ball sampling was used to locate both White and Visible minority nurses.

Semi-structured, one-on-one in-depth interviews were conducted with a largely heterogeneous sample of registered nurses and registered practical nurses who engaged in direct care nursing. Most of the interviews were conducted at the hospitals and the homes of the nurses, with a few conducted at community libraries. A total of 66⁴ RNs and RPNs were interviewed for the study. This number was attained at the point of saturation. A detailed description of the participants is given below. The interviews varied in length from forty minutes to two hours forty minutes. In the former, the respondents were mostly working at night in the hospitals and were interviewed before their work, during their breaks, or after their working time; also, most of the respondents in this category were White Canadians who had been educated in Canada. Longer interviews were more common with Visible minority and immigrant respondents.

Participants were asked if they had experienced any form of conflict with their coworkers. They were then asked more specific questions on the types of conflict they had experienced, the effect conflict had on them, how they were able to cope with it, and how some of the conflicts were resolved. Further, probes (such as ‘can you provide me with details,’ ‘can you explain further,’ ‘describe clearly to me’) were used to investigate their experiences in greater depth, to establish a sense of rapport, and also to reduce the risk of social desirability bias (Barri & Alison, 1994; Doody & Noonan, 2013; Brinkmann, 2014).

There were instances where respondents were not forthcoming in describing the conflicts they had experienced. However, less of this was seen with immigrants who likely identified with the researcher, a fellow immigrant interested in the work they did, and hoped the study would make it easier for subsequent immigrants to overcome challenges

⁴ The original total sample included 70 participants; however, for this particular study we sought to place emphasis on participants who claimed to be visible minorities (immigrants) and White Canadians. Four of the participants excluded from this study were Whites from the US, UK, and Denmark.

they faced in the profession. All the interviews but two were audio-taped with the consent of the nurses. For the two who refused to be recorded, notes were taken.

5.2.1 Data Analysis

The transcription and analysis of the narratives followed a systematic approach using software to ensure rigor and to enable a rapid identification of major strands and patterns emerging from the interview (Seale & Silverman, 1997; Fernandez-Kelly & Konczal, 2005). In the transcription process, the audio recording was played slowly and repeated often using “Express Scribe Transcription Software” to ensure the transcription accurately reflects the respondents’ views and statements. Using the MAXQDA software, the transcripts were systematically coded to develop themes. The first level of coding was done using the semi-structured interview schedule which was already structured in themes. This was followed by a second level of coding (sub-codes) which was done in situ of the first coding to categorise similar and different views on a particular theme. The third level of coding incorporated themes that were newly derived from the study.

The identification of themes followed a particular criterion: (1) frequency (themes with the largest number of mentions were considered important), (2) universality (how predominant the same theme was across different research participants), (3) differentiation (relative importance of different themes in different groups), and (4) emphasis (emphatic speech or emotional speech) (see Baxter & Eyles, 1997). By using various commands within the retrieved segments of the software, we were able to explore the sources of conflict, and the extent to which race, age, and other factors shaped experiences of conflict. A few research participants (4) were contacted again to review the themes to determine if they accurately reflected their experience. They had no queries of the themes; rather they added more details for clarification (Lincoln & Guba, 1985). Participants’ narratives are presented in the following section. Below, pseudonyms are used to protect participants’ identities.

5.2.2 Study Participant Characteristics

Consistent with the distribution of males and females in the nursing profession in Canada, 6 out of the 66 participants were males and 60 were females. Out of the total number of

participants interviewed, 28 of them were White, while 38 were members of visible minorities. Of the Visible minority nurses, 29 of them were 1st generation immigrants, 5 were 1.5 generation (arrived in Canada at an average age of 12 years) and 4 were 2nd generation immigrants (Canadian born). Similar, to the employment distribution of regulated nurses in Canada, 54 nurses worked in hospitals, 9 worked at Long Term Care/Nursing home facilities, while 3 worked at a Public Health Unit. Again, in line with Canadian nursing educational trends, 52 out of the 66 nurses were Canadian Educated and 14 were internationally educated. With respect to work status, 54 nurses out of the 66 worked full-time, 9 worked part-time, 2 were retired, and 1 worked on a casual basis.

On average, the nurses had worked for a period of 10.65 years. The mean age for the participants was 38.26 years. The average age at which participants started working was 27.61 years. The average number of children born to the participants was 1.27. The ethnic background of the participants was wide ranging, 28 of them claimed to be of Canadian origin (White); the rest claimed the following ethnic backgrounds or countries of origin: Ghana, Nigeria, Sierra Leone, India, China, Philippines, Iran, Korea, Hispanic, Malta, Caribbean, Barbados, Serbia, Trinidad and Zimbabwe. The participants worked in several areas within the hospitals and Long Term Care (LTC); this included sub-acute medicine, geriatrics/palliative, general surgery/surgical, neuroscience/neurosurgery, orthopaedic surgery, Intensive Care unit, neurology, operating room, paediatrics, psychiatry/mental unit, Nursing Resource Team, Oncology, Emergency, Cardiac, community, convalescent unit, education and in management

5.3 Results

Conflict was a common experience amongst our respondents: 60 out of the 66 participants indicated they had experienced conflict with their coworkers recently on the job. Although a variety of conflicts were reported, most fell into three groups: (1) conflicts surrounding work tasks and expertise; (2) racial exclusions (social closure); (3) conflicts between older and younger workers. In this section we describe and provide examples of each of these types of conflicts. Then we consider the impact of these conflicts, and nurses' coping strategies.

5.3.1 Conflict over work tasks and expertise

Some of the conflict centred on the work, and who was responsible for it. Nurses had a high workload and felt a pressure to perform. If nurses on a previous shift did not complete all of their work, this left more for the nurses on the next shift, and fostered conflict. As one Canadian-born RN explained:

You are a night nurse coming around; feels like the day nurses didn't finish their case work that day. They get very upset with them and can't reason. I can't think of a reason why you couldn't have enough time to finish your work. They are very upset because they have more work on their plate for themselves, [especially] if it is blood work or if a consultant has to be notified [CEN, RN, 7.5 years, Psychiatry, White]

Getting the work done typically required teamwork. Conflict also arose when colleagues focused on their own work, and seemed unwilling to provide a helping hand to others:

You have to pick up the slack; you have to do the quick thinking... There are certain people, when you work with them, they care for their own and just their own. They do not offer any helping hand yet still they want help. There are other people that get talked about a lot. People don't like working with them. Anything that will cause your fellow nurse to pick up your slack will cause them to dislike you [CEN, RN, 7 years, Sub-acute medicine, Black]

While inter-professional conflict often revolves around which groups get to perform which tasks, conflicts around the task within a profession are more about insufficient teamwork and lack of support by colleagues.

Nonetheless, there is evidence that conflicts around expertise, knowledge and performance can emerge across segments within the nursing profession. If a nurse is not seen to have the requisite knowledge, colleagues can turn against her:

A few nurses ask I did this, I did that, what do you think? There are instances you can do that, it is ok to ask for a second opinion. But you don't want a nurse to come to you always asking... Once that happens, they form an alliance against you. You become the incompetent nurse now. Everybody does not want to get close to you because they think they have to do your work for you and your thinking for you and they have their fair share of their business and they don't want to care about somebody's business [CEN, RN, 7 years, Sub-acute medicine, Black]

In such cases, race and immigration status may exacerbate the situation. Nurses might feel the foreign-born (or trained) nurse does not know her business and close ranks against her.

Further, study participants spoke of conflicts between RN's and RPN's, and between members of these groups and PSW's. Expertise differences, status differences, and heavy workloads combine to foster conflict:

And there is a little bit of RPN and RN thing. Because the job is the same and there is no difference and the pay difference is huge and sometimes the RNs get frustrated when they are expected to take on a more difficult patient that day. That's what they are getting pay for and that's what their extra education caters for. Some RNs don't think RPN can do medication which is totally within our scope of training. Some RNs just don't like RPN period. I have heard of one RN in front of the whole unit yelled at an RPN and said 'don't bother coming back unless you have learnt how do your job' because he had a different approach. Not because he wasn't capable of doing it but because he didn't want to do it the way she was doing it. She screamed at him in front of everybody which was humiliating [CEN, RPN, 3 years, Psychiatric unit, White]

If [PSWs] are told by RNs saying that Mr. A and B need to be changed, no question is asked. The PSWs are not going [to do it] especially if you the RN, according to them, have nothing doing. It is your patient and I am going to do something else. It is a conflict between RNs and PSWs. RNs want PSWs to do all their work, they are so lazy and so forth...it is a constant battle...it has occurred even today...right now and the respect is gone. Not all RNs and not all PSWs, but for the most part it is one of those things I think about because it happens a lot everyday on our floor. Where PSW is quarrelling about something and RN is complaining about something [CEN, RN, 29 years, Neurosciences, Black]

Such conflicts are very similar to those reported by scholars studying inter-professional conflict as some groups seek to claim higher-status tasks for themselves while delegating the lower-status, less-expert tasks to subordinate groups. Through these day-to-day activities, RNs delegate some of the less-skilled tasks to their lesser-trained counterparts; RPNs and PSWs may respond with resentment. Note, however, that these conflicts take place in a context where RNs clearly express being overworked. Indeed our respondents (9 out of 66) suggest that these types of conflicts are worse in some work contexts than others.

There is absolutely a big difference between Hospital A and Hospital B. Hospital A, I find as a unit, ... as a team, they are very strong. They work very well together as far as communication. They are very open to having our support workers, the PSWs and the RPNs. They are very supportive of each other as far as learning....staff will back each other up; everyone is really good about that, every one eats together...there are no problems over there. Over here [in hospital B], it is very different ... nobody eats in the staff room apart from the RNs. Other floors are ... extremely rude to them [RPNs and PSWs]. They don't acknowledge their existence. I find nurses are extremely rude to them here, they don't recognise them as part of the team [CEN, RPN, 4 years, Sub-acute medicine, White]

In ---- hospital, the mental health unit is a total dysfunctional place. The staffs are constantly at each other. There are fights, there are threats; it is unbelievable. Sometimes you think this is a professional work environment, the way the people treat each other up there is bizarre. You would not think that it is possible to not get fired for the things that these people say to each other [CEN, RN, 12 years, General Surgery, White]

Thus, as the literature has shown, organizational context and workload appear to condition and influence these types of conflicts significantly.

Overall, nurses report considerable conflict around who does what and how things are done. RNs and RPNs (and PSWs) conflict over who should be doing what. Nurses at the same level are more likely to conflict when they feel that colleagues are not pulling their weight, not supporting each other, or when they suspect their colleagues do not have sufficient knowledge to do their jobs.

5.3.2 Racial Conflicts

Most of the Visible minority participants (20 out of the 38) reported experiencing racial abuse, excessive scrutiny and monitoring, and being excluded by their colleagues. Some of the racism was direct and blatant

I remember a new Registered Nurse [White] saying to me. “[Esther] drop dead...I need your job” I was stunned and did not know what to do...Racism also does exist between nurses and nurses of different race. Jealousy by White nurses causes them to make allegations which result in them [members of minorities] being sacked...the union does not make any input [Female, CEN, RN, 3 years, Orthopaedic surgery, Black]

Some (15 out of 38) of the Visible minority participants indicated they felt they were constantly watched and monitored. Any mistake they made drew direct criticism, while mistakes made by their White colleagues were more likely to go unnoticed. Esi explains that

There are a lot of challenges...as a Black person you really have to work as twice as hard...you need to be vigilant at all times because someone will be watching...Blacks get harassed more times than the White. Black nurses are picked on more in the nursing homes [CEN, RN, 7 years, Sub-acute medicine, Black]

Minority nurses argued they were socially excluded, and sometimes had their knowledge discounted. Aminata explains that

You know birds of the same feather like to flock together... They see you as a minority. And it doesn't matter how much you know, they don't respect how much you know, they don't respect who you are. For as long as they are concerned you are from Mexico, you are Black or something like that. They will talk with you, they will laugh with you, but behind you it is not pretty [CEN, RN, 7 years, Sub-acute medicine, Black]

Asibi, an international educated nurse, reported similar experiences, describing her colleagues as forming a clique from which she was excluded.

...they grew up here, they are friends, they are in the same profession, so they somehow cover each other's back. Somebody that comes in is like a stranger...they look out for each other. Some of them tend to put down whoever is not in their clique or even lie; they could give more difficult assignment to whoever is not in their clique. If their clique is working, let's say doing the morning shift, they make sure their colleague who is coming on to do the night shift gets a less difficult assignment and then those who work at night, will ... make sure their [day shift colleagues] get an

easy assignment. [This] happens sometimes. When it becomes obvious it can create problems [IEN, RN, 5 years, Sub-acute medicine, Black]

This latter quote reflects the subtlety of some racial discrimination among coworkers. Minority nurses faced greater scrutiny and social exclusions. They also felt that when White colleagues complained about them to their superiors, they were not given a chance to defend themselves. When minority nurses were in positions of authority, they felt that their White colleagues resented them, and that White RPNs and PSWs were less likely to obey them. In addition, nurses in the less diverse mid-size city (16 participants) were more likely to report discrimination, than were those in the larger and more diverse city (4 participants).

Overall, it seems that minority nurses faced additional conflicts that their White colleagues did not, because of their race, and there is evidence of White nurses closing ranks against minority nurses, discounting their expertise, marginalizing them, and undermining their authority on the job.

5.3.3 Conflicts by Age

According to some participants (14 out of 66) there is a tendency for ‘older nurses to eat their young.’ Some senior nurses had no room for mistakes and monitored keenly the actions of new nurses. They rarely offered help to them and would yell at, demean, or shame them in front of patients or other colleagues when mistakes were made:

One time I had a nurse, she is an older nurse, when I was just starting out, she was kind of demeaning like I was asking where something was. Because I wasn’t sure, I was asking where they kept a certain medication. She was just really rude the whole time being like “where do you think it is?” like kind of demeaning, talking to me in a demeaning way. I was like, ‘Is it here?’ She said ‘no...where else will it be’. She will talk like that, her tone of voice. I have had the same nurse question me...why are you doing it that way...you should be doing it this way...or even saying things like what are you doing? [CEN, RN, 1 year, Paediatrics, White].

I don’t describe people as evil very often; I think this one has evil in her. No matter what we tried, she will pick on certain nurses – nurses with little self-confidence. She will just nod at them, pick on their practice, you did this wrong, you did that wrong. She is very difficult. She had one of my co-workers seek legal assistance. She said ‘I can’t take this anymore.’ She is being bullied constantly [CEN, RPN, 28years, Hospice, White]

[For] example, I was on a particular unit at hospital A for placement and they didn’t want to put a student with [a particular nurse] because she was known to be very rude and wouldn’t teach the student anything. My instructor put me with her because she felt I could handle it. There was a lot going on. She was terrible...she wouldn’t look at me. All she did the entire time was nothing. She read a magazine. She was just very rude. She was rude to the patient too....She was just not very nice. By the end of the day, I dropped this clip in the garbage and I couldn’t get it and she

screamed at me. There were people on the way. I couldn't get it [CEN, RN, 5 years, Sub-acute medicine, White]

Some respondents felt that generational differences in work ethics encouraged bullying behaviours:

The older ones could be impatient with new ones—the older ones do not have the patience to deal with new staff...they forget they were once young. Young people are not as motivated as the older ones...the generation Y2K...work ethic is different from baby boomers. They have a sense of entitlement, work-life balance, older people work to death...new nurses are more concerned about family time. Y2K's work to live but the Baby boomers 'live to work'. Boomers think young people are not ambitious. Sometimes the picking on you is based on bad practice...some of nurses might not know what they are doing.... [CEN, RN, 9 years, Emergency, Black]

Study participants were careful to explain that while some older nurses bullied, others were very supportive. As Ogechuku explained:

We see a lot of the older nurses eating their young. Older nurses who just for some reason can't accept the younger ones. On the other hand there are some marvellous older nurses. Amazingly on my floor I have the best nurses. Sometime I want to leave the floor but I like the comfort and company of these nurses. There are some good ones and yet there are some bad ones [CEN, RN, 1 year, Neurology, Black]

There appeared to be little that younger nurses could do in the face of these negative behaviours by their senior colleagues. Some simply hoped that these older nurses would retire in a few years.

5.4 Impacts of Conflicts:

Nurses identified several serious impacts of these intra-professional conflicts. Their job performance was negatively affected, and there was a lack of cohesion and co-operation amongst work teams. They experienced considerable stress, which led to turnover and absenteeism. Further, they felt that patients suffered.

Franklina explains how conflicts undermine work performance:

You need to have co-workers that have your back in situations. If they don't have your back, you will feel like you cannot do your job as you will always be able to. You will not have the kind of assistance that you should have received [CEN, RN, 3 years, Neurosurgery, White]

Other participants agree that conflict undermines teamwork and reduces nursing effectiveness:

It makes it uncomfortable when you have to work with people that you don't respect and you know that they don't value what they do and they don't care so it affects the team work. There is a lack of cohesion which just adds to your general stress level. So when you are going to work and you see I am working with this person or that person, you know whether the shift will be good or not [CEN, RN, 22 years, LTC, White]

It reduces productivity, there is communication breakdown and we are supposed to work together. There is a lack of collaboration. Things get repeated. There is a lot of repetition. Someone might have to do something, and because there is a communication breakdown, one task can be repeated over and over and over; redundancy sets in. All these put together, decreases productivity in the workplace [Male, CEN, RN, 3 years, Psychiatry, Black]

It can affect the work because if one is angry with you, she will not want to talk to you. Something that needs to be done will not be done. If you call them to help somebody, they will say 'I am busy.' It ends up punishing the resident [patient]. If there is a conflict, the residents are those who suffer. People will not put in their best [Lizzy, IEN, RPN, 7 years, LTC, Black]

This conflict increases stress, and that leads to absenteeism:

When we nurses work short, we get fatigued, and we are more prone to be sick and that increases sick calls which further leads to nurses working short. This trend keeps revolving... you could trace all of this to conflict [IEN, RN, 5 years, Sub-acute medicine, Black]

[Conflict] sets an atmosphere or the tone for the rest of the day, making the work more stressful. People do feel... because nursing teams are quite close and quite connected, it doesn't take long for conflicts to escalate [Male, IEN, RN, 15 years, Cardiac, White]

These impacts, in turn, had implications for patients.

When you get into situations where people take more sick time, they may be missing some aspects of work with the patients. They might miss that major thing that needs to be noticed, that need to be called for the patient [Cynthia, CEN, RN, 3 years, Neuroscience, White]

The patient suffers from this struggle all the time [CEN, RN, 2.5 years, General surgery, White]

Nurse-to-nurse conflicts not only have negative impacts on nurses, but also the organizations in which they work and the patients they treat. Nurses strive to minimize conflicts, however, since they recognize a conflict-free work environment is better for everyone.

5.5 Coping Strategies

Nurses identified many coping strategies, from confronting those who treated them poorly, to venting to colleagues to release their frustrations. For example, Jackson and Alice describe their strategies as follows:

If you are going to challenge me on something, I am going to challenge you back. My colleagues know that when it comes to Jackson, understand, don't mess with me. I have a very strong character [Male, CEN, RN, 23 years, ICU, Black]

I have been able to become more confident where I can stand up for myself with them. A lot of the times, I and the other nurses vent to each other about the older nurses who treat [people] poorly [CEN, RN, 1 year, Paediatrics, White]

Some, like Linda, just try to grow a “thick skin,” and ignore the incivilities towards them:

Some people have come to me and said weren't you offended when so and so said this thing to you. I say I didn't pay attention to them [IEN, RN, 8 years, Sub-acute medicine, Filipina].

Other colleagues were an important source of support for at least 20 out of the 66.

Jocelyn explained,

I feel like I have a lot of support from the younger and nice nurses too. A lot of the time I am able to talk to them about it. Usually everybody knows who among the group likes to mistreat people [CEN, RN, 1 year, Paediatrics, White]

To avoid uncivil colleagues and bullies, some (5 out of 66) asked to change departments.

This is the reason why I changed my shift. In my unit, I had several confrontations with the nurses; they did things that I didn't like personally. It got to a point I just wanted to be home and not go to work [CEN, RPN, 7 years, LTC, Black].

However, many of the Visible minority nurses (20 out of 38) appeared vulnerable and isolated; they felt they had to be cautious about who they approached for support. In

Abiba's words,

At times you need the confirmation that you are doing a procedure right or you haven't done it before. Even with colleagues, sometimes I am afraid to ask certain people for help even though I need it. I just go to those who will help. I feel like [the others will] look at me as if I don't know what I am doing and it puts me at risk. Or it takes longer for me to do the procedure because I have to find someone who is ready to help me [CEN, RN, 1.25 years, NRT, Black]

Visible minority nurses who were already vulnerable to challenges to their expertise, had to be very careful. When faced with challenges to their competence, minority nurses tried harder. They endeavoured to demonstrate their expertise and work ethic. Nesba and

Sussie explain:

You got to really prove yourself to protect yourself. If you are showing that you are weak and you are not knowledgeable [they will look down on you]. As soon as you show your weak point, then they will come down and scare you. It's really hard working with old girls [IEN, RN, 3 years, General Surgery, Korean]

When [you are] providing care, you have to provide the care with confidence. Even if you don't know what you are doing, you have to give a brave face. I am the boss...I am in charge [CEN, RN, 7 years, Sub-acute medicine, Black]

Thus, members of visible minorities responded to challenges to their expertise and other conflicts by working harder, carefully selecting colleagues to help and mentor them, and assuming a demeanour of competence and confidence.

When faced with workplace incivilities, participants could also report problems to nursing managers. Matilda explained that there were many workplace rules to eliminate abuse and harassment at the workplace. Rules and regulations provided opportunities for nurses faced with serious conflicts. However, many of our respondents did not invoke these policies or procedures unless the conflict and abuse reached a high level. In interviews, participants emphasized informal and individual strategies: seeking supportive colleagues, standing up for themselves, and demonstrating competence.

5.6 Discussion

The White and Visible minority nurses in our study, who worked in direct care in a large and mid-size Ontario Canada city, reported experiencing intra-professional conflict. Nurses conflicted over workloads and tasks completed or not completed, expertise and authority. They also identified conflicts by race and age, with Visible minority nurses (e.g. Blacks, Filipinos, Koreans, Indo-Pakistanis) and young nurses very vulnerable to bullying, conflict and workplace incivilities, from their White and older colleagues (respectively). There was some evidence of social closure as Visible minority nurses felt cut off from supports and respect. Workplace incivilities had negative impacts on the nurses themselves, as well as their work, their workplaces, and their patients. The nurses most vulnerable to abuse, members of visible minorities (both first generation and second generation immigrants) and young nurses, tended to respond to workplace conflict by demonstrating competence, seeking support from colleagues, and either ignoring the abuse or standing up for themselves. Most of these strategies (except for, potentially, the last one), do little to challenge the status quo, and indeed encourage professional unity, not division.

The literature on the changing nature of professions has identified trends whereby professional groups are becoming internally segmented – divided by age, race, expertise, and job content. It is notable that these are precisely the areas around which nurses

experience conflict. Scholars such as Freidson (1994) and Noordegraaf (2013) postulate that conflict could result within professions as members of the various segments see their interests diverging. Indeed, our study suggests – along the lines identified by Roscigno et al.'s (2009) study of workplace incivilities – that processes of social closure may be at work, as White nurses exclude and marginalize nurses of colour and older nurses are hostile to younger. Nonetheless, there is no evidence in our study of groups organizing around these dimensions (or race and age). Although Calliste (1996) mentions of antiracist groups been formed in other institutions, this was not visible in this study. Most of the conflicts focus on workload, expertise, and the job, and are often identified by our participants as inter-personal conflicts, rather than interest conflicts. For example, participants were careful to note that not all older nurses were difficult to work with. Members of visible minorities could find some other nurses willing to provide support, and when organizational supports were in place they experienced less racism. Such supports, in minimizing conflict, might also help to foster unity. Further, it is notable that the response of the most vulnerable members in our study is often not one that challenges the system, but one that confirms it. They work harder, seek support, and switch to different teams or floors. Their activity confirms and builds professional unity. It does not undermine it.

The conflicts experienced by racial minorities in this study also provide enough evidence to support two of Acker's (2006) inequality regimes as perpetuating and reproducing racial inequality within the nursing profession in Ontario. This consists of 'organizing processes that produce inequality' and 'control and compliance'. The findings of the study show that racial minorities (especially Blacks, Chinese, Indo-Pakistani and Korean) reported being the target of excessive scrutiny and monitoring regardless of generational differences. This reveals the medium by which racialized nurses are controlled and made to comply with the inequality within the workforce. Additionally, a type of Bonacich's (1972) split labour market theory is evidenced among Black nurses in their experience of caste and exclusionary oriented behaviours from white coworkers. Although, this experience did not result in differentials in pay, it has the potential of denying blacks opportunities for upward mobility.

As Abbott (1988) has shown, conflict has the potential to transform professions, and professional work. Battles over jurisdiction, authority, and workplace relations can determine professional development. Freidson (1994) and others have argued that intra-professional divisions could have a similar impact, if different segments come to see their interests as fundamentally divergent. The vulnerability of racial minority and young nurse segments in nursing, however, does not currently appear to have transformative properties. Rather, status distinctions and broader social inequalities leave them in a vulnerable position. In the end they may find it difficult to even improve their own personal situations, let alone form an interest group, battle social closure, and fight for positive change. Nevertheless, as the number of Visible minority nurses increases in Canada, this could change in the future.

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Chapter 6

6 Discussion

This study aimed at exploring several factors that shape skilled immigrants' initial entry and integration into the nursing profession and Canadian society at large. While a number of studies have focused on the factors that influence immigrants' entry into the labour market, there are fewer studies that focus on their integration into professions (Calliste, 1996; Das Gupta, 2009; Flynn, 2011). Further, the studies that focus on nurses' integration fail to examine the factors that shape nursing practice (see Neiterman & Bourgeault, 2015). Using the nursing profession as a case study, I first explored the different career pathways and professional integration experiences of both Canadian-born and foreign-born RNs and RPNs working in Ontario, documenting the hardships experienced by the foreign born. Second, I examined the professional integration of Visible minority immigrants by exploring nurses' conflicts with patients / family members, and with their co-workers. I found that Visible minority nurses' experiences of conflicts differed from their White counterparts. Minority nurses face racial discrimination from patients, and exclusion and marginalization from their co-workers. These experiences affect their ability to integrate into nursing and practice like their White counterparts. The findings of this study not only provide us with an in-depth understanding of the nuances and complexities surrounding the entry and integration of visible minorities in the nursing profession, but shed light on the coping mechanisms that support new immigrants facilitating their entry and integration into nursing. Further, this research challenges age-old stereotypes, and positions minority nurses as equal and competent stakeholders in dealing with the shortage of nurses in Canada.

In this chapter, I review the findings to the main research questions described in chapter 1, and elaborate on how the three separate papers are connected. I situate this present study in the context of the sociological literature and clarify its contribution to knowledge. Then, I outline the policy implications of my findings and provide some directions for future research.

6.1 Summary of findings

The first research question asked if the pathways into the nursing profession experienced by foreign-born nurses differed from those of Canadian-born nurses. Chapter 3 explored the factors that shape the career pathways of foreign-born nurses and Canadian-born nurses. Immigration status, race, and education were found to strongly impact the entrance and integration of participants into the nursing profession. Based on figure 1, the study showed that the career pathways taken by foreign-born nurses and Canadian-born nurses were quite distinct. Canadian-born nurses, even if they were 2nd generation immigrants, had a shorter and more direct pathway into nursing. They had little to no difficulties with their initial entry into the profession. In contrast, foreign-born nurses, especially IENs and Visible minority nurses faced more complex, systemic, and multidimensional challenges in transitioning into the profession. However, IENs were able to transcend the challenges they faced much better if they received mentoring from the CARE Centre for Internationally educated nurses. Canadian-educated immigrants faced difficulties, but once they obtained Canadian nursing education, their transition into nursing was fairly smooth. Also, the study showed that immigrants could easily acquire Canadian work experience by working in Long Term Care facilities. This became a path that eased entry into hospital nursing. Given the nursing shortage, and the availability of work in long-term care, immigrants may have an easier time integrating economically into nursing than many other professions (see Bourgeault, 2007). Future research comparing the pathways to entry of immigrants in different professions is needed to ascertain if this is the case.

Chapter 4 focused on how experiences of patients' abuse varied by immigration status and race. This chapter addressed the second and fourth research questions: Do experiences of patient abuse vary by immigration status and race? And how do nurses cope when faced with abuse? This chapter suggests that the patients' bill of rights and the service ethic privileging the customer fosters the abuse of nurses, and that racial inequality and discrimination lead to minority nurses facing more abuse, and different types of abuse, than their White colleagues. Visible minority nurses were more likely to have their qualifications challenged, their services denied, and to be sexually harassed

than their White counterparts. Racial inequality was perpetuated and legitimized through daily interactions on the job, discriminatory actions of supervisors and the complicity of racial and ethnic minority nurses (Acker, 2006). Nurses were found in this study to experience emotional injuries and absenteeism. Further, nurses in the larger city reported that hospital policies and procedures did provide some protection against abuse; nurses working in the mid-size city reported no such protections.

Chapter 5 focused on answering the third research question – how the experience of intra-professional conflict amongst nurses varies by immigration status and race. The study revealed evidence of social closure among nurses as Visible minority nurses felt excluded and marginalized by White nurses. It also pointed out the hierarchical and gendered nature of the nursing profession and how Visible minority nurses are racialized (McPherson, 1996). Generally, the study found that most of the conflicts identified by participants were interpersonal in nature and focused on workload, expertise, and the job. Coping mechanisms used by visible minorities to overcome barriers (related to research question four) were found not to pose a threat to professional unity.

The findings of chapters 4 and 5 find support in the literature on the barriers and difficulties experienced by racialized minorities. First, members of visible minorities, especially Blacks, experience caste and exclusionary measures that worked to impede their integration into the profession (Bonacich, 1972; Calliste, 1996). Second, members of visible minorities, relative to their White counterparts experienced more verbal assaults, physical injuries, and discrimination. Coping mechanisms included seeking support from coethnic networks, skill upgrading, demonstrating competence, and ignoring or confronting the abuse (see UHN, 2014). These findings put together make theoretical and empirical contributions to the field of migration, sociology, and nursing professional practice.

6.2 Implications for the Literature

From a migration perspective, the findings provide little support for the assumptions associated with segmented assimilation theory, especially selective acculturation (Portes & Zhou, 1993). The segmented assimilation theory suggests that new immigrants,

especially, those from Latin America, Asia, and currently the Caribbean and Africa are considered racial/ethnic minorities, and their minority status will hinder their full integration into the White middle class (Portes & Zhou, 1993; Portes & Rumbaut 1996, 2001). In applying this American model to Canada, the society is seen as stratified and unequal. Hence, different segments of society are available into which immigrants may assimilate. Portes and Zhou (1993) argue that new immigrants and their children will either (1) assimilate into the American middle class, (2) assimilate into the urban underclass leading to poverty and downward mobility, or (3) through the support of immigrants' community culture and values, achieve upward economic mobility. In this study, I find that in spite of the ethnic and racial status of my immigrant participants, they were found not only to make incomes similar to the incomes reported by native Canadians upon entry, but they also made financial investments and acquired assets (houses, cars), which facilitated their economic integration. This level of economic integration allowed them to also engage in other social activities that aided their social integration. This finding goes beyond the critique of Neckerman et al. (1999) to suggest that immigrants do not only assimilate into the Black middle class, but they can also assimilate into the White middle class, which is also a possibility overlooked by the proponents of segmented assimilation theory (Xie & Greenman, 2005).

Second, the use of coethnic networks and foreign human capital played an infinitesimal role in the upward mobility of these nurses. Instead, the acquisition of Canadian education facilitated their initial entry and integration into the labour market regardless of ethnic or racial origin. Third, the nursing profession was identified by participants as providing a faster route to integration than other jobs such as accounting, because it required a shorter period of schooling, a manageable training cost, and a promise of job security (see Bourgeault & Neiterman, 2013). Beyond the barriers and challenges of acquiring the requisite qualifications, Visible minority nurses in this study experienced upward economic mobility, despite their immigration status. Arguably, a blend of market and social forces, such as the ageing population, the shortage of professional labour, and the ageing workforce create enabling conditions that foster immigrants' economic integration.

Also, this study highlights the relevance of the life course theory in understanding the incorporation of skilled immigrants into the Canadian society. For instance, differences in age, marital status, and births of skilled immigrants were found in this study to either facilitate or delay the entry and integration of skilled immigrants into the nursing profession. These factors reflect key tenets of the life course perspective. One key example is “the principle of timing: [i.e.] the developmental antecedents and consequences of life transitions, events, and behavioural patterns vary according to their timing in a person’s life” (Elder et al., 2003: 12). In Chapter 3, older immigrants experienced delays and complications as they sought to enter the profession while simultaneously dealing with children, partners and other family challenges; however, members of the 1.5 immigrant generation entered the profession while younger, without family responsibilities, and had a direct entry similar to Canadian-born nurses. The timing of life events such as marriages and births with associated family responsibilities impeded skilled immigrants’ professional integration. Also, age differences in nursing, as found in chapter 5, also created conditions for co-worker conflicts. Consequently, this study provides compelling evidence in support of Treas’ (2014) theoretical proposition for a synergy of life course theories and immigrant incorporation theories in exploring the complexities and nuances surrounding immigrants’ integration, especially respecting professional jobs.

The study also makes a sociological contribution to the literature on race relations. Studies that have examined workplace incivilities and aggressive behaviours quantitatively have rarely considered the effect of ethnic/racial status (Laschinger & Grau, 2012; Laschinger et al., 2010). This study makes a qualitative contribution to this gap. Racial status was found to impede the smooth integration of nurses into the profession, especially, in their early years in the profession. Combined, the findings of chapters 3, 4 and 5 show that Visible minority nurses especially Blacks, Koreans, Filipinos, and Indo-Pakistanis experienced racial inequalities. The narratives of my study participants provide enough evidence to support four of Acker’s (2006) inequality regimes as perpetuating and reproducing racial inequalities within the nursing profession in Ontario. This includes organizing processes that produce inequality, the visibility of inequalities, the legitimacy of inequality, and control and compliance. In this study,

supervisors were reported to reassign Visible minority nurses to other jobs or shift lines when they were verbally or physically assaulted by patients and family members because of their race. The perpetrator was reported to have been left unpunished or cautioned resulting in the perpetuation of this uncivil behaviour. In other instances, racial minorities reported being the target of excessive scrutiny and monitoring regardless of general differences. These two examples point to the processes that produce racial inequality at the workplace. Also, my study participants reported that through informal interactions while working, racist imagery and discourse and sexual harassment were used to delegitimize them, deny their claims to expertise, and their authority undermined (see Calliste, 1996; Das Gupta, 2009; Flynn, 2011). This was a means by which racialized nurses were controlled and made to comply with the inequality culture at the workplace (Acker, 2006). These uncivil experiences perpetuated by the general public (patients, family members, friends) and coworkers highlight the influence of race on workplace incivilities, invoked notions of cultural particularity and racial hierarchy, which impeded the integration of Visible minority nurses into the nursing profession.

Further, the legitimacy of inequality was found in the many systemic barriers IENs faced when attempting to enter nursing in Ontario. They often had to take bridging programs and additional training in order to get certified as their credentials did not match the Canadian standard (see Acker, 2006). This latent, systemic and subtle process of discrimination reveals the powerlessness of visible minorities to change a system built on hegemonic and White racial supremacy

Additionally, a type of Bonacich's (1972) split labour market theory is evidenced among Black nurses in their experience of caste and exclusionary oriented behaviours from White coworkers. Although, this experience did not result in differentials in pay, it had the potential of denying Blacks opportunities for upward mobility.

Although the racial experiences of Visible minority nurses were insidious and made the work more difficult and emotionally draining, it also resulted in unintended consequences for the profession. To avoid intimidation and discrimination, Visible minority nurses were found to try harder to provide excellent service and be sensitive to the needs of their

patients. In dealing with their coworkers, they took additional courses, sought mentoring and support services, and were diligent on the job. Consequently, within direct care nursing, it is possible to argue that patient and co-worker regulation also aided integration, and ensured the standards of nursing practice were kept and in some cases improved. This culminates in the provision of quality healthcare and the keeping of professional unity instead of division. On the other hand, the coping strategies of visible minorities legitimized the inequalities experienced at the workplace making it difficult for change to be effected (Acker, 2006; Kelly et al., 2015).

From a more empirical standpoint, social networks were found to facilitate primarily the integration of Visible minority nurses after they made an initial entry into the profession. Visible minority nurses turned to their visible minority colleagues in situations of patient abuse and/or co-worker bullying. In addition, they sought support from friends and family members when they experienced incivilities (Hagey, 2001). Generally, these social networks – coworkers – facilitated interpersonal bonding and exerted influence in the integration of newer nurses into the profession (Berkman et al., 2000).

Overall, this study has implications for many areas of sociological research, and has generated propositions that can be tested in future research. First, the research suggests that while foreign human capital does facilitate entry into Canada, it is mainly Canadian human capital (education and experience) that allows immigrants to integrate into the labour force. Second, this study suggests that younger immigrants are more likely to make an easy and faster entry into the nursing profession than older immigrants. Third, social networks support and influence greatly the integration of nurses into the profession and not necessarily their entry. Social networks can provide support for immigrants facing conflict and discrimination on the job. Fourth, racism and racialization appear to be embedded within the nursing profession. However, the effects of these can be mitigated by policies and practices which some hospitals (in larger centres) have implemented, while others have not. Fifth, Visible minority immigrants would appear to have better access to job opportunities in areas experiencing labour shortages. The literature on immigrant integration may benefit from more attention paid to labour market trends. Lastly, conflicts within the nursing profession appear to be shaped by hospital

restructuring, the exploitation of the patient's bill of rights, budget cuts, and increasing workloads.

6.3 Policy Implications

The findings outlined have policy implications for the development and sustainability of the nursing workforce. In order to guarantee the highest quality of care and provide conducive environment for professional practice and users of the healthcare services, I have highlighted the following policy initiatives.

First, adequate funding should be made available to increase and expand institutions that aide immigrants' integration. For instance, in this study, immigrants who had access to the CARE Centre for Internationally Educated Nurses had higher chances of overcoming the barriers to entry. CARE is a not-for-profit professional organisation that receives funding support from the Ontario government. CARE Centre supports IENs in updating their qualifications to meet Ontario entry to practice requirements for RNs and RPNs, obtain employment, advance in their careers and contribute to health care excellence in Ontario. These goals are achieved through nursing-specific language training, exam preparation, mentoring and networking (CARE Annual Report, 2013/2014). With these goals in mind, giving such organizations more resources to expand their activities would be useful. Also, the transfer of best practices from CARE to other organisations with similar goals will promote professional entry and integration of immigrants (see Covell et al., 2014).

Following the structural empowerment model of Kanter (1977) and the empirical evidence provided by Laschinger and Finegan (2005) and Wiens et al. (2014), I call on the College of Nurses of Ontario to restructure its entry and career development procedures with a focus of providing equal opportunity, information, support and resources to both visible minorities and non-visible minorities upon entry. This, when complemented by less discriminatory practices from coworkers and the public – patients and family members – will reinforce healthy work environments that facilitate good work ethics and quality healthcare. This will in turn reduce stressful work conditions, absenteeism, and promote worker efficiency.

Also, the study highlights the role of institutional policies in reducing the incidence of verbal and physical assault on nurses. This kind of support was more predominant in larger metropolitan cities where the workforce was more diverse relative to midsize cities. The universalization and implementation of policies that restrain patients and family members from being abusive and aggressive to nurses within all health care institutions, especially LTCs in Ontario, will reduce the incidence of workplace conflicts and will foster excellence in the provision of care.

Furthermore, in the face of increasing workforce diversity and population diversity, it is important that nurses are socialized and equipped with cultural competence skills in order to relate appropriately with co-workers and the public in general. The issue of racism can be addressed at the point of education. Further, instead of removing nurses from areas where they seem to be the target of racial abuse, management should endeavour to approach the issue and not excuse such behaviour as it serves as a precedent for other uncivil behaviours against Visible minority nurses. Also, IENs need to be resocialized to fit into the new work culture they find themselves. Adapting to a Canadian work culture will require support from both management and coworkers alike.

6.4 Future Research

Although this study makes theoretical and empirical contributions to the field of sociology, the study highlights important areas of research that will complement the findings made.

First, the study highlights key indicators that are useful for comparative quantitative analysis in providing a more generalizable understanding of the factors that shape the integration of professionals into the labour market and also provide policies directed at the satisfaction of professionals (see Kuhlman et al., 2015). The indicators include: age, country of origin, ethnicity or race, source of current education, marital status, number of children, immigration status, verbal abuse scale, physical abuse scale, year arrived in Canada, year of entry into profession, and current position. By using a quantitative approach to explore not only the issues identified in nursing but also comparing across

professions, the limitations associated with this study, such as the lack of generalizability, the focus on only two cities, and the limited sample size are overcome.

Second, a longitudinal study of immigrants from their arrival to their integration in the nursing profession will help establish a cause and effect relationship (see also Covell et al., 2014). Also, data for such studies should consist of the relevant indicators of integration found in this study.

Third, considering the importance of life course theories to understanding immigrants' integration, it will be most appropriate for subsequent studies to use these theories in tandem with other incorporation theories in exploring the nuances surrounding immigrants' integration into the labour market.

Next, future studies should focus on comparing the experiences of Visible minority members in different professions within the service sector. This will further test the theory of segmented assimilation and provide immigrants with the requisite information on which career pathway to pursue as they seek to integrate into the Canadian society.

Also, an experimental study that rewards patients/family members with civil behaviour and penalises uncivil behaviour will allow health administrators to implement policies that safeguard the wellbeing of employees.

Lastly, in the process of finding data for this study, it became evident that the ethnic/race variable from nursing specific datasets such as the Nursing Database (NDBs) was missing, although this information is collected when nurses renew their registration for a particular year. The National Survey of the Work and Health of Nurses does not provide useful information on the ethnicity of participants for a study of this nature. Also, the Longitudinal Survey of Immigrants to Canada (LSIC) when disaggregated by profession will result in small sample sizes that will not be useful in producing robust statistical estimates. An inclusion of such a variable in the NDBs and any other related health dataset will enable researchers replicate this study quantitatively in understanding the factors that shape immigrants' integration across professions. It will allow for a better

understanding of the factors that influence abusive behaviours at the workplace. Further, it will enable the generalization of findings to the entire Canadian population.

6.5 Conclusion

This study has provided insight into both the micro and macro factors that influence immigrants' pathways into nursing and their professional integration. It has highlighted some of the contributing factors that will ameliorate the nursing shortage, facilitate immigrants' full integration into the profession, improve working conditions for racial and ethnic minorities, and increase nurses' satisfaction and retention at the workplace. Based on the policy recommendations made in this study, dealing with the nursing workforce shortage requires the joint efforts of Citizenship and Immigration Canada and the College of Nurses of Ontario. Skilled immigrants seeking to make an entry into Canada with the aim of practising nursing should be provided with adequate information on the requirements and necessary credentials needed for professional integration. This will take away from the complex process of accreditation – delays in assembling of documents, delays in entry as immigrants will already know what is required of them to integrate fully, and will allow immigrants to make informed decisions on the paths to take towards labour market integration. Also, the removal of factors that create toxic work environments and reproduce workplace inequality are pertinent in promoting the wellbeing of nurses and their professional integration. Consequently, it is my conclusion that the removal of barriers to entry and a healthy and empowering work environment will culminate in the safety of a sustainable workforce and the promotion of quality healthcare.

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Appendices

Appendix A: Western University Ethics Approval



**Western
Research**

Research Ethics

Western University Health Science Research Ethics Board
NMREB Delegated Initial Approval Notice

Principal Investigator: Dr. Tracey Adams
Department & Institution: Social Science/Sociology, Western University

NMREB File Number: 105351
Study Title: Exploring the Career Pathways and Experiences of Nurses in Canada
Sponsor:

NMREB Initial Approval Date: June 17, 2014
NMREB Expiry Date: August 31, 2015

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Letter of Information & Consent	Letter of Information and Consent	2014/05/12
Other	Telephone Script	2014/05/12
Other	Email script	2014/05/12
Advertisement	Recruitment Poster	2014/05/12
Instruments	Semi-Structured Interview Schedule	2014/05/12
Response to Board Recommendations	Response Document	2014/06/01
Other	Summary of counseling referrals	2014/06/02
Revised Western University Protocol	clean copy of revised protocol	2014/06/02

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the HSREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of HSREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

[Signature]
Ethics Officer, on behalf of Kiley Finson, NMREB Chair

Ethics Officer to Contact for Further Information

This is an official document. Please retain the original in your files.

Appendix 3: Interview Guide

June 4, 2014

INTERVIEW GUIDE FOR RESEARCH ON THE CAREER PATHWAYS AND EXPERIENCES OF NURSES IN CANADA

Interviewer: The interview is divided into four main sections. The first section involves your journey into the nursing profession and how this was done successfully. The second deals with the social and health impact of the profession. The third focuses on your experience of conflict at the workplace. The fourth asks you to reflect a bit on your career.

A. Examining the Career Pathways of Nurses

1. What motivated you into nursing? How long have you been a nurse?
2. Can you please tell me about your education? When and where were you educated?
3. When and where did you get your nursing education? Tell me more about the other educational and professional certificates you have?
4. Can you tell me about your career? What did you do before your training as a nurse? What did you do after your graduation? Did you have any challenges in securing a job? How did you manage these challenges?
5. If an immigrant, what work were you doing before your migrated? Did you have to change your job on arrival? Can you tell me more about your career leading to nursing?
6. Can you tell me about your current job? Do you like your current employer? How do you like your current job relative to the others you have done?

B. Social and Health Effect of the Nursing Profession

1. What do you like about nursing or this job in particular? How does it impact you positively?
2. How does it impact you negatively (social relations, health – physical, work place injury and mental)?
3. Do you feel emotionally strained from your work?
4. Do you feel emotionally exhausted?
5. How do you manage this exhaustion?
6. If you do experience health problems, are these significant enough to lead to time off from work?

7. Do these (if any) health problems affect how you do your job?
8. How have you coped with the health problems of your occupation?
9. Have you ever been discriminated against? Can you please tell me your experience

C. Your Experience of Workplace Conflicts

I want to ask you some questions about conflicts and challenges at work

1. I have read that it is not uncommon for nurses to be physically and verbally abused by patients. Have experienced this kind of abuse? Physical? Verbal? How often?

Can you please describe a time this happened?

How did you deal with this situation?

Were your co-workers and supervisors or organisation supportive?

Is there more they could do to support?

2. Have you experienced conflicts with supervisors, doctors, or others in positions of authority?

What is the nature of the conflict? Can you provide an example?

How did you deal with this situation?

Were your co-workers or organisation supportive?

Is there more they could do to support or reduce this form of conflict?

3. How would you describe your relationship with your co-workers?

When conflict arises how do you solve it?

Can you please describe a time this happened?

How often do you experience this kind of conflict?

How has the organisation supported in reducing this kind of conflict?

4. In general, how do these conflicts affect your work out?

D. Reflection and General Questions

Different Experiences

1. Do you think men and women experience nursing work (health problems, conflicts, career trajectories, etc) differently?
2. Do you think that foreign-born nurses experience work in the profession differently from Canadian-born nurses?
3. Does age matter? Race – ethnicity?
4. Comparing male and female nurses, which category are more likely to rise to supervisory or management positions and why?

Reflection

1. Are you satisfied with your work? Why or why not?
2. If you were to start afresh, would you still train as a nurse?

3. Do you ever wish for a different career path?

Final Demography

Can you please tell me your age, ethnicity, country of birth, religion?

Thank you for the time spent. This has been insightful and means a lot me.

Curriculum Vitae

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Post-secondary Education and Degrees: University of Ghana
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2001-2005 B.A. (Honours) Sociology, Minor Psychology

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Research Assistant to Prof. Emeritus Paul Whitehead
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Publications:

Baiden, P., Fallon, B., Dunnen, W.D. & **Boateng, G.O.** (2015). The Enduring Effects of Early Childhood Adversities and Trouble Sleeping in Canadian Adults: A population – based study. *Sleep Medicine*, 16 (6), 760-767.

Boateng, G.O., Luginaah, I.N. & Taabazuing, M.M. (2015) Examining Risk Factors associated with Hypertension among the Elderly in Ghana. *Journal of Aging and Health*, DOI: 10.1177/0898264315577588.

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