A study of the overseas student and pupil nurses in training in U.K.

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A STUDY OF THE OVERSEAS STUDENT AND
PUPIL NURSES IN TRAINING IN U.K.

BY

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A MASTER'S THESIS

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Division, DHSS, who was ever willing to help me in the impossible, Dr. Wilson, Research Liaison Officer at West Midlands Regional Health Authority, for checking and commenting on my first draft of the questionnaire for the extensive survey, Dr. Roger Hughes, Senior Research Officer at the Research Unit, Ashridge Management College, who very kindly offered to read and comment on the final draft of my manuscript.

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Finally, I wish to acknowledge the unflagging patience of my dear wife during the two years, and moral support as well as her constructive criticism and comments from her wide range of nursing experiences.
Introduction

Until recently little interest was shown concerning the presence and impact of overseas trainees and qualified nurses in the N.H.S. hospitals. But since the setting up of the Briggs Committee which recognised "the vital part which they (overseas nurses) play in staffing National Health Service hospitals," there has been a fair amount of activity. Still, little is known about these overseas trainees and little done. There seems to be four reasons. First, it is believed that discussion of the presence of overseas trainees and their problems will make the problems worse. Secondly, a more liberal view is that to recognise that overseas trainees have problems will imply discrimination. Thirdly, it is assumed that to recognise that the overseas trainees have problems is to acknowledge that existing training programmes are inadequate to cope with them. A fourth view is that overseas trainees are transient people and will leave as soon as they qualify.

What Kendall found in 1970, that about "30% of the entrants to training in England and Wales are now overseas born" still holds true. An overseas student or pupil nurse is a person coming to the U.K. to follow a nursing course and he is subjected to the rules and regulations concerning conditions of stay in Britain by her immigration laws. This means that he must renew his permit to stay annually or bi-annually or even more frequently. Usually the employing hospital does the renewal for its recruits.

2. e.g. the setting up of Nursing Sub-committee at UKOSA which commission PEP to investigate into the problems of overseas nurses.
4. "He" is used throughout the study as well as its plural unless stated otherwise.
But in some hospitals, the trainee is responsible for renewing his permit with the Home Office which usually grant it if the latter is satisfied that he is employed in the hospital and will be so in the future. In most cases, the permit is renewed for one full year from the last date of the previous permit. When he is near completing his course however, say in two months' time, the permit will then be renewed for three months.

The very few trainees who come from Europe are excluded because their rights to enter here and to seek employment are governed by the E.E.C.'s internal labour movements regulations. The Irish can come and go freely and are also excluded.

By the beginning of 1974, the number of overseas trainees had reached saturation point. Signs are that waves of people travelling thousands of miles in order to be trained as a nurse in Britain, despite the fact that one in every four applicants entering nursing here is from overseas, their contribution to the NHS hospitals was underestimated until the setting up of Sub-Nursing Committees at UKCOSA. Their findings hit the headline in the World of Medicine with "Foreign nurses exploited" claiming that these trainees are exploited both sides of the world. At home, they were exploited by agencies which cashed in on their desire to come to the U.K. for nursing training by demanding extortionate fees. And when they arrived in Britain, UKCOSA suggested that they were being used as "cheap labour."

A critical review of the literature shows that while several studies have been undertaken, there exists a dearth of basic descriptive studies of these trainees, in particular of their motivations and expectations of nursing in the U.K. and of social, cultural and economic background.

1. European Economic Council
2. World Medicine: 5 May 1971 (51)
Aims of the Survey

In view of the scanty work and serious gaps in this field, it is essential to present, by a broad based inquiry a descriptive analysis of the recruitment of overseas trainees, their induction into the NHS hospitals as trainee nurses, and to elucidate their experiences. The emphasis is on their general characteristics—biographical data socio-cultural and economic background; basic educational qualifications; general experience of life before coming to the UK; motivations and expectations in coming here to do nursing training; basis of admission to Britain and reasons in their choice of the UK; choice of hospital and course of training; degree of awareness of nursing school and nurse training in this country; views on and experiences of nursing once they are here; views on personal adjustment to a new social system and quality of life; their job satisfaction and dissatisfaction; career intentions after completion of their courses; factors which attract them to Britain; those that smooth their training and create the acceptable atmosphere for them to stay in the nursing profession; the role the hospitals play—receptive and adaptive or antagonistic and rigidly structured? We seek to discover what relationship exists between expectation and motivation and overseas trainees’ length of stay. We seek data to substantiate or refute the claim that overseas trainees use nursing as a passport to come to the UK, and to establish, if possible, who are the "drop-outs" and also who are the "stayers."

It is hoped that the information will indicate ways of improving the procedures and systems of screening and recruitment and will show whether the organisational systems need reconsidering in order to accommodate the needs of overseas trainees. Nursing educationalists may wish to use the findings to review their training programmes. In the long term, the survey may spur the interest of those concerned with recruiting training and employing overseas trainees; in the handicaps the latter meet in their daily life while in Britain. The knowledge gained could promote their more effective employment while maintaining satisfac
and morale, thus better meeting the needs of the patients
and reducing the trainees' drop-out rate. To achieve
these objectives we need a stable, satisfied and better-
trained nursing staff. Do we have them?

These data may also help hospital personnel and overseas
trainees to a better understanding of each other. The
results can be compared with the findings of the studies
done on native nurses, to facilitate the formulation of
policies on future needs of manpower in the NHS hospitals.

General observation

This study is not trying to make a case either for the
overseas trainees or for the recruiting hospital. It is
only intended to present an enlarged snapshot of these
trainees coming to Britain for various reasons, how they
have or have not adjusted themselves in their host country.
The findings are not watertight either because only one
group of nurse trainees has been studied therefore the
opinions must similarly be one sided. In the absence of a
control group or a sample of indigenous trainees for
comparison, we must not therefore, interpret that whatever
the overseas trainees said as untruthful. As already
argued, it is possible that many of these overseas trainees
may hold strong views on the subject matter, or it could
be that this study was seen as an opportunity to let off
their penned up frustrations and personal experiences.
To give a typical example, one student nurse remarked during
the pilot study that "Due to lack of staff in certain
wards, one has to be moved from ward to ward acting like a
relief nurse or what we commonly call 'a football (nurse)
to be kicked from ward to ward.' One feels so insecure
and always afraid of being kicked away." Such a view
received very little support in the extensive survey (81
respondents only). But does this mean that such an
opinion is untrue?
Chapter 1

Review of Literature

The importance of overseas nurses is being increasingly felt for various reasons, not only for political implications but also because it presents an excellent opportunity to investigate the complex sociological and psychological factors of adjustment to a strange social system. We now review the empirical research which has so far been carried out with special reference to overseas nurses in particular the trainees.

One major stumbling block in trying to review the literature on this subject is lack of coherent detailed information in the nursing libraries. The obvious starting point was to look at the survey of nursing research since 1940 carried out by MacGuire.1 No mention of the overseas trainees was made except a study Martin carried out of 46 West Indian pupil nurses over the period of their training.2 His subjects tended to conform at first but over a period of time they adopted defensive characteristics and became more critical of their training conditions and working atmospheres.

In the mid-sixties the British Council sponsored a research study3 of overseas students including nurses in higher education "to unravel factors contributing to the success or failure of Commonwealth or ex-colonial students and nurses studying in Britain."4 Basically the study focused on five main areas:

2. J. L. Martin: West Indian Pupil Nurses and their problems in Training - Nursing Times 6 Aug. 1965 (27)
(a) Academic ability  
(b) English language proficiency  
(c) Financial resources of students and nurses  
(d) Ability to adjust to new situations  
(e) Biographical sketch of the students and nurses

The findings were based on 553 nurses from a mail survey, followed by personal interview of 97 nurses.

Kendall, in 1972 provided statistics on the overseas nurses' trainee population in Britain and pointed to the large increase in numbers and positional changes of the "donor" countries between 1959 and 1970. He questioned the underlying motives of the receiving and host because the UK had been recruiting vast numbers of overseas trainees annually yet their contribution to the staffing of the NHS hospitals "has... received relatively little attention." He then went on to describe briefly, the economic, the educational system and health services of major "donor" countries and suggested some of the centripetal forces pulling these young trainees towards the U.K. In 1971, in evidence to the Committee on Nursing, UKCOSA presented an elementary descriptive survey of "the conditions of the overseas nurses" and their problems whilst in the UK. Later, UKCOSA commissioned PEP to investigate further the condition of overseas nursing students in Britain. They published their findings in 1972. They employed structure interviews to obtain the social and educational background, and the experiences in the NHS hospitals of 206 overseas nurses, 31 student and 41 pupil nurses and a control group of 46 nurses from care of whom 9 were students and 3 pupils. The survey also looked into

2. UKCOSA: United Kingdom Council for Overseas Students Affairs,  
3. PEP: Political and Economic Planning  
the nurses' early experiences, knowledge of the British Nursing System and language difficulties.

In 1973, The Male Nurse was published and this filled a gap in the nursing research. For a very long time research had been concentrated in the general field and among the female population. The Male Nurse was a longitudinal study designed to follow the trainees through their training and to mark out their career path. It had a subsample of 162 overseas male nurses.

Around the same time, The King's Fund Centre held several meetings to discuss the language barrier of the overseas student nurses.

Broadly speaking, these studies pointed to the importance of the individual characteristics of different countries when looking at the training problems of their emigrants. At the same time the studies pointed to the lack of information given to the trainees before their arrival.

Educationally, the overseas male nurses were "better qualified than the British", but they needed to sit more than once in the examination though their overall pass rate differed very little from their fellow British trainees. That duration of stay is another factor which influences the changes in attitudes of the overseas nurses was clearly borne out in two studies. Their social adjustment was

2. Op cit. Reprints No. 732, 805 (22,23)
not very satisfactory.

From the viewpoint of this research those studies are highly specific and have ignored the importance of socio-cultural and economic, and personal factors. For example, Sen's study threw light upon the nature of their difficulties but failed to take account of the fact that Filipinos are different in their social orientation from Malaysians or other Asians. Their educational system is very Americanised and they leave their country for different reasons.

In "The Male Nurse" one sex is studied in isolation, Mauritians were over-represented in the sample while the Malaysians were under-represented and the Filipinos were omitted.

PER covered much ground with a very small sample. The study assumed that the problems were homogeneous among heterogeneous nationals. Removing other grades of nursing staff for the sample, we are left with 122 student and pupil nurses. The study also assumed that the qualified nurses have the same problems as trainees.

Martin's study on the other hand was restricted to a very small number of West Indian pupils in one particular hospital and in one particular aspect of attitudinal changes which might be explained by deriving their expectations from their cultural and social backgrounds. It is a very specific study.

That a survey into the motivations and expectations of overseas trainees in the UK might be necessary was also suggested by the commonly made statement that foreigners are using nursing training as a means of entering this country. UKCOSA also saw the need to establish a "Descriptive survey of overseas student nurses" to answer

2. UKCOSA: Overseas Nursing students in Britain - evidence to the Committee on Nursing 1971 P.42 (47)
the basic simple questions such as: who are these trainees, where do they come from and go to? And how many of them are coming to the UK?

The Sixties and the early Seventies witnessed a dramatic influx of overseas trainee nurses to the UK. Thousands came every year but now there is only a trickle. This sudden rise among the overseas trainee recruits was influenced by the social and economic conditions of both the donor and receiving countries.

We show in chapter 4 that the population coming from different countries changed markedly over time as a direct result of changes in their social and economic conditions. In Malaysia, for example, a politically discriminating policy against all the non-Malays motivated many parents to seek opportunities within their means for their children to go overseas. This could be for higher education, training courses, nursing because they wish their children to have a 'better future'. These pressures have overcome the strong cultural preferences among Asian families for keeping their children, especially their daughters, at home.

Social expectations have also changed. Going abroad to study, to follow a training or even to work carries prestige. This is further heightened by the lack of facilities in the donor countries such as universities, medical schools or their inadequacy.

We also show in the same chapter that overpopulation and unemployment particularly among the school leavers among the donor countries oblige their citizens to seek better opportunities elsewhere. Thus the Philippines in 1965 had a general unemployment of 8 per cent together with 55 per cent for those with some primary education, 26 per cent for those who had been in high school and 13 per cent for those who had college education. Similarly, over half of all unemployed were under 25 years and were still seeking their first regular job.

In contrast during that period, U.K. was enjoying a boom. Industries were expanding. Unemployment was about 2.5% while there were still many employment opportunities. Table 1.1 clearly bears this out.

Table 1.1. Total numbers of unemployed and number of vacancies notified and unfilled from 1960 - 1973

<table>
<thead>
<tr>
<th>Year</th>
<th>%</th>
<th>Number of unemployed (000s)</th>
<th>No. of vacancies notified &amp; unfilled (000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>1.5</td>
<td>345.8</td>
<td>313.5</td>
</tr>
<tr>
<td>1961</td>
<td>1.4</td>
<td>312.1</td>
<td>320.3</td>
</tr>
<tr>
<td>1962</td>
<td>1.9</td>
<td>431.9</td>
<td>215.7</td>
</tr>
<tr>
<td>1963</td>
<td>2.3</td>
<td>520.6</td>
<td>196.3</td>
</tr>
<tr>
<td>1964</td>
<td>1.6</td>
<td>372.2</td>
<td>317.2</td>
</tr>
<tr>
<td>1965</td>
<td>1.4</td>
<td>317.0</td>
<td>384.4</td>
</tr>
<tr>
<td>1966</td>
<td>1.4</td>
<td>330.9</td>
<td>370.9</td>
</tr>
<tr>
<td>1967</td>
<td>2.2</td>
<td>521.0</td>
<td>249.7</td>
</tr>
<tr>
<td>1968</td>
<td>2.4</td>
<td>549.4</td>
<td>271.3</td>
</tr>
<tr>
<td>1969</td>
<td>2.4</td>
<td>543.8</td>
<td>284.8</td>
</tr>
<tr>
<td>1970</td>
<td>2.5</td>
<td>582.2</td>
<td>259.6</td>
</tr>
<tr>
<td>1971</td>
<td>3.4</td>
<td>755.4</td>
<td>175.1</td>
</tr>
<tr>
<td>1972</td>
<td>3.8</td>
<td>844.1</td>
<td>189.3</td>
</tr>
<tr>
<td>1973</td>
<td>2.6</td>
<td>597.9</td>
<td>397.7</td>
</tr>
</tbody>
</table>

While at the same time the number of immigrants steadily rose despite the 1971 Immigration Act, reaching a peak in the late sixties. (see figs 1.1 & 1.2 below)

1. Department of Employment Gazette; Vol LXXXIII No.12, December 1975 p.1312, table 104 (unemployed figures include school leavers)
2. Office of Population Censuses & Surveys: Population Trends 1, Autumn 1975, p3. (fig.1.1 shows migration between the U.K and the rest of the world. Fig1.2 shows country of origin of immigrants in the U.K.)
Fig 1.1 Net migration between the UK and the rest of the world by citizenship (Mid 1964 - mid 1974)

Fig 1.2 Where immigrants came from 1964 to 1973

Source: Both figs are reproduced from; Office of Population Censuses & Surveys: Population Trends, Autumn 1975, p3, figs 1 & 2
At the same time, available data show that the service sector, particularly, the National Health Services expanded dramatically as shown in the table 1.2 below.

Table 1.2

Total public expenditure in the service sector
(from 1965/66 to 1973/74) *

<table>
<thead>
<tr>
<th>Year</th>
<th>1965/66</th>
<th>66/67</th>
<th>67/68</th>
<th>68/69</th>
<th>69/70</th>
<th>70/71</th>
<th>71/72</th>
<th>72/73</th>
<th>73/74</th>
</tr>
</thead>
<tbody>
<tr>
<td>£m</td>
<td>1319</td>
<td>1447</td>
<td>1588</td>
<td>1709</td>
<td>1797</td>
<td>2111</td>
<td>2405</td>
<td>2746</td>
<td>3101</td>
</tr>
</tbody>
</table>


Consequently, both sectors were competing for labour but the Health services were at a disadvantage. Until the Halsbury Report¹, nursing was still regarded as a dedicated profession with meagre pay. Nurses were (and are) still working 'unsociable' hours while industry was offering good salary and better working hours.

Faced with expansion programmes, with little chance of recruiting local people, particularly among the school leavers², the hospitals turned to the overseas applicants and received a flood of applications. Table 1.3 below demonstrates the steady influence of the overseas recruits while there is an erratic fluctuation among the local recruits.

Table 1.3 The number of trainees recruited between 1967 and 1973 pupil midwives are excluded from the figures.

<table>
<thead>
<tr>
<th>Year</th>
<th>no. of local recruits</th>
<th>no. of overseas recruits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>57190</td>
<td>15557</td>
</tr>
<tr>
<td>1968</td>
<td>57122</td>
<td>14432</td>
</tr>
<tr>
<td>1969</td>
<td>53391</td>
<td>15355</td>
</tr>
<tr>
<td>1970</td>
<td>48068</td>
<td>16573</td>
</tr>
<tr>
<td>1971</td>
<td>51121</td>
<td>16277</td>
</tr>
<tr>
<td>1972</td>
<td>56584</td>
<td>15472</td>
</tr>
<tr>
<td>1973</td>
<td>58993</td>
<td>15428</td>
</tr>
</tbody>
</table>


². A. Briggs: Report of the Committee on Nursing. Cmd5115, 1972, p.125 (It argued that the increase in the nursing personnel recently was only achieved by increasing the intake of older persons)
The difficulty in recruiting local persons into nursing during the boom period can be easily highlighted from the figures released by the Department of Employment. Thus, in December, 1970, there were 11063 unfilled vacancies for all grade of nursing duty compared with only 2582 in 1975 for the same period.

In competing for local labour, the psychiatric and mental handicap hospitals came off worst, followed by the general hospitals. Yet the teaching hospitals had waiting lists and their entrance requirements were far higher compared with the rest. For the psychiatric and mental handicap hospitals the situation was a crisis and they increasingly experienced difficulty in maintaining their entrance requirements.

It was therefore, decided to carry out a comprehensive broad and descriptive, and sociologically orientated study of the overseas student and pupil nurses in the UK. We hope that the results might point to areas deserving more thorough investigation. The aim is, in an exploratory way, to answer the question "is nursing being used as a means to come to the UK with entrants moving on to other fields of employment completely divorced from nursing?" Like many other research studies, the final report of this study written from hindsight is to some degree different from the original conception.

There were no other means to countercheck. In fact to do so might strain the relationship between the overseas trainees and the nursing administrators. It is hoped that the latter, when they have the opportunity to read this study, will judge for themselves, its validity and criticism will be welcomed through the nursing journals. From the research viewpoint, another similar study is very much desired. Only this time, the respondents will be native trainees.

Similarly, problems of adjustments and loneliness are not confined to overseas trainees only but also to the overseas people in general as well as to natives moving from North to South in particular among the eighteen years old leaving home for the first time to take up nursing in a distant hospital.

Chapter 2

Methodology

1. Preliminary Informal Visits to Hospitals

For the purpose of this study, we spent much time in the company of overseas nurses in their nurses' homes. The discussions were very casual as well as social and notes were taken after meeting without their knowledge. The entry was easy and inconspicuous because of friends in these hospitals but they did not know our purpose. The topics were: "how did you come to the U.K. and why? What sort of problems you have met if any? What do you think of your present training and work?" These topics were only introduced if the discussions were touching their periphery to avoid suspicion, they were otherwise left till next time.

Following these meetings, the various routes\(^1\) were charted and seventeen P.N.Os (T) were requested to comment on them. These P.N.Os (T) were picked randomly in the Hospital Annual Book 1973. Their reactions were mixed ranging from outright refusals (10) to useful comments. The seven who commented substantiated the overseas nurses' own account of the various "routes" they had employed to come to Britain during the informal and social discussions. Some of these "routes" are necessarily costly and involved

1. See Appendix A.
agencies as well as bribery and other malpractices in their own country.

2. The Pilot Study

On the basis of these meetings, and comments from the P.N.Os (T) and from the reading materials, the questionnaire was drafted and piloted. The questionnaire was 14 foolscap pages long and detailed. It consisted many 'open-ended' questions to allow for variety of responses but more important to allow the respondents to feel that the study has an intrinsic value rather than that they were being used purely for our need. We believed and still believe that this approach had helped to enhance interest from the respondents, hence we received a higher response rate.

The questionnaire was distributed to ten overseas students in the university and fifteen to overseas trainees in a general and a mental handicap hospital known to represent different nationalities, grades and sex. Both groups were informed of the purpose of the questionnaire and of the study and they were asked to comment on design, wording, length of the questionnaire and the comprehension of the questions.

To the students in the university, the questionnaire was left and was collected later on. The overseas trainees
were off duty and were asked to fill the questionnaire there and then. It was not possible to group the overseas trainees to a focal point because they felt it inappropriate "to wash their dirty linen in the public." One of them commented, "I do not wish anyone else to know what I have written down, besides my problems are my own." We were however, allowed free access to their rooms now and then to see if they needed any assistance and to listen to their comments.

As expected, the university students found the questionnaire difficult to fill because most of the questions did not concern them and one found it "revolting." Four preferred not to comment and the other six thought the questionnaire was too long. The overseas trainees were at first suspicious and apprehensive of completing the questionnaire despite reassurance. Several questioned us: "Who are you? Why do you want to do this research? Where do you work? Where do you come from? Is there anybody else working with you? Do the hospital people (meaning nursing administrators) know you are here and will they see my replies?" Two trainees did not have time to complete the questionnaire on the spot and agreed to do so later to be ready for collection next day. In fact, on the following day they still did not fill it. They were "not sure" and were not "reluctant" but rather "afraid" lest their views were made known to their employing authority. They were in fact questioning the nature of confidentiality like
"are you sure that they (nursing administrators) will not know that we have filled your questionnaire?"

The questionnaire was completed in the end after further reassurance. Perhaps, it would be interesting to know how much belief and trust the respondents had on the personal introduction letter and the letter from the researcher's supervisor, both of which stressed confidentiality. The guess is, in the general population, research is taken as routine and does not raise worries about confidentiality being regarded as part and parcel of the research ethic. This present group and other groups of overseas persons required double assurance on confidentiality and authenticated by the author of the letter in person. It was also observed that after personal assurance, the trainees appeared more relaxed. On the whole, they found the questionnaire interesting and thought "the questionnaire is O.K. and the questions are interesting because it is hoped to help us in the end; I do not mind completing it" or on similar lines. This was clearly borne out on the returns.

The pilot study offered a unique opportunity to observe the trainees' reactions, to listen to their comments and at the same time to learn the nature of difficulties in filling the questionnaire, as well as to "time" them. Thus, we learnt, that not all trainees came as student or pupil nurses and tourists, some came as full-time students.
in higher education, domestics; that the Filipinos found it difficult to complete the section on education as their educational system is American based, that there was also confusion with the flow of the questions owing to lack of clear directions. Their comments and reactions (apprehensions or fear?) prompted alternative method of collecting the data; to go to the sampled hospitals to hand out questionnaires personally to the trainees instead of using the postal services as previously envisaged.

We also learned from one Malaysian trainee that recently someone sent her group (all Malaysians) a questionnaire to complete. They threw the questionnaire into the dustbin because they did not know who was the sender and did not see the person as well. Personal presence at the time of handing out the questionnaire was seen as a vital factor in addition to the introductory letters to reassure the respondents.

3. Modification as a result of the pilot study
The pilot study pointed to the need of the researcher's presence at the time of distributing the questionnaire. Consequently the respondents had to be grouped into a focal place and this meant that as many respondents as possible had to be taken away from their duty for a period of time. This procedure also meant involving the nursing administrators to arrange for the trainees to be released. Yet our aim was not to involve the former or as little as
possible because:

(i) The N.H.S. hospitals were preparing for the re-organisation, 1st April 1974, hence the nursing administrators' work would be increased and there was already a national staff shortage in the hospital. Our request for their involvement might just prove to be the last straw.

(ii) On several occasions the nursing administrators themselves pointed out that they got fed up with researchers as they did not see the end products. It was therefore aimed to reduce "non-permission" rate from the hospitals.

The alternative method of data collection also meant that the length of questionnaire must be trimmed down, but by how much? Fortunately, during the preliminary discussion with the nursing administrators, the general opinion was favourable to allow respondents on duty half-hour off their wards to participate, and a shorter version of the questionnaire was decided in order to meet the time limit.

4. The Research Approach

After the pilot study, a two-fold approach was decided.

(1) Mail questionnaire plus personal presence or extensive survey.
(2) Personal interview.

Most of the questions in the extensive survey were "closed" with alternative answers and the respondents were asked to tick the appropriate one. These answers were carefully selected from the replies to the "open-ended" questions from the pilot study and the preliminary meetings and discussions with the overseas trainees. The respondents were of course given a column to specify "other reasons" they wished to give. The reasons like "I've always wanted to be a nurse" or on similar lines was deliberately omitted because it was thought that its inclusion would attract a larger number of ticks and thus undermine the validity to measure motivations. It was also hoped that the columns for "other reasons" would bring out spontaneous feelings (and true ones?) should the wish to nurse was a strong reason and would thus provide a better idea of respondents' motivations.

A personal interview with a sub-sample of 120 respondents was also scheduled in order to overcome the limitations of the "closed" questions in the extensive survey, to obtain more detailed and qualitative information, and to include the important "open" questions chopped off in the extensive survey questionnaire to elicit some aspects of the trainees' socio-cultural and economic background, their knowledge of British hospitals, etc. In some areas, questions were duplicated chiefly to compare the answers for reliability. It was suspected that some overseas trainees may have

1. See Appendix B.3
2. See Appendix B.4
exaggerated their past in an attempt to elevate their social status as the researcher is an overseas person. As it turned out there was a high degree of consistency between both sources of information with the following exceptions. On the questions of personal experience, two stated they were in full-time employment when the extensive questionnaire they were unemployed. Another three replied that they were in full-time study when in fact they had previously indicated to be unemployed.

At the same time the interview was intensive in order to provide a qualitative frame of reference to the extended survey data.

5. Sampling Procedures

The research had two aims; first, to collect information about the overseas trainees in Britain, and secondly, to seek to explain from the data why do the overseas people travel so many thousand of miles in order to follow a nursing career here when there are nursing schools in their own country, or why do they leave their own country to seek a nursing training in Britain? Ideally, one kind of sampling procedure should suffice the needs of both aims i.e. the first required a representative sample of overseas trainees in this country. Unfortunately, these trainees were split all over the U.K. as the hospitals are, and owing to practical limitations of the resources, finance and assistance in the field work, random sampling
was rejected as it would involve wider geographical areas and as the research would be carried out single-handed.

The second aim required a stratified sample to ensure sufficient numbers from different countries to be included. Unfortunately, information needed for both aims was difficult to obtain and would increase the number of refusals if the nursing administrators were pestered too often. The required information was age, sex, their about and type of nursing training in. It would also have meant longer delays. The DHSS publish an annual statistical report on overseas trainees - i.e., their numbers by R.H.A.'s country of origin. Such information was very inadequate because one RHA has more than one hospital as well as types of nursing. After careful consideration, it was decided to rank the R.H.A.'s according to size of overseas trainees they recruited and to select first six largest R.H.A.'s. These were the four Thames R.H.A.'s, Trent Regional Health Authority and West Midlands Regional Health Authority. We guessed that the chances of a hospital recruited all its overseas trainees from one particular country were very small or almost nil. Rather the opposite was true, i.e., a mix bag as we had previously experienced.

The Regional Nursing Officers of the sampled R.H.A.'s were approached for the 3.B.H. 131A and B forms to provide the numbers of overseas trainees in each hospital of their


2. See Appendix D.
respective region. Later their co-operation was also sought to allow selected hospitals in their region to be included in the sample. It was then still possible to identify trainees by type of nursing on those forms. These hospitals were similarly ranked as the R.H.A's. Originally first two largest hospitals were selected in each of the three types of nursing, that is, General, Psychiatric and Mental Handicap hospitals making 36 hospitals for the six R.H.A's.

According to the statistical information the six R.H.A's recruited over 70% of the total population of pre-registration overseas student and pupil nurses in Britain, and these regions provided a fair location and travelling distances for the researcher. The high percentage of overseas trainees in these regions also implied a concentration therefore, we guessed that regional differences will have less effect on the quality of information to be collected.

During the planning stage, the DHSS were concerned about the size of the sample which they felt might be too large to be handled by one individual. At their suggestion the sample was scaled down to an estimated 2,500 overseas trainees from 18 largest hospitals among the six R.H.A's. It was then noticed that within the 18 hospitals, one recruited only students while among the rejected ones, one recruited only pupils. Both were general hospitals and we thought it interesting to see if these trainees behave.

1. After 1973 the numbers on those forms represent a group of hospitals.
differently. We expected that pupil nurses would be more discontented with their training. Hence, the final sample has nineteen hospitals. Table 2.1. below shows how these were achieved by the type of nursing and by Regional Health Authority.

Table 2.1 Where the hospitals came from

<table>
<thead>
<tr>
<th>R.H.A.s</th>
<th>Types of hospitals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General</td>
<td>Psychiatric</td>
</tr>
<tr>
<td>North West</td>
<td>2(2)</td>
<td>1(1)</td>
</tr>
<tr>
<td>Thames R.H.A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td>1(1)</td>
<td>1(1)</td>
</tr>
<tr>
<td>Thames R.H.A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South East</td>
<td>1(1)</td>
<td>1(1)</td>
</tr>
<tr>
<td>Thames R.H.A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td>1(1)</td>
<td>1(1)</td>
</tr>
<tr>
<td>Thames R.H.A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trent R.H.A.</td>
<td>2(1)</td>
<td>2(1)</td>
</tr>
<tr>
<td>West Midlands R.H.A</td>
<td>0(1)</td>
<td>0(1)</td>
</tr>
</tbody>
</table>

Figures in bracket represent expected number;
* This R.H.A. had to be dropped from the sample later (see part III of section on problems in this chapter)

The interview sample was drawn randomly from the 622 respondents who volunteered their names at the end of the extensive mail survey, or one in five. Four from each country were decided but this turned out to be difficult to achieve as shown in the table 2.2 below.
Table 2.2: Sample of interviewees by status, type of nursing and country of origin

<table>
<thead>
<tr>
<th>Status</th>
<th>type of nursing</th>
<th>Malaysia</th>
<th>Mauritius</th>
<th>West Indies</th>
<th>Africa</th>
<th>Philippines</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENTS</td>
<td>General</td>
<td>6(4)</td>
<td>4(4)</td>
<td>4(4)</td>
<td>4(4)</td>
<td>5(4)</td>
<td>23(20)</td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>6(4)</td>
<td>5(4)</td>
<td>5(4)</td>
<td>3(4)</td>
<td>4(4)</td>
<td>23(20)</td>
</tr>
<tr>
<td></td>
<td>Handicap</td>
<td>5(4)</td>
<td>4(4)</td>
<td>5(4)</td>
<td>5(4)</td>
<td>3(4)</td>
<td>22(20)</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>5(4)</td>
<td>4(4)</td>
<td>5(4)</td>
<td>5(4)</td>
<td>3(4)</td>
<td></td>
</tr>
<tr>
<td>PUPILS</td>
<td>General</td>
<td>5(4)</td>
<td>2(4)</td>
<td>5(4)</td>
<td>1(4)</td>
<td>4(4)</td>
<td>17(20)</td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>4(4)</td>
<td>5(4)</td>
<td>1(4)</td>
<td>0(4)</td>
<td>5(4)</td>
<td>15(20)</td>
</tr>
<tr>
<td></td>
<td>Handicap</td>
<td>4(4)</td>
<td>4(4)</td>
<td>6(4)</td>
<td>3(4)</td>
<td>3(4)</td>
<td>20(20)</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>30(24)</td>
<td>24(24)</td>
<td>26(24)</td>
<td>20(24)</td>
<td>24(24)</td>
<td>120(120)</td>
</tr>
</tbody>
</table>

Figures in brackets represent expected numbers to be interviewed.

Source: respondents who gave their name for interview in the extensive mail survey.

During the selection stage for interview insufficient number of respondents were noted from certain countries if we were to achieve the expected size by country of origin and numbers from other countries were, therefore, proportionally increased. In addition, the nature of nursing duties created difficulties.
to interview all the selected respondents although permission was granted by the nursing administrators to allow those on duty time off; some had suddenly swapped holidays with their friends so that the latter could have longer periods later on, hence expected respondents were away on holiday on that particular day; there were those off on that day and had to go away for personal reasons, some were taken ill and again others were on secondment to other hospital or in the community for experience, or some were allocated night duty. All these factors illustrated a chaotic picture and showed that it was never possible to see all of them on the same day as it was difficult to foretell who will be on or off duty in a month's time and it was necessary to stay overnight in many cases. To maintain the sampling framework, as many selected respondents were interviewed as possible and the rest were substituted. The substitutes were matched as closely as possible by age, type and years of training, sex and country of origin and as far as practicably allowed because much depended upon who was available and whether the person was prepared to be interviewed with short and sudden notice. Consequently, there is a large discrepancy between expected and achieved numbers as shown in table 2.2 column A and B. Some of the respondents who were away for the day and had given the researcher notice to be interviewed later, were contacted by telephone on that evening or later. Six such respondents were contacted and eventually interviewed.
6. Collection of Data

The questionnaire for the extensive survey was given to 2,010 (1,888) overseas trainees altogether. Trainees in fourteen hospitals were personally given a questionnaire and those not met were left with the questionnaire, a stamped addressed envelope sealed in another envelope addressed to the person individually via their "pigeon hole" at the hospital's mailing centre. For the other five hospitals the questionnaire had to be mailed to the trainees addressed individually.

Another source of cooperation from the trainees was achieved during the preliminary meetings with the nursing administrators. During those visits, as many overseas trainees as possible were seen personally either in groups or individually, eg. in school if there were "blocks" or in the nurses' homes sitting room. The nursing administrators gave the assistance. These overseas trainees were informed of the research aims and were also asked to help to disseminate what they had just learned to their friends and to discuss it among themselves. The old "bush telegraph" communication had been a very useful means of making the research known to a wider audience and it had been instrumental to higher turn out to complete the questionnaire. The trainees were also informed of the arrangements made with the nursing administrators and that they were to expect a personal letter informing them of the date and time we would...

1. Please refer section 7c of this chapter.
return with the questionnaire.

It was possible to address to the overseas trainees individually because the tutors were approached to provide a list with their names, sex, age, country of origin and grade and type of nursing was identified by hospital name. This list had allowed a closer personal approach by addressing these overseas trainees by their name. Such contact also gave us a further opportunity to emphasize the confidentiality of the research and the important part they would play. Similarly, the nursing administrators who had liaised with us at first were asked to put up notices on our behalf regarding the next visit and also where we would be stationed within the hospital.

When handing out the questionnaire, the participants were again reassured personally that whatever they put in the questionnaire would be kept confidential. The questionnaire were also collected there and then. Special care was taken to remind the participants not to copy their friends' views or to ask their friends to help them, and to complete all the questions applicable to them.

Those left with the questionnaire were allowed seven
days interval to return it. Two reminders were then sent at weekly intervals to those who had not yet returned. Obviously some might have received the reminders repeatedly when in fact they had already completed and returned the questionnaire but did not volunteered their name for interview. There was no means of identifying them. The last reminder requested the trainee to complete a slip to indicate (by ticking) whether or not they wish to participate.

Of the 1,236 completed questionnaires received, 114 were rejected because the participants did not come within the definition of an overseas trainee, i.e. they did not hold permit to stay in Britain, eight were incomplete. In one mental handicap hospital, the response rate was so low at 16% (13 out of 80) that it was dropped from the sample and there was adequate assurance that the unassayed numbers had no peculiar characteristics having special implications for the research. These trainees were comparable with the rest of the sample. At the same time only two of them had given their name for interview. Table 2.3 reports how the trainees had responded by hospital.
### Table 2.3. Response Rate by Hospital

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of questionnaires sent or handed out</td>
<td>No of Qs returned</td>
<td>No of Qs rejected</td>
<td>No of Valid Qs rec'd as % of Col.B</td>
<td>Valid Qs recorded as % of Col.B</td>
<td></td>
</tr>
<tr>
<td>AM</td>
<td>47</td>
<td>44</td>
<td>1</td>
<td>43</td>
<td>91.5</td>
<td></td>
</tr>
<tr>
<td>EM</td>
<td>194</td>
<td>104</td>
<td>0</td>
<td>104</td>
<td>53.6</td>
<td></td>
</tr>
<tr>
<td>CM</td>
<td>80</td>
<td>68</td>
<td>4</td>
<td>64</td>
<td>80.0</td>
<td></td>
</tr>
<tr>
<td>DM</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>EM</td>
<td>44</td>
<td>23</td>
<td>0</td>
<td>23</td>
<td>52.3</td>
<td></td>
</tr>
<tr>
<td>GG</td>
<td>274</td>
<td>166</td>
<td>36</td>
<td>132</td>
<td>48.2</td>
<td></td>
</tr>
<tr>
<td>HG</td>
<td>36</td>
<td>30</td>
<td>0</td>
<td>30</td>
<td>85.3</td>
<td></td>
</tr>
<tr>
<td>IG</td>
<td>53</td>
<td>34</td>
<td>1</td>
<td>33</td>
<td>62.3</td>
<td></td>
</tr>
<tr>
<td>JC</td>
<td>156</td>
<td>124</td>
<td>36</td>
<td>88</td>
<td>56.4</td>
<td></td>
</tr>
<tr>
<td>KG</td>
<td>42</td>
<td>30</td>
<td>0</td>
<td>30</td>
<td>71.4</td>
<td></td>
</tr>
<tr>
<td>IG</td>
<td>110</td>
<td>87</td>
<td>0</td>
<td>87</td>
<td>79.1</td>
<td></td>
</tr>
<tr>
<td>KG</td>
<td>54</td>
<td>41</td>
<td>0</td>
<td>41</td>
<td>75.9</td>
<td></td>
</tr>
<tr>
<td>NP</td>
<td>209</td>
<td>146</td>
<td>3</td>
<td>143</td>
<td>68.4</td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>95</td>
<td>53</td>
<td>9</td>
<td>44</td>
<td>46.3</td>
<td></td>
</tr>
<tr>
<td>PP</td>
<td>107</td>
<td>64</td>
<td>13</td>
<td>51</td>
<td>47.7</td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>207</td>
<td>127</td>
<td>16</td>
<td>111</td>
<td>53.6</td>
<td></td>
</tr>
<tr>
<td>RP</td>
<td>64</td>
<td>44</td>
<td>0</td>
<td>44</td>
<td>68.8</td>
<td></td>
</tr>
<tr>
<td>SP</td>
<td>33</td>
<td>30</td>
<td>0</td>
<td>30</td>
<td>90.9</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1808</td>
<td>1223</td>
<td>122</td>
<td>1101</td>
<td>60.9</td>
<td></td>
</tr>
</tbody>
</table>

Hospital FM was dropped off from the sample as 13 only out of 60 questionnaires were returned.

(The digraphs under heading "Hospitals", AM, EM etc., are code references to the hospitals)

* These 3 questionnaires were withdrawn at the time of handing out hence the number of questionnaires handed out was 3 and the 3 questionnaires were returned with 100% valid Qs received.
The interview took about 30-45 minutes on the average and the trainees on duty were individually released and reported to us one at a time. The respondents were reminded of the general objectives of the study and reassured. Answers to the questions were written as accurately as possible and verbatim.

One important point to bear in mind when interpreting the data so obtained is how representative are they? or how different are they from those who chose not to be interviewed? Are there in fact differences? A sample of their comments both the volunteers and non-volunteers for the interview were given below.

The volunteers for the interview

(1) Some used this interview for different purposes, "I want to ask you something when I see you personally. I won't mind discussing nursing and many other things with you. I think you will be of great help to me and all nurses." "I would very much like this opportunity, please do!"

Some gave their names with caution. "Trusting that you keep your word and do not reveal my identity ...... I hope I will not be in trouble by submitting my name. If so, I wish to withdraw." "Do keep my information in great confidence".

Non-volunteers for the interview

(1) The reason is "Miss Anonymous wish(es) to be unknown .....

... because you will be disliked if people from here knows
your true feelings and complaints you have" and "for fear of victimization". Another reason why "I will not write my name (is because) I wish to pursue my S.R.N. here (same hospital) or I might need their reference for some other hospitals because do you know this alone could affect my reference."

(2) Some refused to be interviewed for personal reasons and were apologetic. They commented: "Sorry, but I do not like to be interviewed, perhaps I am not good in conversation," "my exams are near, please don't interrupt me during my study time."

(3) Some wanted to be interviewed yet did not give their names because though, "I am willing to be interviewed but I feel insecure to give my name." Several suggested that "if you want to contact, what you could do is to put a notice on the school notice board saying 'will 290,785 meet me at such a date and place' giving me your phone number so that I could call you."

From the above comments one was left perplexed with many questions. In the absence of objective data, the answer could only be hypothetical. The comments also pointed towards differences of different nature. They could be those showing deep "interest" or less "afraid" and "cautious" as well as "approhensive" at each end of the pole. Why were they unwilling or willing to be interviewed? Could it be that in the former, the persons were apathetic?
Apathy as a result of being satisfied with their lot, i.e. with hospital life, training? If this was the case, they could have contributed useful information to this virgin area. If apathy as the direct result of the fact that these overseas trainees felt powerless to influence the administrative policies over their fate whether they participated in the interview or not, they too would have important information to part for the research. This apathy is alienation and Merton sees this a retreatist response which to him "seems to emerge from conditions of great normative complexity and/or rapid social change, when individuals are pushed this way and that by numerous conflicting norms and grades, until the person is literally disorientated and demoralised, unable to secure a firm commitment to a set of norms that he can feel as self-consistent." 1

Consequently, these overseas trainees failed to identify with the aims and objectives of the research as well. It is very possible as to be suggested later that this group could not only have had very little or no practical experience with research, might have seen this research as a threat to their stay in the U.K.

All the enclosed questions on both extensive survey and interview schedule were precoded and the 'open' questions were coded by frequency counts. The completed questionnaires

were coded by two university students and the researcher. A random check was carried out, 1 in 5, 1 in 10, 1 in 20 for errors. The data were then transferred to punch cards and analysis was done by using statistical Package for Social Scientist computer programme.

7. Problems encountered during the study

Three types of problem could be identified:

(a) The entry
(b) Weakness in design
(c) External circumstances

7a. The entry

To carry out a research as extensive as the present one, a careful approach is required in order to create a smooth working relationship with the nursing administrators in particular with the alteration of data collection. Fortunately, the aim to involve the nursing administrators as little as possible in the form filling was achieved. Lesser involvement should have been possible had more comprehensive statistical data been made available. This had in fact, strained the working relationship. Data like numbers of overseas trainees by country of origin, sex, and type of nursing and training, and likewise for those overseas trained who had left their training, were difficult to extract and some hospitals refused outright to assist.
In addition to many hospitals doing a study on overseas trainees spelled "trouble-finding." One can sympathize with their concern. Ten hospitals refused. One C.N.O. offered the preliminary and afterwards turned down the request because "too many studies have already been done on this particular group of trainees," and also their numbers were declining. Three of the hospitals within the West Midlands R.H.A. had to be substituted because they did not have overseas trainees — contrary to expectation. Later on this R.H.A. had to be dropped from the sample because of the nurses' industrial action. One Mental Handicap hospital in North West Thames R.H.A. followed its verbal offer on the phone to allow it to be included in the sample, with a letter to withdraw the offer.

In few cases, where the delineation of authority was clear, the P.N.Os (T) if they were interested there was no problem in obtaining co-operation; some even went to the extent of planning how this study should be carried out in their particular hospital.

1. The researcher was informed by a nursing administrator of one of the hospitals which had refused co-operate that only recently prior to our request, an agency did a research for adverse publicity purpose and we were immediately identified as another threat.

2. Nurses' strike took a worse turn in around June for this particular R.H.A.
Entrance is the most difficult to overcome and hospitals are organisations which are very bureaucratic, autocratic and insular. External communication is very difficult to penetrate with the red-tape ever present. Some interested nursing administrators were very frustrated for being unable to assist and were "embarrassed" to have to inform me that they could not help after all because their "boss" was not keen. Lengthy communication was the common feature but a firm offer to assist could be concluded by one single letter of introduction together with a letter from the R.N.O. and a preliminary meeting to discuss in more details the research; in some cases the offer came after several letters and in two cases two preliminary visits with two different persons were necessary because the first person met did not discuss the project to the second one who rightly asserted that he was responsible for the trainees' welfare and hence he should have been approached first. Similarly, there was a noticeable conflict as to who should liaise with the researcher; i.e., a person from service or teaching side? Consequently, duplications in supplying the required information was very often. On reflection, this jungle of communication up to now one still finds it difficult to edge one's way through. Despite the appearance of a very hierarchical organisation, there was no defined functions for the tenants. On many occasions we were instructed to write to such and such a person instead of passing our letter directly to the person concerned. On several occasions we had unknowingly trodden on the nursing
Thus, who is one to contact first among the array of nursing administrators? A letter addressed innocently to the supposedly "right" person could create awkward situations both for the researcher and the person if the latter turned out to be "wrong" one. On such occasions, the request was either turned down right away or it was delayed for a very long period. It must however, be pointed out that N.H.S. hospitals were preparing for the re-organisation and that very often adaptation and re-organisation could create strains and stress among individuals as well as collectively especially in a corporate whose goal is to improve the health of the general public.

All the six R.H.As heads' blessings were, on the whole, easily come by. The C.N.O.S. of the selected hospitals were in turn approached for their permission together with a request to meet them for more detail discussions, with a view to making arrangements for a return visit to distribute questionnaires personally to the overseas trainees as planned.

The foregoing discussions explained why the anticipated 2,500 overseas trainees target was not achieved. Every hospital substituted, the numbers dropped accordingly.

7(b) Weakness in design

The quality of the information obtained depends very
much on the design of the research itself. A well designed research also depends very much on the quality of the background information available. A social science research rarely achieves this ideal situation because the subjects under study are not inanimate and they react. Present study was very much hampered by the background information on these overseas trainees, consequently the ranking method had many pitfalls like:

(1) It was arbitrary and selective

(2) Linked to (1) it was biased in terms of choice as well as of regional differences.

(3) The method was very purposeful.

Thus, if regional differences ought to be included, the design failed to catch hospitals outside the metropolis (or did it?). How representative are the data so obtained, in particular to other hospitals outside the five R.H.As? How representative are the 1,101 of the 1,808 respondents? The overall response rate was 60.8% and table 2.4 showed their distribution by country of origin.

For economic reasons and less time consuming, this method was preferred while random and stratified procedures were too time consuming before a sample could be drawn and they were not plausible because nursing schools were already
combined for more effective administration. Similarly, the remaining eight R.H.A's shared the remaining 30% of the overseas trainees and the research was specifically aimed at the latter group.

Further analysis revealed that most overseas trainees were concentrated in larger and well-known cities like Manchester, Leeds, Liverpool etc. (well known to these trainees while still at home?). At the same time the eighteen selected hospitals were found in the suburbia rather than in the heart of cities. Some were even in remote villages where transport facilities were "poor" like hourly bus service with very few services on Sundays and public holidays. In addition to the geographical spread, these eighteen hospitals commanded different numbers of overseas trainees, one hospital had only three trainees while at the other end one had 274. The figure would be misleading without further explanation which will be given in the next section.

7(c) External circumstances

This research, at the very start, October 1973, was caught in the process mill of Salmon Committee on Senior Nursing Staff Structure to elevate nursing from "the secondary position which it seemed to occupy."¹ The committee

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¹ Ministry of Health and Scottish Home and Health Department: Report of the Committee on Senior Nursing Staff Structure. H.M.S.O. London 1966. (30)
<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>1 (AM)</th>
<th>2 (EM)</th>
<th>3 (CM)</th>
<th>4 (DM)</th>
<th>5 (EM)</th>
<th>6 (GG)</th>
<th>7 (HG)</th>
<th>8 (IG)</th>
<th>9 (JG)</th>
<th>10 (KG)</th>
<th>11 (LC)</th>
<th>12 (MG)</th>
<th>13 (NF)</th>
<th>14 (OP)</th>
<th>15 (PP)</th>
<th>16 (OF)</th>
<th>17 (RP)</th>
<th>18 (SP)</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaysia</td>
<td>11</td>
<td>41</td>
<td>30</td>
<td>0</td>
<td>29</td>
<td>186</td>
<td>22</td>
<td>10</td>
<td>85</td>
<td>11</td>
<td>96</td>
<td>18</td>
<td>63</td>
<td>11</td>
<td>55</td>
<td>66</td>
<td>42</td>
<td>4</td>
<td>556</td>
</tr>
<tr>
<td>West Indies</td>
<td>3</td>
<td>26</td>
<td>21</td>
<td>1</td>
<td>0</td>
<td>71</td>
<td>6</td>
<td>8</td>
<td>35</td>
<td>13</td>
<td>7</td>
<td>0</td>
<td>75</td>
<td>23</td>
<td>18</td>
<td>45</td>
<td>6</td>
<td>18</td>
<td>168</td>
</tr>
<tr>
<td>Mauritius</td>
<td>25</td>
<td>79</td>
<td>29</td>
<td>2</td>
<td>13</td>
<td>1</td>
<td>4</td>
<td>14</td>
<td>6</td>
<td>8</td>
<td>0</td>
<td>10</td>
<td>18</td>
<td>24</td>
<td>50</td>
<td>7</td>
<td>8</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>2</td>
<td>7</td>
<td>12</td>
<td>10</td>
<td>3</td>
<td>0</td>
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<td>35</td>
<td>2</td>
<td>38</td>
<td>4</td>
<td>1</td>
<td>91</td>
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<tr>
<td>Philippines</td>
<td>8</td>
<td>38</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>14</td>
<td>8</td>
<td>0</td>
<td>4</td>
<td>36</td>
<td>19</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>121</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>47</td>
<td>194</td>
<td>80</td>
<td>3</td>
<td>44</td>
<td>274</td>
<td>36</td>
<td>53</td>
<td>156</td>
<td>42</td>
<td>110</td>
<td>54</td>
<td>209</td>
<td>95</td>
<td>107</td>
<td>207</td>
<td>64</td>
<td>33</td>
<td>1101</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey

* AC* = Achieved numbers
+ XP+ = Expected numbers

The hospitals are numbered 1-18 in this table (the digraphs AM, EM etc., are code references to the hospitals)
recommended restructuring and grouping of hospitals and schools of nursing to a workable unit under one head and of course its recommendations were then very active after initial experiments. But no sooner had these newly born units had time to breathe and orientate themselves to the new "environment" and under a new head, another grinder, in the name of reorganisation was appearing in the horizon and promised further ups and downs in the administrative system by 1st April 1974.

With small nursing schools grouped, it was increasingly difficult to identify the trainees by the type of the hospitals they were first recruited to. It was felt wise not to insist upon identifying the overseas trainees to the hospitals because:

(1) In many cases the P.N.O.(T) of the new school group was too preoccupied with settling down himself, his staff and trainees.

(2) The chances were, the P.N.Os (T) would turn down any request as already experienced recently like "I am afraid it would be too difficult to give the numbers ...... as each hospital in the group was an individual training school" or "we are totally unable to recover figures because this hospital became a group in April 1971 and due to a number of unforeseen problems some of the records have disappeared." 1

1 From correspondence with P.N.Os (T).
Added to this, the training programmes required the trainees to gain wider experience in all hospitals within the group at least for several months spell. This, in fact blurred the demarcation line and during the extensive survey, the trainees explained that they did not root in any particular hospital because their training requirements put them "on the hop all the time." The abnormally large figures like in hospitals GG and DM (Table 2.4) could only be accounted for by this unification policy.

By April 1974, the myth that nurses have "the satisfaction of an instinct for benevolence" and would not think of taking striking actions in order to achieve higher wages evaporated. By early June, the industrial action among nurses was causing serious worries in some hospitals and was spreading quite extensively. This research did not escape from the adverse effect of such action. Because this research was already perceived by some nursing administrators as interfering into their "berth" or their "world", as trying to find "trouble". In fact, many C.N.0s and P.N.0s commented that "many researches have been done and the end results are simply criticism and trouble rather than anything else". Or else that "nothing is heard afterwards." Such apathetic response from the top echelons is understandable or is it?

1 Rt. Hon. J. Enoch Powell: Article in SNAP 12 April 1974.(49)
The nurses' industrial action therefore provided nursing administrators with an excellent excuse to opt out of their previous offer since the study required overseas trainees on duty to be released for at least half an hour when an over-time ban was imposed and the nursing administrators would need all their available staff on the wards than to fill out questionnaires.

One major effect was total lost of the sixth R.H.As. The P.N.O (T) explained that "circumstances have arisen within this organisation which affect the arrangements I have made with you. Naturally, I am not able to specify the circumstances, but hope you will understand. I realise that this will affect your study, but my duty is to my organisation. I will, therefore, have to withdraw my offer."

Understandably, the strike action took a worse turn and it was then end of June and it was too late to find another RHA substitute to start approaches afresh. In addition, a new substitute would delay this research programme in addition to the protracted communication system already experienced. Returns of completed questionnaires from other five RHA's were almost completed.

In another five hospitals, anxiety was real enough because their nursing administrators requested the arranged return visit to distribute questionnaires to be delayed. It was possible to make a return visit to one of them but to the other four hospitals it was decided to send the
questionnaire to the trainees by post instead since it was uncertain when the strike action would cease. Again, it was necessary to allow time for "striking dust" to settle down before another approach could be made. But time was limited and we were concerned about the possible affect of the strike action might have on the data. Sending the questionnaires by post to the trainees also presented an opportunity to evaluate the decision to change the approach to the extensive survey.

The response rate from those four hospitals with one exception was fair at over 44% but lessor compare with the other 15 hospitals at 63.3%. F.M. produced 13 completed questionnaires out of eighty sent and two volunteers for interview. It was decided to exclude this hospital for analysis. How do we explain for this low response rate? One possible reason could be that during the preliminary meeting with the tutor there, I was not able to establish contact with overseas trainees. The tutor did not feel it appropriate to contact the trainees at this "early stage". The lack of informal contact with the trainees precluded the "bush telegraph" communication which had so far proved effective. Could it be this? or the lack of personal contact? The exclusion of that hospital was not thought harmful to the research for the trainees there were as homogeneous as in the rest as revealed when the information given by the tutor was compared with the rest of the eighteen hospitals.
8. Non-response

Reasons for non-response were very difficult to establish, though their importance as a possible source of bias was not ignored. These problems were however widely discussed. One obvious bias could be that the respondents may be more interested in the research topic. This is further collaborated by Chapion and Sear\(^2\) who agreed that "response rates are biased by respondents who are strongly interested in the topic under investigation and have firm opinions about it", and they illustrated Katz and Cantril's findings: "People with intense opinions tended (in fact) to respond to a questionnaire ballot with greater frequency than persons holding moderate or neutral opinions." Moser and Kalton have discussed vividly the problems of non-response\(^4\) and have suggested that sponsorship of, the population for, and the subject


3 R.Cochrane (Ed) Advances in Social Research: Article by P.J.Chapion and A.N.Sear P263, Constable 1973 (7)

matter of the research are important influences in the mail survey.\textsuperscript{1} This research was presented to the subjects as being sponsored by the University because experiences suggested that to mention "D.R.S.S." would mean instant suspicion and recoil from participation.

One possible reason could be these trainees, while still at home, may have had very little or no experiences of surveys and of filling long and detailed questionnaires. They were therefore not sufficiently orientated to the concept that surveys or social investigations are part of the life of the industrialised countries. True, enough before this research, the only period these trainees needed to complete such detailed questionnaires could possible be when they applied for a passport or visa, a driving licence. All those were formal and official. It is also possible that they might identify the questionnaire as a threat to their freedom or stay in the U.K. Dr. Hughes\textsuperscript{2} confirms that Italians and Spaniards were suspicious and the latter view his study as being "chased by police."

\textsuperscript{1} Op cit P262 (32)

\textsuperscript{2} Dr. R. Hughes, Senior Research Officer at Ashridge Management College mentioned this during discussion on problems of non-response.
Attempts to find out the possible reasons for the non-
response suggested that:

(1) Apathy: we were told that many trained
whom we did not meet during the preliminary
visits believe "nothing can be done to
improve our lot." During one of the preliminary
visits one trainee asked "do you really think
that anything will be done afterwards?" "Do
you know they don't care what happens to you
as long as you are on your feet and on duty?"
Another one commented. Many questionnaires
therefore may have been dropped into the
wastepaper basket.

(2) Suspicion: At least three interviewees were
surprised to note that the researcher was
foreign after all! Commenting "I thought you
were English! This at the same time, throws
doubt on the value of the introductory letters
especially those trainees who received
questionnaires by post. One Rhodesian student
nurse commented that "where I come from one is
better off without expressing one's own views."

(3) The questionnaires were distributed near the
examination period and many thus did not care
to read through the introductory letters but
simply threw the questionnaires in the waste-
paper baskets.

(4) It was simply general laziness in replying to letters as one respondent puts it "I do not like writing letters and this applies to most of us because the job is tiring and all we want to do after duty is plenty rest and sleep!"

9. Responses

Informal sources of information and opinions obtained during preliminary meetings, discussions, during personal distribution of questionnaires and during interviews suggested that:

(1) Personal contact with the trainees helped to establish a rapport. It was suggested that the information may be biased because the trainees were coerced to fill the questionnaire, i.e., the official permission to allow them off their duty to complete the questionnaire suggested an element of coercion in itself. It must be pointed out immediately that such arrangement with the nursing administrators never amounted to coercing these trainees. Besides, these trainees were reminded that participation was voluntary and they may withdraw if they elected to do so.

(2) A general interest in the subject of the research shown by the trainees. Many commented on the returned
questionnaires that they had enjoyed participating.
Some requested to read the findings of the study on
completion. Perhaps, as argued above, filling ques-
tionnaires might be their first experience and it was
a novelty. Instead of being suspicious, they were
curious. At the same time, they might actually feel
that there was someone, of their kind? interested enough
to take the trouble of coming from so far to collect
their views. Their comments suggested this; "Thank
you very much for showing an interest in our problems;"
or "thank you for listening to my woes." Again, "It is
very nice of you taking so much trouble to find out our
problems. I hope with your kind help, these problems
that the overseas students have, would be solved eventually."

(3) As the research is from a university, it assured
them of respectability of the research. With a letter
from a Professor requesting their co-operation was some-
thing of an unusual treat and might even have raised
their self-respect.

(4) It might be possible that some really had strong
attitudes towards the topic of research.

(5) Economically, they could not lose because a stamped
addressed envelope was enclosed. Psychologically, the
s.a.e. might be a "moral obligation" to return.
(6) Some might have been so glad to receive something from someone, therefore, more impulse to complete the questionnaire and return it.

(7) It might be that some were bored stiff and found filling a questionnaire as a break to their monotony.

(8) Could the nationality of the researcher have influenced the response?

10. Limitations of Generalisations

From the onset, it was appreciated that a survey of a sample of areas representative of the whole country could be impracticable with the manpower available. No attempt was therefore made to do so and it was decided to carry out the study in selected areas.

The sampling methods have made generalisations limited. Two obvious limitations to the generalisations of the survey. The generalisation of the findings within the sample and secondly generalisation outside the sample to the entire population of overseas trainees in the U.K.

Similarly 60.8% of the sample population replied to the questionnaire. How far can such findings be considered representative of the entire sample? Why the remaining
40% or less did not reply? Are their characteristics different from those who replied? and in what ways they are different from each other? What about those who volunteered to be interviewed? Are they representative of the sample? In the absence of reliable and empirical data the answers must be speculative. The non-respondents, argued earlier, were of:

(1) The apathetics who felt that "nothing can be done to improve their lot," because (a) "they (hospitals) don't care what happens to you as long as you are on your feet and on duty" - an alienative reaction; (b) they failed to identify with the aims and objectives of the research; (c) they were generally satisfied with the facilities and services of the hospital they were working with.

(2) Those who were suspicious of the researcher's motives and nationality.

(3) Persons who did not reply because of pressures of examinations, general laziness and any other reasons.

Do these non-respondents differ from the respondents? A comparison of the early and late respondents did not show any marked differences so does the comparison of the views of the respondents who were personally handed with the questionnaire and of those who received the question-
table shows three different views of the respondents identified "as By Post" in column A, they received questionnaires by Post. "Left at Hospital" were late respondents in column B, "Handed out" in column C they were handed with a questionnaire and completed it on the spot. The two exceptions noticed here are response 5 and 7 in section (iii) column A which show a dramatic rise in the numbers of trainees "by Post" felt that the "staffing situations" and "more money" must be improved. Similarly those trainees in column B by "Left at hospital" showed a significant percentage rise. What could be the explanations. Earlier on, it was suggested that industrial actions may be contributory factors because the nurses' industrial action was widespread by then and the crux of the strike was for better working conditions and more pay. In addition, they may have felt the pressure of the shortage of staff as a result of the overtime ban that was resorted. In general, against the absence of any significant differences among the late (left at hospital), early (handed out) and non-personal contact (by post) and, with minimum informal contact in the latter case, a fairly large number of respondents were achieved, it can be argued that the handicap imposed by the non-response, is not a very serious one.

The second limitation of generalisation arises mainly from the selection procedures of the respondents. The sample included mainly trainees from the London area and
Table 2.5(A)

<table>
<thead>
<tr>
<th>Q.11.A Why did you decide to come here to do the nursing course?</th>
<th>A By post(118)</th>
<th>B Left at the hospital(415)</th>
<th>C Handed out (568)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Better pay here</td>
<td>5 4.2%*</td>
<td>12 2.9%*</td>
<td>25 4.4%**</td>
</tr>
<tr>
<td>2. Better career</td>
<td>56 47.5</td>
<td>194 46.7</td>
<td>251 44.2</td>
</tr>
<tr>
<td>3. A prestige for young persons</td>
<td>30 25.4</td>
<td>103 24.8</td>
<td>142 25.0</td>
</tr>
<tr>
<td>4. A job that pays</td>
<td>28 23.7</td>
<td>89 21.4</td>
<td>116 20.4</td>
</tr>
<tr>
<td>5. Difficult to obtain</td>
<td>61 51.7</td>
<td>278 67.0</td>
<td>298 52.5</td>
</tr>
<tr>
<td>6. Lack of employment</td>
<td>66 56.0</td>
<td>259 62.4</td>
<td>327 57.5</td>
</tr>
<tr>
<td>7. Other reasons</td>
<td>30 25.4</td>
<td>110 26.5</td>
<td>152 26.7</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey

Figures in brackets represent the number of questionnaires returned from various means

* percentage of 118
+ percentage of 415
** percentage of 568
**Table 2.5(B)**

<table>
<thead>
<tr>
<th>Q.13 While still at home how much did you worry about:</th>
<th>A By post(118)</th>
<th>B Left at hospital(415)</th>
<th>C Handed out(568)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very much</td>
<td>Much</td>
<td>Not at all</td>
</tr>
<tr>
<td>1. Life in a hospital</td>
<td>16 13.6%</td>
<td>32 27.1%</td>
<td>70 59.3%</td>
</tr>
<tr>
<td>2. Living with people of different...</td>
<td>13 11.0%</td>
<td>20 17.0%</td>
<td>85 67.0%</td>
</tr>
<tr>
<td>3. Dirty article</td>
<td>10 8.4%</td>
<td>25 21.8%</td>
<td>83 69.8%</td>
</tr>
<tr>
<td>4. Whether the work would be...</td>
<td>12 10.1%</td>
<td>31 26.2%</td>
<td>75 63.7%</td>
</tr>
<tr>
<td>5. Types of patients</td>
<td>33 28.0%</td>
<td>34 28.8%</td>
<td>51 43.2%</td>
</tr>
<tr>
<td>6. Whether people would be...</td>
<td>28 23.7%</td>
<td>36 30.5%</td>
<td>54 45.8%</td>
</tr>
</tbody>
</table>

Source: extensive mail survey

* } please refer to footnotes of table 2.5(A)

** **
### Table 2.5(C)

**Q.20c. Under what conditions would you be contented and likely to pursue nursing as a career?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>A (Exit post 118)</th>
<th>B (415)</th>
<th>C (Handed out 568)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better working atmosphere</td>
<td>72 61.0%</td>
<td>257 61.2%</td>
<td>356 62.7%</td>
</tr>
<tr>
<td>Change attitudes among officers</td>
<td>60 50.8%</td>
<td>206 49.6%</td>
<td>303 53.3%</td>
</tr>
<tr>
<td>Better training programme</td>
<td>29 24.6%</td>
<td>98 23.6%</td>
<td>135 23.7%</td>
</tr>
<tr>
<td>Closer link between school &amp; ward</td>
<td>36 30.5%</td>
<td>111 27.0%</td>
<td>175 30.3%</td>
</tr>
<tr>
<td>Improve staffing situation</td>
<td>110 93.2%</td>
<td>96 23.3%</td>
<td>98 17.3%</td>
</tr>
<tr>
<td>More specialisation opportunities</td>
<td>37 31.3%</td>
<td>108 26.0%</td>
<td>142 25.0%</td>
</tr>
<tr>
<td>More money</td>
<td>94 79.6%</td>
<td>167 40.2%</td>
<td>191 33.6%</td>
</tr>
<tr>
<td>Raising nursing standards</td>
<td>18 15.3%</td>
<td>90 21.7%</td>
<td>158 19.8%</td>
</tr>
<tr>
<td>No comments</td>
<td>30 25.4%</td>
<td>109 26.2%</td>
<td>111 17.8%</td>
</tr>
</tbody>
</table>

Source: extensive mail survey

* please refer to footnotes of table 2.5(A)

+ please refer to footnotes of table 2.5(A)

** please refer to footnotes of table 2.5(A)
also that the sample mainly covered the metropolis and in well known areas. It is therefore logical the findings should be limited to those areas, perhaps to areas with high numbers of overseas trainees. But then as discussed above the original six R.H.As recruited over 70% of the overseas trainees in U.K. and that the majority were to be found in the four Thames R.H.As 58% or together with Trent R.H.A., there was 62% of the trainees in U.K. Do the findings here reflect the general opinions of the trainees in U.K? or should the remaining R.H.A. have been included in the study? It is not certain if the survey population was representative of the overseas trainees in U.K. because the sample was not based on a random selection of hospitals but what is apparent is we had a very high response rate and the characteristics of the respondents suggested no significant departure from the general overseas population.

11. Ex-Overseas Trainees

A sample of ex-overseas trainees was included in the research plan. Those who had left training between January 1973 and May 1974 among the selected hospitals were to be considered. Difficulties in contacting them were envisaged with added problems that as a policy, the hospitals do not supply information about their ex-employees. Advice and assistance were again sought from nursing administrators during the preliminary discussion...
meetings. The final arrangement to seek out that "elusive" group were:

(1) The nursing administrator liaising with me at the time would forward the questionnaire to the ex overseas trainees if any with postage and s.a.e. enclosed so that the latter could return the completed questionnaire direct to me at the university.

(2) The nursing administrator would provide some background information such as sex, age, year of training reached when the person withdrew, country of origin.

The questionnaire was a modification of the extensive survey questionnaire with some added items.² There were 78 drop-outs during the specified period among the eighteen instead of nineteen hospitals. One hospital refused to co-operate with arrangements discussed above. Of the 78, eight had transferred to another type of nursing training and eighteen had returned home. Consequently, fifty-two questionnaires were sent out. The number could have been more had the 19th hospital co-operated.²

1. See appendix. N.5
2. Several respondents had informed the researcher that many trainees in that hospital were demoted because they were vociferous against authority, but reasons for demotion were "unsuitable for training." In their words, those demoted "were fighting for their own rights." They were re-employed as nursing assistants. No verification was made with the authority as doing so may antagonise the hospital more and jeopardise whatever co-operation had been achieved so far for both part of the research.
Through experience, this group of people are more elusive than nurses in training and in anticipation that they may have changed their addresses since leaving the hospital, four weeks were allowed before the first reminder was followed. Only five had completed and returned the questionnaire. Thirty-eight were returned as undelivered. Of these, twenty bore "gone home" or "gone away" on the envelopes and seven had been re-directed back to me as "not here". Those envelopes were opened and resealed with sellotape before they were returned. The remaining nine, after two reminders did not return the questionnaire.

Since the sample is so small (5 respondents), it was decided to abandon this group in the mainstream of the research.
Chapter 3

Characteristics

The general opinion suggests that persons coming to nursing were from the lower middle class and working class, in particular trainees from Ireland and overseas, and also overseas persons are less educated. The Potato Famine of 1848 has been constantly put forward as a reason for the Irish emigrants. For the overseas, instance of remittances were given as an indication of their socio-economic status. Are these assumptions right? But first, several other questions need to be answered.

These questions have both practical and sociological importance and their practical significance lies in their implications for recruitment and administration in the schools of nursing. They are of sociological importance because of their relevance to the general questions about vocational choice, the place of work in the organisation of these trainees' lives and their career patterns.

Who are the overseas student and pupil nurses? What kind of people are they? What are their social and geographic origins? What do we know of their age, sex and race? Why do so many overseas persons come here to do a nursing course? To what extent are they active in the social life of their communities? How do they spend their off-duty hours? From what kinds of families do they
spring?

But first, "where do these trainees come from?" This question can be answered in two ways (1) whether they come from a happy or unhappy home (2) by their social origins. At this early stage, in nursing research, there is little or no empirical data for the first alternative because we know nothing about the particular styles of life of these trainees preceding their arrival in the U.K. What then can we learn from their social origins?

Social origins mean a host of things but the research will concentrate on the occupational rating of the trainees' fathers and some aspects of the family structures they were brought up.

Of the literature reviewed by MacGuire all refers with one exception, exclusively to female indigenous trainees.\textsuperscript{1} The one referred to was a study on the attitudinal change of West Indian pupil nurses. Until recently there was no major research which looked into the increasing number of overseas trainees and by 1972 the figure stood at 26\%\textsuperscript{2} of the trainee population. Despite the study of

1. J.MacGuire Threshold of Nursing: occasional Papers on Social Administration No.30 (26)

Sen, PEP, their study was specialised but failed to give a clear comprehensive picture of the socio-economic, educational and cultural backgrounds of these trainees.

It is the aim of this survey to collect empirical data to fill the gap and to provide an enlarged snapshot of the kind of the overseas trainees who had travelled so many thousands of miles in order to follow a nursing course here. The extensive survey and interview data are the main source of information.

Country of Origin

This classification is used by the D.H.S.S., G.N.C. and British Council to identify these overseas trainees by their country of birth. Table 3.1 columns A and B shows the population sample by sex, and total. For the purpose of analysis, it was more convenient to group these countries further. The grouping was made on the assumption that some characteristics are similar, thus in Malaysia, Sri Lanka, Hong Kong and Asia were grouped


to Malaysians because of their similar socio-cultural similarities. "Other" to Mauritians because of European outlook. Table 3.1 shows the new groupings.

The table also shows that higher numbers of females than males came to do nursing in Britain and that over three-quarters of the overseas entrants were student nurses. On closer study of the analysis we found that more persons from Malaysia and Africa were registered as student nurses. This high figure could be due to the sampling method.

Table 3.1 Breakdown of Trainees by Status, Sex and Country of origin

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Status</th>
<th>Students</th>
<th>Pupils</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>females</td>
<td>males</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td></td>
<td>356</td>
<td>120</td>
<td>556(85.6%)</td>
</tr>
<tr>
<td>Mauritius</td>
<td></td>
<td>22</td>
<td>88</td>
<td>165(66.6%)</td>
</tr>
<tr>
<td>West Indies</td>
<td></td>
<td>83</td>
<td>34</td>
<td>116(69.6%)</td>
</tr>
<tr>
<td>Philippines</td>
<td></td>
<td>46</td>
<td>6</td>
<td>121(43.0%)</td>
</tr>
<tr>
<td>Africa</td>
<td></td>
<td>42</td>
<td>33</td>
<td>91(82.4%)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>549</td>
<td>281</td>
<td>1101(75.4%)</td>
</tr>
</tbody>
</table>

figures in brackets represent students as % of the total.

Source: extensive mail survey.
The population of student nurses in the West Indies group appeared high compared to the general overseas population, i.e. 69.6% against 38% in the Philippines. What are the explanations for this anomaly? Looking at the DHSS statistical data, it was noted that of the total numbers in the teaching hospitals, about 21% pupil nurses compared with only 5% student nurses were from overseas. At the same time, the teaching hospitals were excluded from the sample.

Similarly, it appeared that more pupil nurses tended to be in the hospitals outside the R.N.A.s in the sample. For example, the rejected West Midlands R.N.A. recruited 14.3% overseas students against 24.7% pupils.

Apparently the Philippines recruited in the Metropolis had higher students population than in other regions. This could be the result of stronger competition in the former to gain places and those who were rejected had to accept pupil nurse courses in the hospitals outside the Metropolis, or could it be that in the outside more

2. Op cit (10)
3. It was decided to exclude the trainees in the teaching hospitals in the study because it was believed that the majority of the trainees were government sponsored or those who could come for personal interviews before being offered a post.
potential local recruits were available therefore the
Filipinos could not compete?

The trainees from Mauritius presented an exceptional
case to the general pattern of overseas trainees by sex
ratio as shown in Table 3.1.

The possible reason to be discussed in greater details
in the chapter below, was that much was contributed by
socio-cultural norms constraining the educational
opportunities for the females in Mauritius. On the whole,
overseas female trainee population was much lower than
the 37% of the total trainee population including part-timers
in 1971. The implication was nevertheless there, that
the nursing profession is still very much regarded as a
woman's speciality.

With only 32% of the survey population males, our
population represents a highly biased sample of all
immigrants where we would expect predominance of males;
in any migratory movement men are more apt to move and
to seek their fortunes outside their own country of origin.
In our case there is a proportion of females because as
we have said, nursing has been traditionally looked upon
as a female profession. The figure for overseas male
trainees was nevertheless higher than expected and when compared with proportion of British male trainees (19%) - to the nursing course.

2. Age

The minimum age to enter into either a school or pupil nurse course is 17½ in Scotland and 18 in England, though in practice, a typical indigenous girl starts training at the age of 18. Available data show that generally, most local entrants are under 20. This trend has varied very little. Thus, the Lancet reported (in 1947) that the Working Party's Report found that "about 17% of the hospital nurses enter training before the age of 18, but 19 is the most popular age of entry. Half enter before the age of 20." 2 In 1968, Cross reported that over 55% of the females entered nursing training before and at 18 or, more than 69% entered before they were 20. 3

What is the age of entry for the overseas trainees? We would expect them to be much older than their indigenous fellow trainees. At the time of the survey the bulk of the trainees were between 20-25 years old and the rest were scattered equally towards both end of the continuum i.e. 18-19 to 30+ age as shown in Table 3.2.

Table 3.2 Age of the Trainees at the time of the survey by status

<table>
<thead>
<tr>
<th>Age group</th>
<th>Students</th>
<th>Pupils</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-19</td>
<td>88(10.6%)</td>
<td>27(10.0%)</td>
<td>115</td>
</tr>
<tr>
<td>20-21</td>
<td>303(36.5%)</td>
<td>75(27.7%)</td>
<td>378</td>
</tr>
<tr>
<td>22-25</td>
<td>334(40.2%)</td>
<td>113(41.7%)</td>
<td>347</td>
</tr>
<tr>
<td>26-30</td>
<td>82(9.9%)</td>
<td>44(16.2%)</td>
<td>126</td>
</tr>
<tr>
<td>30+</td>
<td>23(2.8%)</td>
<td>12(4.4%)</td>
<td>35</td>
</tr>
<tr>
<td>Totals</td>
<td>830(100.0%)</td>
<td>271(100.0%)</td>
<td>1101</td>
</tr>
</tbody>
</table>

Source: extensive mail survey
*Column percentage

Is there any age difference among the "donor" countries and among the different types of training course? The figures in the table suggested that trainees among younger age groups tended to be students and infact there was a relationship between age and types of course. Thus, as the age group increased the proportion of pupil nurses increased and that of student declined. Further analysis provided in Table 3.3 showed that male students in general nursing tended to be older than their fellows.
in either psychiatric or mental handicap nursing.

Table 3.3. Age of the trainees at the time of survey by status and type of nursing

<table>
<thead>
<tr>
<th>Status</th>
<th>type of nursing</th>
<th>sex</th>
<th>age groups</th>
<th>10-19</th>
<th>20-21</th>
<th>22-25</th>
<th>26-30</th>
<th>30+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENTS</td>
<td>General</td>
<td>F</td>
<td></td>
<td>52(17.8)</td>
<td>142(48.5)</td>
<td>84(28.6)</td>
<td>13(4.5)</td>
<td>2(0.6)</td>
<td>293</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>1(2.6)</td>
<td>8(21.1)</td>
<td>19(50.0)</td>
<td>8(21.1)</td>
<td>2(5.2)</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>F</td>
<td></td>
<td>17(9.8)</td>
<td>57(33.0)</td>
<td>85(49.1)</td>
<td>8(4.6)</td>
<td>6(3.5)</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>7(4.5)</td>
<td>33(21.4)</td>
<td>78(50.6)</td>
<td>26(17.0)</td>
<td>10(6.5)</td>
<td>154</td>
</tr>
<tr>
<td></td>
<td>Mental handicap</td>
<td>F</td>
<td></td>
<td>5(6.0)</td>
<td>33(39.7)</td>
<td>31(37.4)</td>
<td>12(14.5)</td>
<td>2(2.4)</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>6(6.7)</td>
<td>30(33.7)</td>
<td>37(41.6)</td>
<td>15(16.9)</td>
<td>1(1.1)</td>
<td>89</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>F</td>
<td></td>
<td>74(13.5)</td>
<td>232(42.3)</td>
<td>200(36.4)</td>
<td>33(6.0)</td>
<td>10(1.8)</td>
<td>549</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>14(5.0)</td>
<td>71(25.2)</td>
<td>134(47.7)</td>
<td>49(17.4)</td>
<td>13(4.9)</td>
<td>281</td>
</tr>
<tr>
<td>PUPILS</td>
<td>General</td>
<td>F</td>
<td></td>
<td>21(19.3)</td>
<td>36(33.0)</td>
<td>38(34.8)</td>
<td>11(10.1)</td>
<td>3(2.8)</td>
<td>109</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1(100.0)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>F</td>
<td></td>
<td>3(4.9)</td>
<td>16(26.2)</td>
<td>32(52.5)</td>
<td>8(13.1)</td>
<td>2(3.3)</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>1(2.9)</td>
<td>9(25.7)</td>
<td>14(40.0)</td>
<td>10(28.5)</td>
<td>1(2.9)</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Mental handicap</td>
<td>F</td>
<td></td>
<td>1(3.1)</td>
<td>6(18.7)</td>
<td>15(46.9)</td>
<td>7(21.9)</td>
<td>3(9.4)</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>1(3.0)</td>
<td>8(24.3)</td>
<td>14(42.4)</td>
<td>7(21.9)</td>
<td>3(9.1)</td>
<td>33</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>F</td>
<td></td>
<td>25(12.4)</td>
<td>58(28.7)</td>
<td>85(42.0)</td>
<td>26(12.9)</td>
<td>8(4.0)</td>
<td>202</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td></td>
<td>2(2.9)</td>
<td>17(24.6)</td>
<td>28(40.6)</td>
<td>18(26.1)</td>
<td>4(5.8)</td>
<td>69</td>
</tr>
</tbody>
</table>

Source: extensive mail survey

F= female respondents

M= male respondents

Figures in the brackets are percentage of row totals
Among the female population there was a reverse position except for the trainees for both sexes who were generally much older than other overseas trainees.

Looking at the pupils we found a wider variation among both sexes. They were older. But contrary to general expectation, the females started their courses later than their male counterparts. Breaking the data by different type of nursing, the general observation is that trainees in general nursing were much younger than the other two types of nursing (see Table 3.3).

The difference between the two types of nursing courses by age distribution became less significant for the male population when the figures were viewed as a whole. Male males tended to enter nursing at an older age than the females as expected.

What was the trainees' age at the commencement of their training? Neither source, the extensive survey nor personal interviews produced a straightforward answer. Since information like the status of the trainees, their age and the year of training they had reached at the time of this research, was available, it was therefore possible to estimate the age of the trainees when they started their course. First, taking those who said to be first year as constant with whatever age group they had ticked. Those in different age groups who claimed to be in their second year of training were then added to the first year group.
year group by their respective age group. Table 3.4 were the results and it also showed that among student nurses, entrants in general nursing were the youngest at the mean age score of 21.1. They were being followed very closely by mental handicap and psychiatric entrants with the mean age of 21.8 and 22 respectively. The overall student nurses' mean age at the commencement of their training was 21.6 years old. The pupil nurses, as expected, were older by few months, at 22.3 years old. Those in the mental handicap nursing were oldest with a mean age of 23.2; the general pupil nurses, the youngest with a mean score of 21.5 and the psychiatric trainees in between at 22.4 years old.

Why overseas trainees in general enter nursing in Britain at an older age than native trainees? The obvious reason would be the geographical distance and this would mean that longer time is required to process an application. We show later that an overseas trainee may need to wait up to two years to obtain an offer and that not all of those who came started the training immediately.

Coming to Britain is not a matter of packing up and leaving especially when it involves going to a foreign country. After an offer of a post, a trainee has to prepare himself and that involves time. He has to get the necessary immigration papers through the bureaucratic procedures. In many cases more time was lost by the over-present red-tape which is part and parcel of bureaucratization.
Table 3.4 Age of the trainees at the start of their training by status and type of nursing

<table>
<thead>
<tr>
<th>Status</th>
<th>Age group</th>
<th>type of nursing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>General psychiatry</td>
<td>mental handicap</td>
</tr>
<tr>
<td>STUDENTS</td>
<td>18-19</td>
<td>91</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>20-21</td>
<td>138</td>
<td>116</td>
</tr>
<tr>
<td></td>
<td>22-25</td>
<td>85</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>26-30</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>30+</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>331</td>
<td>327</td>
</tr>
<tr>
<td>Mean age</td>
<td></td>
<td>21.1</td>
<td>22.02</td>
</tr>
<tr>
<td>PUPILS</td>
<td>18-19</td>
<td>29</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>20-21</td>
<td>42</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>22-25</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>26-30</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>30+</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>110</td>
<td>96</td>
</tr>
<tr>
<td>Mean age</td>
<td></td>
<td>21.5</td>
<td>22.4</td>
</tr>
</tbody>
</table>

Source: extensive mail survey
he needs to prepare his personal belongings, to book an air passage. In addition, nursing schools in the U.K. do not entertain to accept overseas trainees under 18 and this means that all trainees do not start applying until 18 or over.

It was therefore, not surprising to find that overseas started their training much older than their fellow indigenous trainees. Age group 20-21 was the most popular among these trainees (compared with the indigenous entrants who are most likely to have started training by 19 for the girls and somewhat older for men.) In actual fact, those trainees appeared to have started earlier than otherwise suggested by other studies 1, 2, 3 but agreed with Brown's and Stone's observation that larger number of overseas trainees would start nursing course at 21 or over. 4

2. P.E.P.: Overseas nurses in Britain: 1972, P.11 (33)
4. Op Cit P.35 (39)
3. Marital Status

Very high proportion of these trainees were expected to be single and the results confirmed this but they were much higher than other studies had found. \(^1,^2,^3\)

It was therefore thought during the questionnaire design stage, that it would be a waste of space and time to probe into the family size of the few married respondents. Also personal experience and observation suggested that very few came here already married. It would also be difficult for the hospitals to accept married overseas trainees or couples because of housing shortage, also the hospitals would view the married applicants with suspicion and would most likely reject these applicants. That only 7% of these trainees were married was therefore not unexpected while 92.5% of them were single and only six trainees were either divorced or widowed.

4. How long have these trainees been in U.K.?

Table 3.5 showed that over 30% of them had only sojourned in Britain for less than one year or over 2/3rd of them.

1. R.G.S.Brown & W.H.Stone; The Male Nurse P.35 \(^{(5)}\)
2. P.E.P Overseas nurses in Britain 1972 P.11 \(^{(33)}\)
3. Amya Sen; Problems of Overseas students and nurses, NFER 1970 P.15. \(^{(39)}\)
Table 3.5  Length of stay in the UK at the time of survey

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>no of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-6 months</td>
<td>152</td>
<td>13.8</td>
</tr>
<tr>
<td>7-12 months</td>
<td>182</td>
<td>16.5</td>
</tr>
<tr>
<td>1½-2 years</td>
<td>180</td>
<td>16.4</td>
</tr>
<tr>
<td>12-2 years</td>
<td>214</td>
<td>19.5</td>
</tr>
<tr>
<td>2-3 years</td>
<td>278</td>
<td>25.3</td>
</tr>
<tr>
<td>3-4 years</td>
<td>87</td>
<td>7.9</td>
</tr>
<tr>
<td>4-6 years</td>
<td>7</td>
<td>0.6</td>
</tr>
<tr>
<td>Total</td>
<td>1101</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: extensive mail survey

had been here for less than 2 years. On the other hand 91.5% had been in Britain for less than 3 years and the rest had been here less than 6 years.

Education of Overseas Trainees

Present research findings tallied with earlier studies by Brown and Stone,1 PEP2 and Sen3 that many overseas trainees left secondary full-time education at the age of 18 or over but it was not expected to find so few trainees with 'A' levels. In fact, a substantial number

1. Op cit P.35 (5)
2. Op cit (33)
3. Op cit (39)
was expected to have at least the minimum entrance requirement to higher education, i.e. for a degree course. This expectation was based on the belief of many hospital administrators that it is higher education rather than nursing these trainees are seeking, using nursing as a passport to get into higher education once in Britain. The figures in Table 3.6 refuted the expectation. Only 5.4% of the trainees had 'A' levels, but the proportion of trainees with 'O' levels was very high while some 13.3% had sat examinations of different kinds like the 121 Filipinos who possessed B.Sc. or B.A. in education, technology etc. Others had school certificates issued by their own schools. Their equivalents

Table 3.6. Age at leaving full-time education and educational qualifications achieved

<table>
<thead>
<tr>
<th>Age when leaving full-time education</th>
<th>No of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 15 years</td>
<td>5</td>
<td>0.5</td>
</tr>
<tr>
<td>16 &quot;</td>
<td>53</td>
<td>4.8</td>
</tr>
<tr>
<td>17 &quot;</td>
<td>215</td>
<td>19.5</td>
</tr>
<tr>
<td>18 &quot;</td>
<td>236</td>
<td>21.4</td>
</tr>
<tr>
<td>18+ &quot;</td>
<td>522</td>
<td>53.8</td>
</tr>
<tr>
<td>Total</td>
<td>1101</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational qualifications achieved</th>
<th>No of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;O&quot; level or equivalent</td>
<td>832</td>
<td>81.1</td>
</tr>
<tr>
<td>&quot;A&quot; &quot; &quot; &quot; &quot;</td>
<td>60</td>
<td>54.0</td>
</tr>
<tr>
<td>Sat no exams</td>
<td>632</td>
<td>57</td>
</tr>
<tr>
<td>Other</td>
<td>146</td>
<td>13.2</td>
</tr>
</tbody>
</table>

1. Because no separate coding space was allocated for multiple ticks i.e. "C"/"A" levels in the extensive mail survey, 60 respondents with "A" levels are added to 832 respondents with "O" levels
2. 121 Filipinos with college degrees
3. percentage does not add to 100
to 'O' levels were questionable. For this reason, they were excluded from 'O' level. In the case of Filipinos, GNC only recognises degree in education as equivalent to 'O' level standard or as an alternative qualification to student nurses courses.

Over three-quarters of these overseas trainees completed their full-time education after the age of 18. The rest had studied up to the age of 17 or left full-time education at 16 or less. The high proportion of overseas trainees with 'O' levels (81%) or equivalent educational qualifications, was therefore no surprise.

Of the sixty trainees with 'A' levels, 36.7% had only one subject, 26.7% had two passes and another 26.7% had 3 passes. The rest 8.3% and 1.6% had either 4 or 5 passes respectively.

Among 'O' levels or equivalent educational qualification 19% had 3-4 'O' level passes, over 77% had 5 or more passes, of whom 1.7% had more than 10 passes, 45% had 7-10 'O' levels and 25% had 6 'O' levels. The remainder (less than 4%) had either one or two passes. Similarly 36% of the 'O' level and 'A' level holders claimed to have passed English language at 'O' level.1

1. This high proportion of 'O' level passes in English language may be true because according to Cambridge School Certificate ('O' level) grade 7 & 8 is a pass though it is not 'O' level equivalent but they count towards deciding the division the person will be allocated by units obtained.
Since there were variations among sexes and country of origin of the entrants into different type of nursing and courses, one is prompted to ask "could there be differences between the sexes of these trainees as well as by their country of origin in their educational qualifications?" A comparison is shown in the table 3.7 below.

Table 3.7  Number of "O" & "A" levels by sex and country of origin

<table>
<thead>
<tr>
<th>No. of &quot;O&quot; levels</th>
<th>Malaysia</th>
<th>Mauritius</th>
<th>West Indies</th>
<th>Africa</th>
<th>Philippines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F1</td>
<td>M2</td>
<td>F1</td>
<td>M1</td>
<td>F1</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>3</td>
<td>5</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>32</td>
<td>18</td>
<td>6</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>66</td>
<td>36</td>
<td>9</td>
<td>31</td>
<td>25</td>
</tr>
<tr>
<td>6</td>
<td>74</td>
<td>32</td>
<td>8</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>7-10</td>
<td>207</td>
<td>34</td>
<td>9</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>10+</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>409</td>
<td>128</td>
<td>39</td>
<td>109</td>
<td>85</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No of &quot;A&quot; levels</th>
<th>Malayasia</th>
<th>Mauritius</th>
<th>West Indies</th>
<th>Africa</th>
<th>Philippines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F1</td>
<td>M1</td>
<td>F1</td>
<td>M1</td>
<td>F1</td>
</tr>
<tr>
<td>1</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>15</td>
<td>2</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey
1. F= Female respondents
2. M= male respondents
** Philippines do not hold "O" /"A" levels examinations and they have instead college degrees
The evidence showed very little difference between both sex among the Malaysia and Mauritius trainees. On the other hand male trainees from West Indies and Africa had more 'O' levels than female (1.0 62.2%) against 69.1% and 95% against 35% respectively. The country of origin, sex, appeared to affect educational attainment of these overseas trainees and the effect was contrary to expectation. Male overseas trainees were expected to have higher mean 'O' levels. As it turned out female trainees scored higher with the mean number of 'O' levels of 6.8, 5.8, 4.6 and 6.3 from Malaysia, Mauritius, West Indies and Africa compared with 5.8, 5.3, 4.6 and 5.3 for the males respectively. On average, a trainee from Malaysia would start nursing courses with 6.6 'O' level subjects while his partner from Mauritius, West Indies and Africa would do so with 5.6, 4.6 and 6.1 'A' levels respectively.

What does it all show? It showed that trainees from Malaysia and Africa were better educated whereas those from West Indies scored fewer number of 'O' levels. This pattern was further demonstrated in Table 3.7 among the trainees with 'A' levels.

Another point of interest was that more male than female trainees stayed on full-time education until the age of 18 or over. Yet girls scored higher in mean 'O' levels attainment. This tendency was more marked among the male Mauritians especially among those in general nursing.
For example, 34% of them in this group did not leave full-time education until over 18 compared with 18% of the females. The Filipinos showed similar trend as the Mauritian. One possible explanation also formed a question by itself. Could it be that there were less employment opportunities in those two countries? It could be argued that many parents who could afford to pay their children’s school fees will continue to do so in the face of lack of employment opportunities. More boys stayed on or went to school because social values on education differ the sexes in those countries. In countries like Mauritius and Hong Kong, parents saw education for daughters beyond the minimum, as a waste of money and effort because the daughters would marry once they were old enough and are expected to be full-time housewives. Therefore, there is no point in providing expensive education. Similarly, the parents lay great stress on the results of educating their sons; that is to obtain a certificate. Some would go far to provide the extra cash to allow their children to have private tuition for the subjects they are taught at school. Consequently, when at the end of five years in college, the son does not receive a certificate, facing the prospect of unemployment the father prefers to pay another year’s school fees so that at least he may receive a certificate. There were instances I knew of where a person had been studying ‘O’ levels for at least three years.
Family Background

It was expected that the majority of the trainees would come from large families and that social adjustment would be very difficult for these trainees if nursing administrators operated by hunch rather than knowledge of their life style. We expected trainees to come from the middle of the birth order of the families and from a fairly secured family with enough financial means to invest in the cost of the project—going abroad. We expected that first children would tend to be in employment while the youngest one were still in school. It seemed unlikely that these trainees would in fact come from working class families which in a developing country lacks the security to borrow the money to pay the fare. So far, only Malaysia has some form of scholarship for the gifted but disadvantaged applicants, even this is privately financed.

From the interview sources, it was learnt that of the 180 respondents, all (except 14.2% and 3.3% said to have neither father nor mother respectively), reported parents still living. The evidence in Table 3.8 confirmed our expectation that these overseas trainees would come from very large family units with an average of 5½ siblings and from the middle rank of their families. The findings suggested between third and fourth rank.
Table 3.8. Family Size the Overseas Trainees Come From

<table>
<thead>
<tr>
<th>No of Sibs</th>
<th>Respondents' Frequency Distribution A</th>
<th>Respondents' Frequency Distribution No of Sibs in Employment B</th>
<th>Frequency Distribution of Respondents No of Sib Working Away from Home C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>15</td>
<td>90</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>29</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>15</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>24</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>21</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>11</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>8 or more</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

Source: Interview data

Only 15% of the trainees were the eldest of the family and this proportion was very low compared with the findings of Scott Wright's in which she found that 43.3% of her respondents were the only or eldest children. Why so few eldest or only children of the family came to Britain, could it be that they were required to stay near their parents to give immediate moral and physical help when needed? that they may not have the required educational qualifications because educational opportu-

1. A Scott Wright: Student Nurses in Scotland - Characteristics of success and Failure (Scottish Home & Health Dept.) 1968 P.29 (40)
nities may have been scarce during their time?, or because their parents' family was too young to afford the extra expenses to pay their school fees beyond the primary free education? Could it be that employment opportunities were brighter, hence they were already in a secure job?

Table 3.8 column B and C pointed out that over half of the trainees' siblings were in employment at the time they left for Britain or about 2.8 siblings of theirs were working. Of those in employment, 25% were working away from home.

All the interviewees were able to give a brief description of their parents' occupation. Those, whose parents were dead, were also able to recall the kind of job their father had. Table 3.9 is an attempt to classify these trainees' parents' occupation. Because of numbers in some categories, we decided to collapse the sub-groups of the International Occupational Classificatory Index, into 8 most easily identifiable major groups. Thus, taxi-driver was classified as Employee - non-manual (lower). A Sidar as Employee - non-manual (higher). A Sidar is usually a person who supervises sugar cane field workers. In many developing countries there are many street corner traders who sell "soft" drinks, cigarettes and many other food provisions (snacks) and these were classified as / trader (other). Similarly, there are salesmen who go around villages with goods bought direct from either
factory (usually family business) or wholesalers to sell to the retailers. Although, they are more or less their own boss, their earnings are very small and for this reason they were classified as the street corner traders (above). At the same time, this single index of socio-economic background, using father's occupation opens the possibility of some error in assessing the social class origins of these trainees. Within any given occupation, there is a range of income, of prestige and of style of life which occupational title alone does not reveal. For example, the data of this study provide no reliable way to differentiate between wholesale and retail shopkeepers or retailers and street corner traders (unless stated) - but then we must query the reliability of the trainee's claim of their fathers' occupation. These limitations should therefore be kept in mind in interpreting findings related to socio-economic class as shown in the table below.

Table 3.9. The Occupations of the Overseas Trainees' Parents

<table>
<thead>
<tr>
<th>A</th>
<th>B Parents' Occupation</th>
<th>C No of Respondents</th>
<th>D</th>
<th>E**</th>
<th>F+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Group 1</td>
<td>Professional</td>
<td>20</td>
<td>(16.7%)</td>
<td>10.3%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Social Group 2</td>
<td>Farmer (owner) 13 (Trader) 26</td>
<td>39</td>
<td>(32.4%)</td>
<td>31.1%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Social Group 3</td>
<td>Trader (other) 7 (Employee (higher non-manual) 21</td>
<td>46</td>
<td>(38.3%)</td>
<td>36.3%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Social Group 4</td>
<td>Employee (manual) 13</td>
<td>13</td>
<td>(10.8%)</td>
<td>13.3%</td>
<td>54.7%</td>
</tr>
<tr>
<td>Social Group 5</td>
<td>Farm Labourer 2</td>
<td>2</td>
<td>(1.7%)</td>
<td>9.3%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

Source: Interview data
* unknown
** from K.S. Wright's study (op. cit. p28)
+ from R.G.S. Brown & W.R. Stone (op. cit. p.37)
Column A of the table 3.9 shows the occupational classification just arrived when collapsed for comparative purpose and the regrouping was carried out as closely as possible to that employed by Wright\(^1\) and Brown and Stone\(^2\). That is allocating the overseas trainees' parents' occupation to five social groups. We could reduce them to four social groups by combining groups 4 and 5 for comparison with the other two studies just mentioned. As demonstrated in the table, this study corroborated Wright's study. It must, however, be immediately pointed out that in Wright's study 9% of the parents' occupations were "unknown" and in Brown and Stone's there were more than 15% in such category. Who were they? On the other hand we noted one significant discrepancy with Brown and Stone's study. Fewer of their trainees came from social group 3 upwards. About two-thirds of the parents of their male trainees were manual workers or in groups 4 and 5\(^3\) - a figure much higher than ours. While only slightly more parents of our overseas trainees than Wright's were in groups 1, 2 and 3. This was not surprising because we have already argued that the initial outgoings which these overseas trainees' parents had to bear are very high and applicants from less advantaged backgrounds may simply be unable to afford such high initial financial outgoings. It could also be argued that those from the higher social class would be more willing to defer their gratifications. The implication is that selection for the train-

3. Op. cit. p. 35. The figures provided by Brown and Stone were re-calculated by combining the students and pupils, hence the figures in Table 3.9 column E.
ing works selectively to eliminate, as is the case, applicants from certain socio-economic backgrounds on the lower end of socio-economic class.

Another significant variation was the overseas trainees' mothers' occupations at the time of their departure. 81.7% said that their mother was a housewife while in the Scottish study there was only 44%. This supported our early suggestion that women in these countries have had less opportunities to liberate themselves both educationally and socially.

As expected, the overseas trainees' fathers were better educated than the mothers. For example, 38.2% and 8.3% of the fathers had secondary and higher education against 22.5% and 2.5% respectively. Only 1.7% of the fathers compared to 13.3% of the mothers did not have any formal education. Why only a small number of mothers of these overseas trainees had formal education? The underlying significant factor was that the societal expectations of women in those countries were very different from the West. Also that in those countries too, a woman's place is still very much at home to attend to the needs of her husband and children - "lady of leisure" minus servants and household help gadgets. One must however hasten to add that these cultural values are changing in the face of economic pressure as well as pressure from Western values. In many of - if not all those developing - countries women are in fact contributing towards household budgets; for example, rearing domestic birds, making cakes,
sweets, roasting peanuts, fresh vegetable gardening or helping in family businesses such as retail shops.

Pre-nursing Experience

Many studies\(^1\) on the indigeneous trainees suggested previous nursing experience or contact is one of the influencing factors to those who take up nursing. Among the overseas trainees only 5.8\% (7) had any nursing experience at home prior to their coming to Britain but nevertheless as many as a third (30.5\%) of them had lodged an application in the nursing schools of their own country. Asked if they had any friends or relatives who were qualified nurses, almost 90\% replied positively. This finding which is 36\% more than Sen's\(^2\) finding confirms the importance of informal contact to these trainees in their application for nursing courses in Britain, that many in fact relied upon these informal contacts for hospital addresses. It also raises several important questions like: How many of these trainees came here because they have been influenced by their nursing contacts? How useful will the hospital information be to those trainees? How many of them had actually read the information given by the hospital or had they simply relied upon their nursing contacts, i.e. relatives and/or friends as source.

1. Reported in MacGuire 1969 \(^26\)
2. A.Sen Problems of Overseas Students and Nurses N.F.E.R. 1970 P.65, \(^39\)
of information? How biased is the informal information? These questions are important to the recruiting hospitals for whom the cost of sending the information is high and who are also concerned with the problems of adjustment of the recruits when they arrive. Later, it will be shown that whatever information sent, was digested by the trainees but the information was inadequate and "too rosy."

A substantial number were still in full-time education (see Table 3.10 below). On the other hand, nearly half of the trainees were in employment (34.4% full-time and 11.8% part-time). Less than a quarter (23.3%) were unemployed. There is a general suspicion held by the nursing administrators that the compelling reason these trainees came was lack of employment at home. How far was this substantiated?

Table 3.10 Pre-nursing experience of the trainees

<table>
<thead>
<tr>
<th>What experience?</th>
<th>No of Respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time employment</td>
<td>379</td>
<td>34.4</td>
</tr>
<tr>
<td>Part-time employment</td>
<td>130</td>
<td>11.5</td>
</tr>
<tr>
<td>Full-time education</td>
<td>275</td>
<td>25.0</td>
</tr>
<tr>
<td>Part-time education</td>
<td>61</td>
<td>5.5</td>
</tr>
<tr>
<td>Unemployment</td>
<td>256</td>
<td>23.3</td>
</tr>
<tr>
<td>Totals</td>
<td>1101</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: extensive mail survey
Table 3.11 Length of employment or unemployment before coming to UK

<table>
<thead>
<tr>
<th>Length of time</th>
<th>In employment A</th>
<th>%</th>
<th>Unemployed B</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-6 months</td>
<td>69</td>
<td>13.6</td>
<td>10</td>
<td>4.0</td>
</tr>
<tr>
<td>7-12 &quot;</td>
<td>104</td>
<td>20.4</td>
<td>73</td>
<td>28.5</td>
</tr>
<tr>
<td>1-2 Years</td>
<td>43</td>
<td>8.4</td>
<td>11</td>
<td>4.3</td>
</tr>
<tr>
<td>1½-2 &quot;</td>
<td>65</td>
<td>12.8</td>
<td>7</td>
<td>2.7</td>
</tr>
<tr>
<td>2-3 &quot;</td>
<td>68</td>
<td>13.4</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>3-4 &quot;</td>
<td>50</td>
<td>9.8</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>4-5 &quot;</td>
<td>31</td>
<td>6.1</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>5+ &quot;</td>
<td>61</td>
<td>12.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Since leaving school</td>
<td>18</td>
<td>3.5</td>
<td>153</td>
<td>59.7</td>
</tr>
<tr>
<td>Totals</td>
<td>509</td>
<td>100.0</td>
<td>256</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: extensive mail survey

It must also be remembered that a very substantial number of trainees were expected to say that they were unemployed "since leaving school" and this was confirmed in the breakdown in Table 3.11, column B. Over a quarter of them said that they had been unemployed. There was also a long record of employment among the overseas trainees who were working before their arrival here as shown in column A of Table 3.11. Some of them had over five years of employment experience. The average number of jobs an overseas trainee had among the "employed" population was 1.5. Sixty-eight percent had had one job "since leaving school." About 25% had two jobs, while 6% and 1.5% had either 3 or 4 jobs respectively. 1.3% had worked in 5 different jobs and one trainee claimed to have had six jobs since he left school. Without detailed
analysis like above, the complication would have been clear and the nursing administrators' suspicion would be confirmed. One third of those had worked for about one year, 21.2% worked for two years and 29.3% were in employment as long as 5 years, 12% had worked for more than 5 years. In contrast to the unemployed population, only 3.5% of the employed had worked "since leaving school" against 59.7% of the former.

To push this analysis a step further, it would be helpful to look at the "unemployed" figures by country of origin and sex. More than half of them (55.5%) were Malaysians followed by Mauritians (17.2%) and West Indians (13.3%). On the other hand only 8% and 4.3% of the unemployed were Filipinos and Africans respectively. Nearly three quarters (73.4%) of the 'unemployed' were females. For example, all the unemployed Filipinos were females. Similarly, 81.7% of the unemployed Malaysians were females, while 70% of the Mauritians, unemployed were males. When figures were ranked by country of origin, Mauritius had the highest unemployed rate (26.6%), Malaysia (26.3%), West Indies (20.2%), Philippines (17.3%) and Africa (12.1%).

Most of the overseas trainees who were in employment however had been in teaching, government services (in particular those from Mauritius), and other clerical occupations. Thus, 44.2% of them were in non-manual work
comparing with one-third for the British trainees\(^1\) and this corresponded to Brown's and Stone's study.\(^2\)

On average, those in employment earned about £25. The sum is directly converted without taking the following factors into account: cost of living is lower in these overseas trainees' countries, that most of them may not need to pay income tax. In fact, the £25 is not monthly income.

Why did these trainees who were working at home decided to take up nursing in the U.K.? Is it because of low salary? During the interviews, these trainees were also asked to compare their previous salary with their present nursing training allowances. All admitted that nursing training allowances were more than what they earned at home. These answers were interjected with "but," "of course, the nursing pay here is more but I did not have to pay tax at home, food was cheap and so was standard of living low. Most important, I had my parents, relatives and friends and here I am a loner. I do not dispute that the present pay is a larger sum if it is used at home."

2. Op cit. P38. (5)
The Type of Nursing

When the overseas trainees were grouped by country of origin, sex, grade and type of nursing, Table 3.12 showed that over two-thirds (72.2%) of the trainees came as student nurses, 21.4% as pupil nurses, 4.1% as tourist while 2.3% entered the U.K. by other means like nursing assistants, full-time students in higher education, domestic help (Chambermaid in the hotels) or as dependent of a relative already in the U.K. To which type of course and nursing did they go and who were they? The breakdown in Table 3.13 indicates that among Malaysia group, more girls than boys went into general hospitals either as student or pupil nurses. While among other groups, more of both sexes went into psychiatric or mental handicap training for both student and pupil nurses except the female trainees from the Philippines, of whom 61% are in general training as pupil nurses. It also appears that it was easier to obtain a vacancy as pupil nurse rather than student nurse in Mental Handicap and Psychiatric hospitals for trainees who came to the U.K. either as "tourists" or "others" category because less than a quarter (22.6%) of them are in the general hospitals. More Mauritian trainees came as a tourist or in the "others" category compared to other groups.

Why did some of them come as tourists? The following excerpts will explain: "well, the nursing selection committee in Mauritius found me suitable for a pupil nurse
Table 3.12 Enter UK as by country of origin, sex and by types of nursing

<table>
<thead>
<tr>
<th>Enter the UK as</th>
<th>sex</th>
<th>Country of origin</th>
<th>Malaysia</th>
<th>Mauritius</th>
<th>West Indies</th>
<th>Africa</th>
<th>Philippines</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurse</td>
<td>F</td>
<td>226 76 45</td>
<td>4 11 11</td>
<td>31 34 8</td>
<td>6 32 1</td>
<td>19 14 25</td>
<td></td>
<td>543</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>6 66 37</td>
<td>21 23 32</td>
<td>1 25 4</td>
<td>5 25 1</td>
<td>1 1 4</td>
<td></td>
<td>252</td>
</tr>
<tr>
<td>Pupil nurse</td>
<td>F</td>
<td>49 12 3</td>
<td>1 1 1 2</td>
<td>21 22 0</td>
<td>3 5 0</td>
<td>29 9 8</td>
<td></td>
<td>175</td>
</tr>
<tr>
<td></td>
<td>M</td>
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<td>2 9 14</td>
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</tr>
<tr>
<td>Tourist</td>
<td>F</td>
<td>2 1 4</td>
<td>1 0 3</td>
<td>1 2 1</td>
<td>4 1 1</td>
<td>0 1 0</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>1 1 3</td>
<td>1 2 13</td>
<td>0 0 2</td>
<td>0 0 0</td>
<td>0 0 0</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>&quot;Other&quot;</td>
<td>F</td>
<td>2 1 2 0</td>
<td>0 0 0 0</td>
<td>3 0 2 1</td>
<td>1 0 0</td>
<td>5 2 1</td>
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</tr>
<tr>
<td></td>
<td>M</td>
<td>0 5 2 1</td>
<td>0 2 2 3</td>
<td>0 1 4 0</td>
<td>1 1 0</td>
<td>0 0 0</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>286 172 98</td>
<td>30 58 77</td>
<td>55 94 19</td>
<td>20 68 3</td>
<td>50 31 40</td>
<td></td>
<td>1101</td>
</tr>
</tbody>
</table>

Source: extensive mail survey
1. as students in secondary or higher education
2. as dependents
3. as nursing assistants
4. as a laboratory technician
5. as domestic help
Cols A denotes trainees from that group of country in general nursing
"B" psychiatric nursing
"C" mental handicap nursing
course in the UK in 1972 but, as my file number was 10756, it was a long waiting list so I came with a tourist passport and started work straight away at 'this hospital.'

"I came here as a tourist at first and after a month, I felt bored because my brother did not have much free time to take me around as I had anticipated. I asked him if he could get me a job in the hospital, he was working for more than six years. Next day he took me to see the Chief Male Nurse who offered me a nursing assistant's post and I have been in that post for over a year when I thought of applying to be a pupil nurse and I was accepted."

Looking at the figures from another angle, as in Table 3.13, we noted that among the population of students from Malaysia, three-quarters were females and nearly two-thirds of them were doing a general nursing course and about one-fifth (21.6%) in the psychiatric nursing. The rest of them (13.8%) were in mental handicap nursing. On the other hand, less than 6% of male students from Malaysia were following general nursing; most of them were either in psychiatric (60%) or mental handicap nursing (34.2%). This pattern repeated itself for male students from the West Indies and from Africa, whereas among those from Mauritius and Philippines, more found their way to mental handicap nursing. The female student nurses showed greater variation. Very few from Mauritius were in general nursing. The rest were mostly doing psychiatric or
Table 3.13. Status of Trainees by country of origin, sex, type of Nursing

<table>
<thead>
<tr>
<th>Status</th>
<th>Sex</th>
<th>Malaysia</th>
<th>Mauritius</th>
<th>West Indies</th>
<th>Africa</th>
<th>Philippines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>P</td>
<td>230</td>
<td>4</td>
<td>11</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>7</td>
<td>72</td>
<td>41</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Pupil</td>
<td>P</td>
<td>49</td>
<td>13</td>
<td>3</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>0</td>
<td>10</td>
<td>5</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>286</td>
<td>172</td>
<td>98</td>
<td>30</td>
<td>58</td>
</tr>
</tbody>
</table>
mental handicap nursing whereas Filipinos were equally spread among the three types of nursing.

All male pupil nurses were either in psychiatric or in mental handicap nursing except that one was doing general nursing and he was from Mauritius; otherwise all females were similarly distributed among the three types of nursing as their fellow students except in mental handicap nursing for Filipinos; more of them found their way there than trainees from other countries. The findings too confirmed earlier studies that more male Mauritians were in general and mental handicap nursing and that trainees from other groups were concentrated in psychiatric training.1

Summary

The analysis of this chapter indicated that despite the constraints imposed by the sampling method, the sample population in this research did not lack heterogeneity. There was in fact a wide dispersion of age groups among those overseas trainees who were fairly distributed by country of origin, by sex and by types of nursing and courses. Very few (5.3%) left full-time education at 16 or younger and about similar number (5.7%) did not sit formal examination of some kind and the rest had achieved either 'O' or 'A' level or some other forms of educational qualifications. For example, the Filipinos had degrees in education, technology or economics, etc. But the number of trainees with 'A' levels left us with much to be desired and was far less than expected. There was also wide variations in the educational attainment of these overseas trainees.

The best qualified trainees educationally were those from Malaysia and Africa, both in 'O' levels and 'A' levels, the females, those doing student nurse courses, in particular those in general and psychiatric nursing, 94% and 92% respectively, of the trainees had 'O' level passes. But mental handicap trainees were not less qualified, 82% of them had 'O' levels as well. On the other hand, 72% of those with 'O' levels in general pupil nurse course came from Malaysia (40% of them had 5 or
more 'O' levels) and similar proportion of Mauritians were in mental handicap pupil nurse course. To repeat the point made by Brown and Stone, too many overseas trainees were "over qualified for the pupil training scheme." ¹ Over half of the pupil nurses (52%) had 'O' levels and one-fifth of them said to have five or more 'O' levels.

Nearly half of the overseas trainees had employment experience of some kind, either full-time or part-time, while 23% had experienced unemployment of varying length of time. No set pattern of distribution of trainees to the types of nursing and courses was detected by country of origin. It was, nevertheless, apparent that trainees from Malaysia; females in particular were more likely (8 out of 10) to be accepted for a general nursing course for either student or pupil training; trainees from Africa were more likely to be in psychiatric nursing (7 out of 10); half of those from Mauritius were in mental handicap nursing. On the other hand sex is a very important variable. A female was more likely to be accepted for general training while male for either psychiatric or mental handicap nursing (with the exception of Mauritius). Similarly, with 'O' levels, which include English, an applicant with these qualifications was more likely to be accepted for student nurse course.

¹. Op Cit p.44 (5)
It was also established that overseas trainees were much older than their indigenous fellows starting at the age of 21. On the other hand the majority of these trainees were from the middle rank of the siblings rather than the eldest or only child and from good socio-economic origin.
Chapter 4

Socio-cultural Aspects of Overseas Trainees

These trainees were widely scattered among the N.H.S. hospitals among the fourteen R.H.A.s and among the different types of nursing and courses. They also came from distant and varied countries. Officially, the U.K. recruits annually trainees from 87 Commonwealth and Foreign countries, excluding the Republic of Ireland.¹ PEP as early as 1955 stated that "the increase in the numbers of colonial students in Britain in recent years, however, is scarcely more significant than the increase in the number of territories from which they are now coming, or the changing proportions of student as between these different countries of origin."² Although this referred mainly to students in higher education, it is equally applicable to the overseas trainees nurse, who come in their thousands annually.

In this chapter, the main focus will be on the socio-economic and cultural aspects of the countries these trainees come from. Douglas Manley pointed out that "If one wishes to understand the social phenomena of the West Indian migration to Britain, and the behaviour of

2. PEP Colonial students in Britain 1955 P.2. (33a)
the West Indians themselves, it is necessary to know something of the culture of the region.\footnote{1}
Similarly, each country has its own customs, beliefs and values which differ from each other and determine the learning environments in which children are brought up and socialised.

The growing numbers shown in Table 4.1 makes it clear why it is important to know something about the socio-economic and cultural backgrounds of these trainees. They are important in order to understand their motivations, aspirations and expectations of nursing in the U.K., similarly, to provide effective orientation course for these trainees, to strike a harmonious relationship between superiors on the nursing ladder and those at the bottom rung of the ladder (overseas trainees). Similarly, the past history has a profound effect on future interaction and adjustment.

The Table 4.1 showed overall increases between 1959-1973 and the figures before 1964 were only estimates. Before 1959 the numbers of overseas trainees who had already found their way to British hospitals, but figures were not recorded. The post 1964 figures suggested that

\footnote{1} S.K. Ruck (Ed) The West Indian Comes to England P.3 1966 (36)
Table 4.1. Overseas Trainees in Britain 1959-1973

<table>
<thead>
<tr>
<th>Year</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1959 - 1960</td>
<td>5350</td>
</tr>
<tr>
<td>1960 - 1961</td>
<td>8484</td>
</tr>
<tr>
<td>1961 - 1962</td>
<td>9954</td>
</tr>
<tr>
<td>1962 - 1963</td>
<td>13542</td>
</tr>
<tr>
<td>1963 - 1964</td>
<td>12603</td>
</tr>
<tr>
<td>1964 - 1965</td>
<td>14526</td>
</tr>
<tr>
<td>1965 - 1966</td>
<td>15673</td>
</tr>
<tr>
<td>1966 - 1967</td>
<td>16745</td>
</tr>
<tr>
<td>1967 - 1968</td>
<td>17735</td>
</tr>
<tr>
<td>1968 - 1969</td>
<td>16356</td>
</tr>
<tr>
<td>1969 - 1970</td>
<td>17203</td>
</tr>
<tr>
<td>1970 - 1971</td>
<td>18546</td>
</tr>
<tr>
<td>1971 - 1972</td>
<td>20120</td>
</tr>
<tr>
<td>1972 - 1973</td>
<td>19839</td>
</tr>
</tbody>
</table>

there was a steady stream of these trainees coming here except for two years 1967-1968 and 1972 and 1973 when there were an actual drop of 7.7% and 1.3%. Among the pre-1964 figures there were great fluctuations from a positive increase of 45% to a 6.9% drop and in that period the average increase was 21.2% compared to 4.3% in the post 1964 period. If the drop continues in 1974 it would suggest that the upward trend of overseas trainees coming to the U.K. has stopped and the decline will continue.

In present economic crisis, with cut-backs in health services spending and increased airfares, it is becoming less economical to recruit overseas trainees directly because the hospitals are now required to lay out orientation courses. The recent increase in training allowances and nurses' salary in general had put nursing profession into a competitive position in the labour market. These factors all contributed very much to the decline in the recruitment of overseas trainees.

It would be impossible in this study to describe even briefly the socio-economic and cultural background of the trainees from 87 Commonwealth and Foreign countries. We have therefore selected 10 countries for this purpose because according to past and present trends, they have maintained the position of "major donor country."

Since 1970, the Philippines has emerged as the leading "donor" country among the foreign (non-commonwealth)
countries and was in fact in the 6th position by 1973 (see Table 4.2) among the 10 major donor countries of which the other nine are: Barbados, Jamaica, Trinidad and Tobago, Guyana, Malaysia, Mauritius, Hong Kong, Nigeria and Ghana.

Table 4.2 Trainees from the 10 major donor countries in historical perspective

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>West Indies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbados</td>
<td>1329</td>
<td>1006</td>
<td>902</td>
<td>820</td>
<td>644</td>
<td>493</td>
<td>361</td>
</tr>
<tr>
<td>Jamaica</td>
<td>3034</td>
<td>2667</td>
<td>2645</td>
<td>2450</td>
<td>2037</td>
<td>1665</td>
<td>1458</td>
</tr>
<tr>
<td>Trin. &amp; Tobago</td>
<td>1831</td>
<td>1589</td>
<td>1900</td>
<td>2203</td>
<td>1811</td>
<td>1393</td>
<td>1125</td>
</tr>
<tr>
<td>Guyana</td>
<td>1034</td>
<td>849</td>
<td>739</td>
<td>687</td>
<td>564</td>
<td>455</td>
<td>361</td>
</tr>
<tr>
<td>Malaysia</td>
<td>966</td>
<td>1174</td>
<td>1824</td>
<td>2798</td>
<td>3698</td>
<td>4306</td>
<td>4837</td>
</tr>
<tr>
<td>Mauritius</td>
<td>1370</td>
<td>1623</td>
<td>1793</td>
<td>2018</td>
<td>1973</td>
<td>1996</td>
<td>2076</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>610</td>
<td>560</td>
<td>799</td>
<td>789</td>
<td>693</td>
<td>500</td>
<td>436</td>
</tr>
<tr>
<td>Africa:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>930</td>
<td>622</td>
<td>522</td>
<td>452</td>
<td>414</td>
<td>385</td>
<td>312</td>
</tr>
<tr>
<td>Ghana</td>
<td>523</td>
<td>553</td>
<td>560</td>
<td>626</td>
<td>676</td>
<td>699</td>
<td>720</td>
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<td>Philippines</td>
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<td>146</td>
<td>192</td>
<td>384</td>
<td>602</td>
<td>676</td>
<td>966</td>
</tr>
</tbody>
</table>

Table 4.2 at the same time shows how the patterns of recruitments have changed over a period of 7 years. They still remain, including Philippines, since 1969 the major countries in providing manpower to the N.H.S. hospitals. The degree of concentration of recruiting overseas trainees has grown even greater since 1970 from "just over nine-tenths of overseas students from the Commonwealth and more than two-thirds from the nine major sending countries", to only 85% of the overseas trainees.

1. M. Kendall; Nursing Students in Britain. Int. Nursing Review Vol.19 No.3 1972 (21)
who came from the Commonwealth and nearly nine-tenths (88%) were from the same nine countries in 1973. By 1970, West Indies lost ground to both Malaysia, Mauritius and Philippines with Malaysia taking and maintaining the lead. From 1970, the number of Malaysians almost doubled while the Philippines increased five-fold beginning only between 1967 and 1968 and by 1973 contributing about 45% of the total number of trainees from foreign countries or over 5% of all Commonwealth and foreign countries or over 7% of the 10 major contributing countries.

In attempting to give a brief description of the varied backgrounds of the trainees from these ten countries, there are necessary severe limitations because of the nature of this study. First, we know little of their culture; secondly, we have little information about their background; consequently, it must be asked, are they typical of their compatriots still at home living in similar socio-economic backgrounds? What influences them to emigrate? However, it could be assumed that these trainees may be different, they were more ambitious than their compatriots or it could be that they had the financial means to come here. In addition, the data

presented here may not be true anymore according to the speed of development in these countries. At times, the necessary information is difficult to obtain and is not in black and white. The essential point to bear in mind when looking at overseas trainees, is everyone is an individual and that they are not the "same" as they are often seen as such whether they come from the West Indies, Malaysia or Hong Kong. Lastly, for information much reliance is placed upon the annual reports of these countries concerned.

What do overseas trainees have in common with one another? Are they all the "same" in terms of needs, motivations and expectations? A brief look at their upbringing or cultural background would show that they differed by country of origin even at the broad level by sex and age. They also differ in appearance in their customs and social norms, i.e., outlook, taste and habits merely upon the fact that they come from different countries in many cases physically separated by oceans or mountains, e.g., Mauritius is different from Malaysia geographically as well as in size and wealth and natural resources. The trainees had however, the following attributes common; most of them came from "developing" countries, most of these countries had been a British colony for many decades. They had tended to identify the middle class life style of administrators in their country with that of ordinary
English life. This life style served as a model for many trainees who had a hazy, outdated and unrepresentative image of England. They share the desires to do a nursing course in the U.K. Their ties with Britain are still very strong; they had inherited the British educational, legal and political systems on independence. The long association with Britain had a lasting effect. Institute of Race Relations pointed out that "it should be remembered that those who emigrate to Britain were brought up in a British Colonial culture and regarded England as their mother country". In most cases, English is still the official language except in the former French colonies. But, the 10 major donor countries under discussions rely very much upon English as the official medium of communication. But behind the official scene, several different languages with hundreds of dialects are spoken. Nevertheless, English as the official language marks the important commonness among these trainees. They came from multi-racial or mixed societies which have reached a very high degree of integration though ethnic identity is still marked.

It is also not possible to present a homogeneous picture of the socio-cultural background of these trainees, at least cultural pattern had some similarity as it

orientates towards joint family. Similarly, to many societies that these trainees came from, western education, especially from Britain, is still a status symbol and any person who acquires western education outside his own country is at a premium to achieve higher positions and better paid employment, and with ease. The value of the certificate is secondary to the label "I have been to England" or "he has studied in England." An analogy would show why to have been in England is a social status achievement. In Mauritius, British goods are held in high esteem as being very reliable and very good quality, therefore, anything "made in England" is bought without second glance, and with pride. The cost matters less. England, therefore, is a mould through which a trainee is expected to go and emerge as perfect. Indeed, they have great admiration for foreignness even to the extent of fanaticism. One Filipina pupil summed this up: "Most of the articles and machinery in our home are from the U.K., Germany or U.S.A. I was made to believe that foreign goods are far superior and it is fashionable." Another male Mauritian student explained that "to send a son abroad is an achievement most parents aspire for and they will sweat themselves and make sacrifices, live sparingly in order to give their sons the education they had missed."

Malaysia and Philippines are two countries situated in the South East of Asia which S.Karnow et al described as "a vast ethnical mosaic" while anthropologist

1. S.Karnow: South East Asia, Life World Library P.10
de Bois suggested that "there is probably no other area of the world so richly endowed with diverse cultural strains". The great diversity of people is the result of "the high degree of accessibility of the area, specifically by water, its location between two great culture worlds of India and China, its 'Pioneer figure' role in relation to the densely settled lands of Eastern and Southern Asia - all these things have encouraged what Dobby has described as 'a constant convergence' of people on these South Eastern fringes of Asia."  

Malaysia

Malaysia is now a federation established in 1963 after she became independent in 1957. She consists of two "geographically discreet units," West and East, each with an area of 50,700 and 77,730 square miles respectively.

The latter unit is made up of Sarawak and Sabah. The West is richly endowed with high grade iron resources, rubber, palm oil, copra and other natural resources. In

1. Quoted in 1. p.9
3. " " p.497 " " (12)
contrast, the East has only minor deposits of coal, gold and other medals. The capital of the Federation is Kuala Lumpur situated in the West.

In 1971 her population numbered 11.1 million persons of several ethnic groups: 47% Malays, 34% Chinese, 9% Indians, 8.5% Borneo Pudigens, the rest being classified as "others". According to Karnow, she is "divided between Moslem Malay farmers 80% of whom are rural dwellers," most of them poor and uneducated, and wealthier Chinese who live in towns for the most part." Most Indians and Chinese live in the West as the area is more developed with higher rate of urbanization. For example, there are ten towns of over 50,000 people in the West and only one, Kuching, in the East.

Two-fifths of the Malaysian are urban dwellers and migration plays an important role in the stability of Federation. Thus in 1970, the official figures showed that more Malays and Chinese left than entered in while more Indians and Pakistanis and "others" entered than left.

Historically, Malaysia was and still is a crossroad of international trade which was used as a convenient stop-over point. She first developed as a marketing centre for merchants and travellers plying between Europe,

1. Karnow et al: South East Asia, Life World Lib. P 14(20)
Middle East, India, Indochina, Japan and China. Today, she is still playing this vital role as well as a meeting point for the East and West.

On gaining independence, her government instituted a clause in her new constitution to help the Malays whom she believes to be less fortunate than other ethnic groups especially the Chinese and the Indians by granting them special rights in respect of land tenure, entry to the civil service, award of government scholarships, etc. She also set out to make Malay the national language (at present English is still the official language), Islam as the state religion; however, freedom of worship to all Creeds is guaranteed. The leaning towards favouring the Malays has not gone down without trouble. A racial riot ensued between the Malays and the non-Malays. The former felt the constitution did not go far enough and demanded greater share of the economic wealth (presumably from the Chinese), the latter on the other hand felt that they were discriminated against, the urban Chinese, especially wanted to be recognised as equal citizens. Later, in 1971, the first development plan further emphasized the social and economic position of the Malay in an attempt to restructure the Malaysian society "so as to create a Malay commercial and industrial class and (to eradicate) unemployment and poverty among all Malaysians." 1

Urbanization in Malaysia takes opposite routes in the West and in the East and the inevitable sour fruit of two rapid urbanization has appeared: rapid industrialization has not produced an expansion of job opportunities, thus there is a noticeable amount of unemployment and underemployment. Unemployment continues "to rise steadily."

At the same time "working class incomes rural and urban alike stagnate." 2

Apart from Singapore, Malaysia's neighbour, Malaysia has the highest proportion of Chinese population in the South East Asian region. These Chinese play a vital economic role. Some are very distinguished industrialists. Karmow saw their importance in the fact they command about 60% of the Malaysian national income, and remarked that the secret societies' favourite pastime there is "kidnapping Chinese millionaires, sometimes sending the victim's ear pinned to the first ransom note." 3

Although the first Chinese contacts in Malaysia were traders and sailors, on the whole most Chinese came from Southern China, especially Kwang Tung and Fukien as.

2. Op cit P.512
3. S. Karmow et al; IDID (20)
impoverished peasants because during the 19th century these two areas were very distressed and overcrowded with added damages caused by floods and rebellions. Karran argued that "impoverished peasants were willing to go anywhere, and work brokers organised the "pig trade" packing people into flimsy junks and shipping them off to south east Asia like African slaves." 1

But the Europeans economic development in the late 19th century had also drawn great numbers of Chinese as well as Indians, as indentured labour to develop the tin and rubber industries in Malaysia. In addition, the diligence and industrious native of these labourers had won the approval of those European industrialists who "cast about for more diligent workers than the native Malays." 2

Not all Chinese emigrating abroad especially in Malaysia and Singapore, were impoverished peasants driven out of their own homeland by natural disasters, many were also recent emigrants driven out by political crisis with the creation of the People's Republic of China in 1949. Many of them were army officials and wealthy middle-class.

1. Op cit. P.123 (20)
2. Op cit. P.123 (20)
The Educational System

In a multi-ethnic society like the Federation of Malaysia, as well as in most of other countries, the medium of instruction for her people is also multi-lingual. For example, Malay, English, Chinese and Tamil languages are taught in the educational establishments. Until very recently, the parents had a choice of the medium their child/children were to be taught. At the same time, the government, while allowing the four languages in the educational curriculum, is striving to establish the national language, Malay, which will eventually become the main medium of instruction. It is expected that by 1980 the national language will be in use in all secondary schools. At present, English and Malay are taught and students have a choice of language to sit examinations.

A parent can choose how to educate his child, i.e., in a private, state assisted or state school. Primary education starts at the age of 6 and lasts 6 years. It is free and compulsory up to the age of 15. The students then spend 3 years in comprehensive schools at the end of which they sit a Lower Certificate of Education
examination. The aim of the examination is to select candidates with different skills, i.e. academic, technical or vocational, and to channel them accordingly. In the fifth year after the primary education, the students sit for the sixth Form Entrance Examination either in Malay or English (or 'O' level standard). The sixth form takes a similar length of time as the British students and at the end of the two years they take the Higher Certificate of Education or 'A' levels as we know it here to qualify them for university courses.

**Nursing**

In Malaysia nursing is a "very respected and a secure profession. Maids (Amahs) do all the dirty and domestic work and there is still a lot of work pressure because nurses do a lot of clinical work which nurses here are not allowed to do. It is more of a female profession but now boys are entering as well. Unfortunately, it is very difficult to obtain a training place because of the government policy which gives priority to the Malay applicants and most other government posts are now closed to other ethnic applicants. As a result, more girls are applying for the training and the queue increases with severe competition. Also, getting a place is a matter of whom you know to get a place rather than what you have got academically." This condition of more applicants chasing after a few vacancies is not only in
Malaysia but in all other countries these trainees come from and it is certainly so in the other 9 countries under discussion. Malaysia provides both basic nursing as well as post basic of which psychiatric, paediatric and orthopaedic nursing are only available. 1 Basically, there are two types of training (a) a three years course leading to full registration with the Nursing Board, (b) a two years Assistant Nurse Course. The minimum qualifications are for (a) MCE/SFM (or equivalent): MCE is Malaysia Certificate of Education in corporation with Cambridge University and it is equivalent to 'O' levels, whereas SFM is also 'O' level equivalent like MCE but the examination is taken in Malay. In both certificates, the candidate must have a pass in Malay. (b) LCE/SRP. The former is Lower Certificate of Education already mentioned above 2 and the latter is similar level but took the examination in Malay language.

Health service is not free as we know of in the U.K. and it is expensive to be sick, consequently "people use the hospital as a last resort and only when the herbal medicines have failed."

1. Appendix G.1.
2. See section on "Education"
The Philippines, an island between the South China sea and the Pacific Ocean, gained independence from the U.S.A. in 1946 and became a Republic at the same time. It is larger than the U.K. in area with a population of about 40 million in mid 1972. The capital is Manila.

Before American colonization in 1898, she was under Spanish control for more than three centuries but “United States tutelage was benevolent and no people to-day are more deeply pro-American than the Filipinos.”

Perhaps this explains why her educational and nursing systems are replicas of U.S.A.'s.

The economy of Philippines is based on private enterprise (most of them have their parent companies in U.S.A.), provided there is 60% Filipino participation in the capital. Like the Malaysians, Filipinos have rice as their stable food and agricultural economy is very predominant in the economy especially in coconut products, logs and wood products. For example, in the 1960's agricultural products and sugar accounted for about one-third of its domestic products employing 60% of the labor force.

1. S.Karnow et al: South East Asia, Life World Library P.58, 1968 (20)
2. J.Powers et al The Philippines, Taiwan: Industrialisation & Trade Policies. P.53 Table 2.9
labor force. According to the Annual Publication editorial, she is run on "a system built on economic and political nepotism, a system built on widespread corruption (which, according to Manila experts, consumes one-third of government revenue), and a system long sustained by heavy United States investment (some $2,000 million) and military and paramilitary involvement (exemplified not only by the presence of military bases, but by the funding of counter-insurgency operations and - through a branch of A.I.D. - the virtually complete control over developing, managing and equipping the Philippines internal security forces)"

It was this system that the nationalist Senator Benigno Aquino, writing in 1972 claimed had built "a self-perpetuating, lop-sided society of castes in which 1.5% are privileged to enjoy the good life, the rest, the 75% poor - even the 23.5% middle middle-class can barely make a living." 3

The same editorial suggested that looking at the employment trends more and more young persons are returning

1. J.Powers et al The Philippines, Taiwan: Industrialisation & Trade Policies P.59 Table 2.9 P.53 (35)

2. Far East Annual P.385 1974 (12)

to school in order to postpone the evils of unemployment and many "may have ceased to look for work for lack of job opportunities." ¹

Philippines' outlook is very much Europeanised by the long sojourn of the Spanish colonialists and is politically mature and vigorous. Unfortunately, such a vigour is not matched by social or economic progress. Millions of working people are underemployed in addition to over one million unemployed. ² At the same time, her population is growing at the rate of 3.5% annually and some 400,000 job-seekers enter the already overspilt labour market every year. ² Today almost 35% of the peasants are still sharecroppers whose productivity is among the lowest in the world with the landlords having all the vested power.

Changes are expected however to solve the problems of underemployment and unemployment as more and more labour intensive industries are being built instead of highly capital intensive, in order to tap the rich source

of the unproductive labour force. Her employment difficulties are further complicated because of a young population with 40% between 25-44 years, 36% between 10-24 and about 20% between 45-64.

The Chinese population is very small at about 12% but then, despite the European influences, there are traces of much older civilization such as Hinduism, Buddhism and Islam and physically the people resemble the Chinese rather than Indians or Arabs. It appears that the ways of life in the Philippines as well as in other countries or islands in the South East Asia are similar to those of Southern and South Western Asia. They share similar natural hazards like the summer typhoons season. Philippines is in the worst position; most of the typhoons are born nearby.

Nursing

The Philippines has a two-tier nursing training system, the Degree and Diploma programmes are similar to the U.S.A. There are many entrance qualifications before a person can become a trainee nurse. 1 It is also very expensive to embark on a nursing career because it

is a fee paying course unlike the system in the U.K. and other Commonwealth countries where allowances are paid. According to the trainees, the cost for the first two years in the university is between 1000-2000 pesos per annum and for the three years of internship the cost is about 3000 pesos annually including board and lodging. The cost varies very much from village to urban hospitals and universities or colleges. Internship consists of sessions devoted to practical experience to be gained in the hospitals. But the trainees receive full-student status during their years of training.

Despite the high cost, nursing is a very popular career especially for the girls because the general attitudes towards the nursing profession are very favourable. Nursing is "very respectful." People think nurses are "kind and helpful," and there is a group of persons who will do "the dirty job." These persons are known as "Janitors" or "domestics" as we know of here. The training may be very easy but "it is a hard work as well once you qualify because nurses do a lot of clinical work which doctors here carry out but at home we have fewer hospital doctors." Despite the expensive training, the demand for training vacancies is greater than the vacancies available. As in the U.K., nursing is still very much a female profession and in the Philippines "most male staff are attendants but this is changing."
Education

The educational, like nursing, system is very much a mirror image of that of the U.S.A. A child starts nursery school at the age of four and joins the kindergarten next year. At the age of six, he is in the preparatory. He will then spend the next seven years in the primary school. From 14-18 years he studies in the High School. If he graduates, he will (if he so wishes and if his parents can afford the fees) join a college which usually teaches Diploma courses or a university for a degree course.
Hong Kong

Hong Kong, a crown colony of 403.7 square miles since 1842, consists of Hong Kong mainland, Kowloon and new territories. It lies south of China, next to Canton. In 1972, her population was at bursting point at 4,103,500 compared with about 2,500 in 1844. Her dramatic bulge started in 1949 when the People's Republic of China was set up, millions of people from China sought her refuge, that of Taiwan and other south east Asian countries. Of the 4 million people, 95% are Chinese, the rest consists of Britons, Americans, Indians, Pakistanis, Portuguese and Japanese. She too has a very young population with 55% under 25.

She enjoys a mild climate with a tropical monsoon weather of 15°C in February and 28°C in July. Theoretically, Hong Kong has four seasons but the differences are less marked in between to feel the change over of each season. Malaysia and Philippines enjoy similar tropical weather.

Hong Kong became a temporary place of residence for these persons who took her refuge hoping that Taiwan would regain mainland China and that they would return to their place of birth. They were also people from upper class, entrepreneurs and industrialists. Once in Hong Kong, they reemployed their past experience, and expertise and tapped the plentiful human resources.
As sojourners, they also transplanted the socio-cultural norms and values in Hong Kong. They started with small industries and to-day she is the most industrialised island in South Asia employing most of her workforce leaving only less than 5% of them for daily produce like fresh vegetables and poultry.

Much of Hong Kong's prosperity is a produce of the immigrants' hard labour and their great ability to adapt because "the immigrants gave Hong Kong its most valuable economic asset, a reservoir of industrious, hard working and docile labour capable of being trained in industrial skills." 1 It is indeed a feat considering that she does not have natural resources as raw materials. Her life depends very heavily upon foreign trade, commerce and manufactured goods. The Financial Secretary, Philip Haddon-Cave gave a vivid description of Hong Kong's survival kit: "We in Hong Kong, live by foreign trade, commerce and finance and we trade with the four corners of the world. We believe in free trade, free enterprise and self-reliance, having no protective tariffs and restriction on imports or on the inward or outward remittance of funds." 2 She is also a vital link (commercially, a middle man) for

2. Hong Kong, 1974, P.7 (13)
China with the rest of the world. She provides a very congenial and strategic environment for China and the rest of the world to meet for both social and economic intercourse.

Her business has been booming since and prior to the Middle East Oil embargo, Hong Kong was actually experiencing a shortage of labour because there were fierce competition among employers for workers and various inducements were used to retain them such as improved working conditions and reduced working hours. "Because of a continuing shortage of labour, a few large factories, mostly engaged in cotton spinning, were authorised in 1970 to employ women at night." 1 The textile industry was in 1973 working twenty-four hours a day with 3 eight hours shifts.

Similarly, her industries are mostly labour intensive and are home-based, eg., a tailor may start off with a capital of two or three sewing machines and families do piece work at home. In addition, many illegal immigrants from China, provide a pool of ready cheap labour.

Education

The educational system is based on the British system.
with free primary education (6 years) but it is not compulsory. Secondary education is free-paying, but if a student who has proven his ability by passing the primary six's examination above a certain percentage, will get free education up to G.C.E. 'O' level (form V). Matriculation takes a further 2 years ('A' levels).

Both secondary and higher education is very expensive and the cost varies from HK $60 per month (in government secondary schools) to HK $100 in private schools. Many children of the "less well off" parents have to pull out in order to help to contribute towards the family budget unless they can obtain the government scholarships. In spite of this, the literacy rate is between 80-81% of those 10 years old and over because many young persons pursue their education on part-time basis and attend evening classes.

One possible reason why primary education is still not compulsory could be that Hong Kong has too many students (as she has a very young population) and demands for school places exceed the available places. This kind of disequilibrium is more prominent among the primary places than others. A shift system was introduced to ease the pressure while more school buildings are being constructed; students attend either a morning or an afternoon shift.
Health & Nursing

At present, there are 16,843 hospital beds spread over the three islands or 4.1 beds per 1000 population. Of these, 2,053 beds are owned by private agencies. Taking away 4.127 beds for specialist treatment only 3.1 beds are available for general treatment per 1000 population. Medical care is not free for a hospital visit to see the doctor, a person pays a nominal charge of HK $1 plus charges for medication. In the case of hospitalisation, the charge varies according to the type of room, i.e. third, second or first class; and diets required, from HK $2 - HK $6 per day for maintenance and treatment.

Hong Kong has three government hospital nurse training schools; two for general training and one for psychiatric training. Each provides two types of courses, i.e. three years leading to SEN or RMN and two years: SEN (G) or SEN (H). Some other hospitals have been approved since July 1972 to train personnel leading to SEN enrolment. Now all the courses and qualifications obtained there are recognised by the CNC here.

The entrance qualification for the three years' course is Hong Kong School Certificate with compulsory passes in English, Chinese and Maths and two other subjects. The subjects if passed with credit are equivalent to 'O'
level here. The two years course requires a minimum of three years' secondary education. All trainees must be at least 5 feet tall and single. The contract stipulates that the trainee must stay single throughout his training or he will forfeit the training. It has been alleged that even female visitors are not allowed in the female trainees' room except the sitting rooms. He must reside in the nurses' home. One trainee remarked that, "that's why we are not bothered by the nurses' home's restrictions here because Hong Kong is worse." He also receives a training allowance ranging between HK $400 - HK $750 a month.

The status of the nursing profession is very high as among the countries already described. Another profession which many girls aim at is teaching. Many trainees here reported that they did not recollect knowing a male friend as a nurse, although there are male nurses in the psychiatric hospital. Again, there are fewer training vacancies to meet the large numbers of applications.

Life and Religion

In this section, we discuss our trainees' religion in general terms applicable to Malaysia, Philippines and Hong Kong and other countries. The three countries have been very much influenced by the Chinese immigrants who play an important part in these countries' economy.
Among the Malaysians for example, there are few physical differences between the Chinese and the Malays but there is however a distinct ethnic identity especially since the government's policy of raising the Malay's status. Thus, Chinese have tended to congregate in separate communities, to speak Chinese and to send their children to Chinese schools. In general, they live in towns where they run shops and others business. Pakistanis and Indians in Malaysia also work in the towns but many work on rubber plantations.

Immigrants always bring with them their own culture and congregate together in their host country. Chinese have by far, the strongest desire to maintain their ethnic identity. "The strength of these national bonds varies from one immigrant group to another, and in diminishing order of strength the immigrants may be ranged from Chinese, Moslem, African to West Indian," and suggested that the first three groups had the strongest links because they "retain traditional institutions and place the greatest importance on the bonds of clan and kinship." 1

This tendency, if temporary, is understandable because

1. S. Collins: Coloured Minorities in Britain P.19. (3)
in a totally strange environment, it is easier for a person to obtain morale and emotional support from his own kind. However, in the case of the three countries this tendency has evolved into a new way of life in their host country but are yet strongly orientated towards their homeland. For this reason, the Chinese in these three countries have successfully made a replica of life-style, cultures, socio-economic norms and other values of their homeland - China, or a miniature of China. Therefore, it is necessary, when looking at the trainees here, to look at the socio-cultural aspects of China prior to the People's Republic of China and that of the 19th century.

Over generations, mixed generation between ethnic groups has occurred. That is why physically, the people resemble each other more than would their religious beliefs would suggest. Another common feature to all these countries is that rice is their stable food and they grow it as well either in small or large quantity.

The general experience in Britain is that most of the trainees from Malaysia, Philippines and Hong Kong are Chinese or have Chinese traces and their religious beliefs and practices are as varied and complex. Today, Buddhism, Christianity, Confucianism, Hinduism and Islam, all flourish and coexist peacefully with other cults and sects throughout South East Asia. In fact another mark of European influence among these people is
the use of Christian names. In these countries, with
colonization many of the English teachers who either
through missionary service or other scheme, went to
teach, found it difficult to pronounce long Chinese
names, and gave their students a free choice of Christian
name without the requirement of baptism or Christening.
For this reason, many if not all the trainees from these
countries have Christian names without Christian beliefs.

The concept of spiritual beliefs and practices differ
from the West. In the East the universe is seen as
coherent while the West distinguishes the physical from
the spiritual. In the Far East, all forms of life are
unified and religion plays a vital part and ordains
these people's life. Basically the "moral qualities
of man (is more important) than his intellectual and
material qualities. The sense of duty is stronger than
the love of liberty." 1 Western culture stresses
individuality, competitiveness with other individuals,
ability to subdue nature in search for his own salvation
and for progress. In Asian culture, group endeavour
and proper group behaviour occupy a place of over-riding
importance. It "stresses co-operation and balance in the
relation of man to man, upholds order and harmony with

1. Chu Chai et Winberg Chai - The Changing Society
of China P.23, (6)
nature, accepts the subordination of the individual to the group and follows a secular rather than metaphysical outlook upon life." 1

The family is the foundation of Chinese society and this family concept is very deeply rooted over centuries and has influenced the moulding of individual personality and ensured the perpetuation of the Chinese cultural pattern. We cannot here make a detailed study of Chinese history, suffice it is to point out that most, if not all the Asian (Chinese) trainees' parents' upbringing were very much influenced by Confucian ethical principles. According to Confucius, family is the pillar of the society and his social norms are "Li (rites) which rest on three bases: Heaven and Earth, which are the source of life, ancestors, who are the source of the human race, sovereigns and teachers, who are the source of government. (For he asked); without Heaven and Earth, where would life come from? Without ancestors, where would off-springs come from? Without sovereigns and teachers where would government come from? If any of the three had been lacking, there would be no men (he said), or no peace. Therefore, according to the rites, man must pay homage to heaven above and earth below, worship ancestors and honour sovereigns and teachers." 2 Within the family circle, Confucius said that "A youth

1. Ping-Chia Kiu - China P.18 (34)
2. Chu Chai et al - quoting a passage of the Hsun Tzu P.77. (6)
should be filial at home and brotherly abroad; then
he should be earnest and sincere and have kindly feel-
ings towards all, but feel a disposition towards
humanity. 1

There is no doubt that the parents of these overseas
Asian trainees have inherited Confucian teachings and
they in turn have passed on these socio-cultural beliefs
to their children. This is so, because as already
pointed out especially so before the Communist regime
in China, family played the most vital function in
maintaining social order. It is still very true, because
the aspirations of the parents of these trainees are
related to the China they once knew and were forced to
leave. Western influences had so far affected little
the upbringing of their children who are the trainees
in Britain because to them family is still "embracing
not only father and mother, but grandparents, children,
grandchildren, uncles and aunts and cousins. The
oldest member of the family is the patriarch, the
centre of authority and respect. Age(is) held in esteem;
filial piety and ancestor worship (aro) considered
fundamental virtues. A child's marriage, his career
and his entire course of actions (aro) determined by
the family group." 2 Earnings in the family form a

1 IBID, P.77 (6)
2 Ping-Chia Kiu - China P.21 (34)
* According to my experience, many Chinese parents
shunt anything that is communist in terms of news-
papers, film shows, etc.
common fund. The family business, small shops in Hong Kong, Malaysia and Philippines support this view. Every member of the family can expect support from the common fund.

It is therefore, very important to remember that these trainees have been very much influenced by and instilled in this sort of traditional social attitude which emphasizes conformity and respect, though it may seem very authoritarian and autocratic. "Manners were regulated to ascertain who was senior and to ensure that the proper respect was shown. A first question chance acquaintances was 'What is your honourable age?" and the answer determined the standing of the two parties." Consequently, this kind of social attitude produces a "quieter" and more "docile" child than their counterparts in the West, a courteous and responsible teenager in all aspects of their activities.

It is difficult to dissect religions from the ways of life of these people because religions are important to a person's life, they order his life by himself, among his family group, workmates and in the wider society itself. But there are many ways to demonstrate one's belief and similarly, different religion lays down

1 Louis Heren et al: "China's 3000 Years" p.23 (14)
different rules for its adherents. These different rules produce different types of behaviour. Thus, the Islamic faith lays down moral and social codes which affect its followers' daily life. To a Moslem, customs and laws are the highest order to abide by because they originated from the Koran.

Literally, Islam means submission to the will of Allah. But Allah's prophet is Mohammed. If some Moslems feel superior to other non-Moslem, it is because their religion tends to create this image - or superiority feeling. In short, Islam requires a Moslem to say prayers five times daily if possible; every year during the month of Ramadhan from dawn to sunset he must fast for one month. If he can afford to, he must give alms and make pilgrimage to Mecca. He is forbidden to eat pork or drink alcohol. Although, it is required of him to eat animal meat that have been killed according to laws similar to those of the Jewish religion in many of these countries which had colonial influence, this last requirement is not very strictly observed. Such a taboo will obviously create anxiety among the newly arrived Muslim trainees concerning meals prepared by English people in the canteen.

Hinduism which can cause similar anxiety, is one of the oldest religions in the world. Its influence like that of Islam had spread from India and Pakistan to most Asian countries. Hinduism is more complex than Islam.
A Hindu worships several gods and goddesses. The most important being Brahma, as the Creator, Vishnu the Preserver and Shiva, as the Destroyer. Hindu festivals are most important occasions for they serve as an important social and emotional focus for its followers. A Hindu believes in the transmigration of souls - i.e., poor and benevolent now, in his next birth he will be rich (is it here we have the expression of 'Pie in the sky?') His religion forbids him to eat neither pork nor beef. Many Hindus are vegetarians.

Hence, our expectations of the way these trainees should behave towards each other and in their various roles; during off-duty hours, on duty hours, towards authorities must pay regard to the fact that their culture is different and their behaviour is the result of the expectations they had before coming to Britain.
Africa

Africa - the cradle of humanity, covers a quarter of the earth's land surface, but it was only inhabited by 328 million persons in mid 1967 or 10% of the world population. Africa was virtually under the tutelage of European countries until early 20th century and was chopped up into many states. About fifteen years or so ago, only few states were independent; now there are over 42.

Before colonisation, Africa was a society with a history unique to itself. It had evolved independently. When the Europeans took over, they stopped a historical process and imposed instead another kind of historical progress which is alien and at the same time inappropriate in time to Africa. The history of Africa and its progress have thus stopped; T. Davidson, colonial rule was "less favourable to progress than before the colonial invasion had begun, for they had lost their independence and with this, their capacity to develop along their own lines." 1 Consequently, "they had lost .... the command of their own history." 2 It has instead inherited the "colonial legacy of unbalanced development," 3 thus creating problems of economic growth.

1. Africa - South of Sahara (1974), P.14  (1)
2. IBID. P.14 (1)
3. IBID. P.38 (1)
and social progress.

Agriculture and herding are the spearhead and provides "the foundation for development as a whole" ¹ for Africa though national conditions are not very kind to its population and very widely. In addition its population too is dispersed very thinly across the continent. On the other hand, colonization has in many ways meant urbanisation forcing rural labour to migrate to the towns to work in those administrative, ² ³ ⁴ industrial or commercial centres. Like the Chinese in the South East, West of Asia, migration for the Africans is not a new culturally phenomenon.

1. IBID P.20 (1)
2. I. Schaper: Married Life in an African Tribe (38)
3. J.C. Mitchell: The causes of Labour Migration (31)
Ghana

Ghana, a country with 92,000 square miles is situated in the West of Africa, on its east side separated from Nigeria by Togoland and Dahomey. She is bordered by Upper Volta to the North and the Ivory Coast to the West. Her climate is hot and dry with average mean annual temperature between 77.9°F and 84.2°F. Her capital is Accra.

As in most of the African countries the population in Ghana is very mobile and this high geographical mobility in response to economic opportunities renders population enumeration very difficult. At present it is estimated her population is about 8.5 million with an annual growth rate of 2.4%. She also has a very young population. In 1961, 61% were 25 or under.

There are no less than 75 different languages and dialects, each distinctive to different tribal groups. The largest tribal groups are Akan, Mole-Dagbani, Elve and the Ga-Adangbe, each forming 44.1, 15.9 and 8.3 percent of the whole population respectively1 or the four groups form 81.3% of Ghana's population. With the British colonial rule, English was introduced as the

1. Africa - South of Sahara, Annual Publication P.366. (1)
official language to bring about a common understanding and is still in use since her independence in 1957.

Despite her size, Ghana is not agriculturally viable and is at subsistence level. She relies very much upon cocoa farming for export. Her other natural resources are chiefly gold, timber, manganese and rubber. With increasing population coupled with a large number of immigrants, Ghana is facing serious unemployment difficulties. The government is at present combating this problem by enforcing the legal requirements relating to residence permits against the foreign African immigrants. This policy is also aimed to relieve urban pressures which are causing concern not only in the African towns but also in the industrial areas in the West of Ghana because her population is badly distributed with the largest concentrations in the urban centres and in the cocoa farming in the south and also in the extreme north east corner.

Education

The Ghanaean educational system is similar to the British system of the time as in all other countries once under British tutelage. Unlike Hong Kong, primary, secondary and technical education in Ghana is free and compulsory. At the end of secondary education, a student will sit for examinations equivalent to 'O' levels and 'A' levels (High School Certificate) according to his
ability, set by the West African Examinations Council. Information about the literacy rate for Ghana is not obtainable however, a reasonable guess would be the people in the southern part have better education than the northerners part because they have been more directly and longest under the influence of modern European life and the Christian religion and Northern people are still with traditional modes of life and religion with little change.

Nursing

Ghana established her first nurse training school in 1945 for SRN training. The SRN course lasts for 3½ years. The candidate must have a minimum of school certificate (equivalent to 'O' level) with English, or he must have the Middle School leaving certificate (one year lower than S.C. standard) and must be prepared to spend one extra year in pre-nursing training. This training emphasizes English, Elementary Science, Arithmetic and Housewifery.

As no official source was available on request, it is necessary to rely upon the respondents. It appears that Ghana also has an SEN course but it appears there are no or very limited places for psychiatric nursing. Our male Ghanaian informant believed that the Scholarship Secretariat, which was conducting the interviews with the prospective trainees "allowed me because I am
doing psychiatry which will be valuable to my country." Unfortunately he was in a mental handicap nursing training instead of the psychiatric for which he had hoped.

Nursing status is as high as in other countries already described and in the villages, nurses are regarded upon as doctors. It is as difficult to enter and over 95% of the nurses are females. Most male nurses are said to be in psychiatric nursing. Demands for training posts outstrip the supply and the fact is "we have few hospitals, less mechanised, fewer doctors, It also means that we get a lot of pressure as nurses to do a lot of clinical nursing and no dirty work. Another group, the nursing assistants - do them." The training is like that in England, i.e., some time is spent in school and the bulk in the wards for practical experiences. Trainees receive allowances ranging from 60 to 100 cedis per month and live in the nurses' home during their traineeship.

* At this juncture one is tempted to ask: "who is misleading whom?" Did the Scholarship Secretariat believe mental handicap and psychiatric nursing to be the same?
Nigeria

Nigeria, a vast country, three times larger than the U.K. has an area of 356,669 square miles with Lagos as its federal capital. Despite her size, she ranks only 14th among the African countries. She is a very close neighbour (geographically speaking) of Ghana on her West, lying on the Eastern end of the West Africa, "bounded on the West, North and East by the French-speaking republics of Dahomey Niger and Cameroon respectively and on the South by the Atlantic Ocean." ¹

Like Ghana, she was a British colony and gained independence later than the former in 1960. She is also the most populated on the continent with about 70 million in 1970. Most of the population are concentrated in the southern part and also in the dense settlement around Kano in the north, leaving the middle belt sparsely inhabited. The Nigerians are "racially negroid with extreme ethnic diversity." ² Over 250 ethnic have been identified with less than 10,000 people. However, the following ten groups make up 80%

of the population: Hausa-Fulani, Toruba, Ibo, Kamuri, Tiv, Edo, Nupe Ibibio and Igaw. Similarly, with 16% of the population as urban dwellers, Nigeria is perhaps "the most urbanised in Black Africa." 1

Being near the equator, she has a high temperature throughout the year with average maximum of 95°F in the North and 87°F in the South while the average minimum is 73°F in the South and 65°F North. Her economy is very much agricultural which absorbs about 70% of the population. Similarly, she has a very young population; 40% under 15, 50% 15-49 and 8% over 50 and this further hinders her social progress despite her rapid industrialisation and urbanisation. This is not marked by social development because mechanisation has not matched the numbers of skilled labour with an equal number of job opportunities. At the same time, the number of school leavers increases every year but not the skilled labourers. Consequently, there are two totally different problems; the numbers of unemployed and under-employed rise. This vicious circle plaguing Nigeria has been observed by Green who said that in Lagos "although employment opportunities for skilled work have multiplied, there is no doubt that thousands of young immigrants have been unable to find work." 2

One important advantage on her side is that she is well

1. Op cit P.606 (1)
2. S. Amin (Ed.) Modern migrations in Western Africa, article by L. Green P.294. (2)
endowed with mineral resources like oil and gas, gold, tin etc. and has about 9,000 square miles of timber which is her main industry. Her major exports are ground nuts and oil, cocoa, palm kernels, palm oil.

**Education**

In fact, "not more than 16% of Nigeria's total population can be regarded as literate in any admissible sense," and this could be a contributing factor to the unbalanced development between urbanisation and social development. Since the World War II however, formal education has greatly expanded and her educational system is similar to that of Ghana or Britain with a three-tier system: primary, secondary (including technical) and university education. Education is still a means of entering the elite class not just in Nigeria but in many other African states and other developing countries.

**Nursing**

Appareently, nursing in most African states was introduced by the missionaries personnel who not only built schools to teach christianity but also built hospitals. Later hospitals were built and staffed on a similar basis to

1. Africa - South of Sahara, Annual Publication P.616(1)
the missionary hospitals.

Information about nursing is lacking and not easy to gain access to. It was learnt from the respondents that nursing is very much a female profession though "this is changing," and nursing generally means acute nursing. There are few nurse training schools in Nigeria which provide two types of courses - SRN for three years and shorter period for SEN. The minimum entrance qualification is 4-5 'O' levels with English and maths compulsory. Whatever psychiatric training there is, is incorporated into the SRN course and is not a separate course. Many respondents claimed that nursing has a very high status as already described in other countries. The reason why the nurses there do not do much domestic work is again contributed by the lack of sufficient doctors. At the same time more and more school leavers are chasing the few vacancies there are.

**Way of Life in Africa**

In Africa, most share same values with particular insistence on the duality of the physical and spiritual worlds, especially in Ghana. Amid a rich diversity of ritual practices and doctrines, a remote supreme being is generally recognised, approachable through manifestations of the spirit or through minor deities. To these minor deities libations and sacrifices are offered.
The earth is sacred and ancestors are respected. There are also christians as christianity was part and parcel of the colonization.

70% of the population live on tilling the soil or herding and dwell in small towns, villages or hamlets. Workers and professional men maintain their farming interests because land is of primary value. The principal food crops are maize, guinea corn, yams, cassava, rice and millet.

Men hunt, fish, pursue handicrafts, while "most of the wholesalers of Ghanian foodstuffs in Southern Ghana are women." In fact, most African women engage in petty trade and domestic chores. Both sexes farm and either may practise as herbalist or diviner. It is an extended kinship family structure which conditions social intercourse and economic endeavour. Like the Asians, Africans believe in a large family; prosperity is measured by the size of family. Children are also looked upon as an insurance against their old age and distress. Filial duty is the dominant underlying emphasis with regular invocations of ancestors to renew lineage solidarity, while wider ties are reinforced by ceremonies linking localised groups.

Achievement is less meaningful in Africa where inheritance

1. P. Hill: A plea for indigenous economics; the West African Example P.100. (16)
to office, status and most property is much emphasized. This, very often is seen as corruption and Reno Dumont complained that "too many positions are filled by nepotism and not on the basis of competence. The top staff of a minister usually belongs to the same ethnic group as its chief." ¹

Another point of interest to note here is in the towns, many of the male wage earners are either seasonal or long term immigrants from the neighbouring villages or further afield and they are mostly single or leave their families behind.

¹ R. Dumont: False start in Africa P. 84. (11)
Mauritius

Mauritius, a volcanic island, lying very isolated in the vast Indian Ocean, is only thirty-eight miles long by twenty-nine miles wide or 720 sq. miles in area. She is 500 miles East of Madagascar with a subtropical climate and is infested with cyclones between December and March of the year.

She was first discovered in 1598 by the Dutch who abandoned her in 1710. In 1715 France claimed her. Over the next century, after a long drawn war since 1740 with France, Britain captured Mauritius in 1810. She is best known to outsiders for her famous large flightless bird, the Dodo, which was exterminated during the Dutch occupation. Hence, the famous expression "Dead as a Dodo."

Mauritius became independent in 1968 with Port Louis as her capital. She has an ethnically heterogeneous population as mixed as Malaysia, all of whom came as immigrants because "there were no indigenious inhabitants of Mauritius. All Mauritians are descendants of immigrant forced laborers who arrived voluntarily or involuntarily over a period of nearly two hundred years." ¹ In 1971 her

¹. B. Benedict; Mauritius — Problems of Plural Society 1965 p.7. (3)
total population stood at 830,606 and she suffers a population explosion. The single most influential factor was eradication of malaria after the World War II. She has managed so far to counterbalance the increase with increasing emigration but fails to contain it otherwise by family planning scheme. Her birthrate was still 25 per 1000 in 1971. 65% of her population are Indo-Mauritian, 30% Creoles — descendants from French colonials, African slaves and mulattos and 5% Sino-Mauritians.¹

**Economy**

Perhaps Mauritius is the single country in the world that is dependent on one product for her existence. Sugar and its by-product make up 99% of her exports and account for more than one-third of her national income. It is also a large employer. About one-third of the working population are employed in connection with sugar production. At the same time her fortunes are vulnerable to the fluctuations in the world sugar price.

¹. *Africa — South of Sahara* — P. 742.(1)
As a volcanic island, she has no mineral deposits of any commercial value to supplement her income. Her other crops are tea and tobacco, otherwise she must import most of her foodstuff like rice, her staple food, wheaten flour, grains, edible oils and fats, animal meats. Very recently she has been experimenting with high yield rice crop plantation in an effort to diversify and increase her productions. The islanders also consume a large quantity of fish and other sea products.

Mauritius faces similar perhaps worse problems than the other countries owing to her lack of natural sources of raw materials and overpopulation. Many of her school leavers face a bleak prospect of obtaining a job. In 1971, with a young population, she was experiencing an unemployment rate as high as 12% or 26,000 out of 21,000 working population.

As already mentioned, Mauritius constitutes a plural society with a multitude of religious beliefs and socio-cultural values among her different ethnic groups. 44% urban dwellers, over two-thirds of the Chinese, 48% of the Creoles and 31.5% of Indo-Mauritians are living in the urban areas.

1. B. Benedict, Mauritius, Problems of a Plural Society. Pall Mall Press P.23 Table II.
Education

Without exception, Mauritius also shows the striking features of variety of languages which are associated with their ethnic and national heritage. Controversies over the medium of instructions are not absent. Despite the fact that English and French are official languages, Creole is the lingua franca and is understood by everyone. English and French are compulsory and taught with Hindi, Urdu and Tamil as optional, while there are schools where Chinese is the only medium of instruction.

Her educational system is a replica of the British one with examination papers for school certificate ('O' level equivalent) and Higher School Certificate ('A' level equivalent) being set by London and Cambridge Universities. Primary education is free but further education is fee-paying and it is very expensive. Nevertheless, "Mauritius enjoys a high rate of scholasticity (with) a long tradition among the middle classes of sending their children to university abroad, in particular Britain, France and India," despite the fact that she does not compel her school children to attend.

Nursing

With three large government hospitals on the island

1. Mauritius Annual Publication I. P.57 (28)
2. It means that treatment and consultation are free within.
plus several private clinics. Mauritius has only 
one school of nursing. The training offered covers 
psychiatry and general and lasts for three years: 
leading to registration similar to SGN but the standards 
of training and supervision are not recognised by the 
CNC here.¹ No pupil nurse course is conducted; though 
there is a midwifery school attached to her only 
school of nursing. The course lasts 18 months. Both 
produce very small numbers of trained staff annually 
compared with the size of trainees coming to the U.K. 
Available data show that in 1967-68 academic year there 
were 261 trainees and 76 graduated for the 3 years 
course while out of 20 trainees, the midwifery school 
produced 18 qualified midwives. ²

"The minimum educational qualifications required for 
entry are English language and four other academic 
subjects obtained at one sitting. In addition all 
candidates are expected to pass an interview."³ In 
actual fact, like other countries, she can pick and 
choose because of the large number of applicants. The 
flood of applicants is caused by the scant employment 
opportunities available in general for the school leavers 
with 'O' and 'A' levels resulting in severe competition. 
for a few vacancies and "the higher the qualification 
the better the chances to be accepted."⁴ With so many

¹. M. Kendall: Overseas Nursing Student in Britain; 
    International Nursing Review. Vol.19 No.3 1972 (21) 
². Ibid. (21) 
³. Correspondence from Mauritius High Commission 
⁴. From respondents
people chasing a scarce commodity, nursing status may have been over-inflated with the consequent vicious circle where applicants may have many 'A' levels.

"Nursing is a very popular career among girls as well as boys (although) it is still very much a female dominated profession with good prospects and prestige. It is very respected because they (nurses) are regarded next to the doctors. People respect you as somebody who cares for them, looks after them, improves their health, somebody to go to when in sickness."

Another reason for the high status for nursing stems from the fact that in Mauritius, her islanders are very health conscious. They are orientated towards maintaining good health because of the cost of care. A visit to a G.P. will cost about as much as a poor man's weekly wages unless he cares to wait at his nearest health centre which is always packed and where there is always someone needing more urgent treatment. Also most of the doctors find it more profitable to practise privately thus increasing the number of people per doctor available in the hospitals.

Nevertheless, nursing in Mauritius as anywhere else in developing countries is "very hard work because we have fewer doctors as most of them are in private clinics and we do a lot of doctor's work there, like taking blood, giving intravenous injections. Nurses in my country do not give bedpans, there are domestics or maids to do it and other menial jobs."
As in Britain, trainees are paid allowances between Rs 400-500 per month.

**Mauritian Life**

Comparatively, the occupations of the different ethnic groups in Mauritius are very much similar to those achieved by the different ethnic groups in Malaysia. For example, Chinese predominate in business, retail and wholesale and as shop assistants to their own kind. Most Indians are land owners and workers, i.e. in sugar, tea or tobacco plantations, while the Creole descendants are mostly craftsmen and artisans. And despite the increasing western influence, kinship and family ties are still very strong and occupations are still handed down from father to son. For this reason, many respondents are very conscious of corruption among the government officials when they apply for a vacancy. Although kinship operates differently among the ethnic groups, the size of the families is necessarily large as it is very much influenced by the precarious economy. There are often relatives of either spouse living in the household. In particular among the Chinese, Hindu and Muslim, it is a patrilineal joint family type as described in the section on Malaysia, Philippines and Hong Kong. A large family has many advantages providing unpaid family labour among many small holdings which are otherwise uneconomic to run.
Benedict gave a vivid descriptive account of the working of a joint family in Mauritius, "Joint family households, like all households, go through a developmental cycle, beginning with a married couple, expanding with the addition of children, expanding still further as sons marry and bring in wives and produce children. Daughters leave on marriage. Contraction begins when one of the parent dies. The joint family household may stay together, but when the second parent dies the forces working for partition of the joint family household - now composed of brothers, their wives and children - increase. Eventually, the household splits up and a new cycle begins." ¹

It is only a recent phenomenon to see so many girls in gainful employment as a result of their increased educational opportunities. This developmental move towards liberation for the woman could be very much hampered by her present unemployment problem continues. It was and still is in many cases, customary for girls to miss secondary education. They stayed behind to help with household work and wait to be married off.

¹ B. Benedict: Mauritius, Problems of a Plural Society Pall Mall Press 1965 P.30 (3)
West Indies

West Indies, a name given to a group of islands in the Caribbean sea, lies along the tropic of Cancer between North and South America. It is divided into two main groups: (1) the larger islands like Hispaniola - Haiti, Dominica Republic, Jamaica, Puerto Rico. (2) The smaller islands of (a) The Leeward Islands: Barbuda, Antigua, Montserrat, St. Kitts, (b) The Windward Islands, St. Lucia, Barbados, Grenada, Tobago, Trinidad.

On the whole, these islands are quite mountainous and the climate is always very hot and wet. In racial composition, the West Indies bear similarities to Malaysia and Mauritius. The population is ethnically heterogenous with the Negroes, East Indians, Mixed White, Chinese, Lebanese Syrians, Caribbean Indians in the ranking order with largest first. One report observed that "There has been a considerable amount of intermixture between the various racial and national groups and today the racial composition of the population is extremely complex, including, as it does, pure representatives of all the racial groups plus all the possible mixtures." 1

Historically, the West Indian islands had been colonised by the Dutch, French, Spanish and Portuguese before the

British. These islands were developed with the use of slaves from Africa and after the abolition of slavery in 1834 with indentured labourers from China and India. These different cultures, customs and degrees of civilisation have played and still play important parts in the behavioural patterns of these islanders, building a culture of their own proves very difficult because they have been taught to be Europeans especially to be English. Collins found that "West Indian culture is Western Orientated." 1 while the report suggested that "European values (have) come to be accepted on all levels of society and West Indian culture is similar to that of Europe in many respects" 2 because their own, in particular the African slaves were not allowed to practise according to their own tribal values by their masters. This is reflected in the West Indians' thinking. For example, the report explained that in the West Indies "to be successful a man must be European, if not in appearance, then in education, manners and so on." 3

Despite the blend of so varied ethnic groups with considerable segregation, the islanders have accommodated themselves and coexisted with relatively little friction and hostility. Socially, the ethnic group plays lesser

1. S: Collins: Coloured minorities in Britain 1957. p.2²⁶(8)
2. IDID P.2²⁵(8)
3. IDID P.2²⁵(8)
importance than the shade of one's skin colour. The lighter shades tend to be ascribed with higher social classes. This is further reinforced by the fact that "opportunities for mobility from lower to middle class are extremely limited and take place mostly through education. Lower class individuals are expected to behave with much more submissiveness towards the middle and upper classes than would be expected in Western Europe, and in general, the relationship between the two groups is very authoritarian."

One important socio-cultural aspect of behaviour comes as a shock to a misinformed person outside West Indies. To Europeans, marriage and family life is interrelated to each other. The former is sacred and predetermines the family life. (Is this the accepted norms among the Europeans or is there a gradual shift to the West Indian norm?) It has been suggested that in the West Indies, the pattern of family life vary by social origin. Thus, descendants of African, Indian and European origin live fairly close to each other and intermarriage is not unusual among them, but the West Indian family structure is rather unstable and insecure in particular as a result of slavery.¹ As slaves they were forbidden to preserve their own tribal customs and were not allowed legal marriage by the white. On the other hand the slaves were encouraged to procreate for their masters' own benefit, i.e., to have more slaves but they were not

¹ put forward by Henriques, F., at al. quoted by S. Collins IBID p. 46. (8)
allowed to assume paternal or any other responsibility over their children. Instead, the bulk of the responsibility for their children's upbringing fell upon the latter's mother thus instilled a matriarchal family system at the same time and this is still so today. Consequently, the values of marriage are different. Smith et al found that "Country folk conceive of marriage as a status change marking maturity or ripeness, something appropriate to the late middle age rather than to early (adulthood). The status transition which determines adolescence for both sexes is parenthood, the status transition which marks maturity in social, economic and age context is ideally marriage. The achievement of marriage itself indicates a fair level of individual success in discharging one's social and economic roles." 1 The report further added that "The marriage of couples whose financial means are not considered sufficient by the community invites ridicule." 2 Thus, a West Indian couple may have lived happily for a number of years and have several children but are not necessarily married. Indeed, there are many preliminary or "trial" relationships before legal wedlock. In other words cohabitation as we know it here is almost an accepted norm in West Indies. Any child born out of this "trial" marriage, if rejected by the father, is cared for by

2. IBID P.33. (36)
the girl's mother while the former goes out to work. I wish to emphasise that though such conduct may appear unusual it is seen as quite right and proper in the West Indies.

Children are still brought up very strictly as the Victorians did. Their parents demand of them unquestioning obedience and respect and often allocate certain household tasks for them to do at an early age. Many sociologists see a comparison of this upbringing with the present British working class parents. If the picture presented here demonstrates a certain degree of insecure and loose family structure, this is not at all false.

West Indies and Guyana are predominantly agricultural industries with sugar cane as the chief export revenue, banana, maize, rice, pineapple, coffee, citrus fruits, tobacco and cocoa. These farming people suffer from poor wages and poor working conditions. Their difficulties are further heightened by tropical storms (hurricanes) which are not infrequent and sometimes by earthquakes and volcanoes.
Jamaica

A British colony, gained independence in 1962, with Kingston as her capital town. She has an area of 4,411 square miles with about two million inhabitants of many different ethnic groups as described above and these islanders are brought together by the use of English as the official and commercial language while other national dialects are also spoken. Her population growth has been dampened by migratory movements in particular emigration.

The islanders receive free primary and secondary education up to the age of 15 in a British type educational system but one that represents an archaic approach to education as it has not undergone liberalization which British education has been undergoing.

Nursing

A nursing training scheme dates back to 1895 and the General Nursing Council of Jamaica has reciprocal recognition with the GNC of England and Wales since the former gained recognition in 1958. She has 22 general hospitals, 90 health centres, 6 special hospitals for psychiatric treatment among them and 5 private hospitals.

In 1969 the population ratio per doctor was 1,819 to one. ¹ There are three training schools in Jamaica and "the entrance requirements for student nurses approximate to those of the United Kingdom and training is available in mental and general nursing. There is, however, no type of training which equates to that leading to State Enrolment. The training of practical nurses or nurses' aides is at a lower level." ²

Jamaica enjoys a warm to hot climate all the year round and is very famous for sugar cane and her rum. At the same time she leads in sugar cane products among the Caribbean territories.

1. West Indies: Caribbean Year Book 1974 P.243
2. from correspondence.
   , from Jamaican High Commission
Trinidad and Tobago

Like Jamaica, both islands, Trinidad and Tobago were discovered by Columbus and gained independence from Britain in the same year as Jamaica. Her total area is 1,980 square miles with a population less than one million. Both islands enjoy similar climates to Jamaica. In the wake of a swelling population, Trinidad and Tobago have much to thank migratory movements to deflate this situation because more and more people are emigrating than immigrating. The capital of Trinidad and Tobago is Port of Spain in the former island.

Education is free as far as it is provided and compulsory between the age of 6 and 12 years old and English is the medium of instruction with similar system as Jamaica's. The islanders also speak other national dialects.

The health services are being rationalised as envisaged in the National Health Plan (1967-1976) which "provides for the rationalization of the use of existing resources, the integration of traditional fields of curative and preventive medicine, managerial decentralisation; appropriate authority being delegated to the execution level for the performance of day to day functions and overall programming of health activities." 1 Her nurse

1. West Indies and Caribbean Year Book 1974, P.360(49)
training schools provide similar training as Jamaica's requiring similar entrance qualifications. The status of nurses is as high as in other countries already described for similar reasons and nurses are also well respected. All the trainees in the West Indies receive training allowance as the trainees here do.

At the time the Year Book was published, unemployment which was at 14% and "will still be high at the end of the five year period 1969-73" and in fact the government could not see other solutions to this problem but the use of emigration policy to encourage a "reasonable" number to emigrate and to encourage family planning.

In these two small islandd, Trinidad relies mainly upon sugar as its source of income and it provides about 17,000 jobs in an area of 95,000 acres of land whereas her neighbour, Tobago, is more diversified with cocoa, coconuts and bananas. The staple food for the West Indians is rice with hot and spicy food.

1. See Appendix C:3
2. West Indies & Caribbean Year Book 1974 P.383 (49)
3. Ibid P.383 (49)
Barbados

Since her discovery, Barbados had been a British colony until 1966. She is smaller than Mauritius, only 166 square miles in area with Bridgetown as her capital. Barbados enjoys "one of the healthiest climates in the West Indies with tropical temperature tempered by the North East trade winds." 1 The mean annual temperature is around 70°F.

Despite her size she is inhabited by about a quarter of a million of negroes, whites, mixed and East Indians, half of whom are very young and under 20. Like her fellow islands, she relies heavily upon emigration to check and reduce the population bulge and increasing unemployment for school leavers because "without large scale emigration which the island has experienced in the post-war period, the labour force would have grown faster and the unemployment rate would have been much higher." 2

Barbados provides free education and compulsory attendance up to 14 years of age in government maintained schools or independent schools. The students sit the GCE papers set by the Cambridge Examination Board here.

Barbados has health services similar to other Caribbean

1. West Indies & Caribbean Year Book 1973 P.85 (49)
2. M.Kendall, Overseas Nursing Student in Britain, International Nursing Review Vol.19 No.3 1972 (21)
islands and run a similar National Insurance scheme as UK's except that the cost of the stamps is shared equally between employer and employee. She has one general nurse training school with an enrolment of 250 and provides several courses of varied depth depending upon applicants' educational ability. ¹

¹ See Appendix G.4.
Guyana

Guyana means "the land of waters" because of her many fast flowing waterways broken by rapids. Her capital is Georgetown and she has an area of 83,000 square miles lying north of the vast continent of South America. She was the only country colonised by Britain in this vast continent which is about 4,000 miles away from the U.K. Four years later after Jamaica gained independence; she obtained hers and became a republic in 1970. Like the Caribbean islands she enjoys very hot weather of no less than 70°F. Owing to the intricate fabric of ethnicity, she is also popularly known as the "land of six peoples".

For her size, with a population of three quarters of a million she is very much underpopulated compared to the other countries already described because more people are emigrating than otherwise. Similarly, Guyana is very mountainous. Her six peoples are Africans, East Indians, Portuguese, Chinese, Europeans and Americans.

Education and Health

Her official and national language is English while many other languages are also spoken. If places are available, education is compulsory and free up to 16 years old. At the end of secondary education, the students sit for the 'O' and 'A' levels where appropriate, which are equivalent to what we have in the U.K.
Health development in Guyana is not as advanced as in the U.K., but is making great strides. Unfortunately, she is very much hampered by the shortage of trained technical health staff, \(^1\) with only 15.9 nurses and 3.2 auxiliary nurses per 10,000 population and provides 3.1 beds per 1000 population. There are two basic nursing programmes and one basic midwifery training.\(^2\)

The government encourages nurses to practise in the Rinterland areas and those selected for training from the Rinterland areas are "expected to return to contribute to the delivery of health care in the particular area" \(^3\) when they qualify.

Her economy depends upon sugar and rice which are main crops, followed by coconuts, coffee and citrus fruits and is very much similar to her Caribbean neighbours.

1. West Indies & Caribbean Year Book 1974. P.209 (49)
2. See Appendix C.5.
3. From correspondence. Appendix C.5.
When considering the state of the nursing profession in the West Indies, the general picture is not dissimilar from that of other countries under consideration. Generally, nursing is "very respected" and also commands "a lot of prestige." "We do not have many doctors and hospitals at home, so nurses have more opportunities to do some of their (doctors') work. But there is a lot of pressure because of so few hospitals for so many people." Otherwise, "it is similar to the U.K.'s but nurses do not have very much domestic jobs because they have helpers to help them - assistant nurses." Some respondents complained that "the hospital conditions are not as nice and good as here and better salary here as well." Another condition of entering the nurse training is that a trainee, once qualified must remain in that hospital for at least five years. Their training is provided on a similar basis to that in Britain and trainees receive allowances. Between £150-175 of the country's currency concerned. Similarly the nursing Administrators will be able to understand the strain, disillusionment and disappointment in their West Indian trainees' expectations of Britain. Disillusionment and disappointment because
Britain did not only impose her own customs but also her legal, social and educational institutions and many West Indians were orientated to believe that Britain is their motherland. Disappointed because they feel that they have been rebuffed with a cold reception, ignored etc.
Summary

We have given a very brief description of the socio-economic and cultural aspects of the ten major donor countries, necessary because each country has its own customs, beliefs and values which determine the learning environment in which children are brought up, thus influencing their behaviour. We consider that administrators should have a knowledge of their different national and cultural backgrounds as both can create unnecessary pressure and anxiety.

Western education was introduced in all these countries and the British educational system is being followed very closely, except Philippines, but is behind in the degree of liberalization. The students are taught in English primarily which is also the official and commercial language. Philippines, being an American colony, had accepted the American educational system but again using English as the medium of teaching. English is also an alien link which has welded these varied nationals together. Education and particularly foreign education is now one of the hallmarks of high social rank in social which is still a matter of great importance. Consequently in many developing countries people's primary goal is maintaining the high rank and achieving higher rank still. This produces a strong motivation in the middle and upper classes to give their children the best possible education. Foreign education is considered to be a guarantee of elite.
position which is away from the ancestral village and in the bright lights of the cities.

Command of English differs for different nationals, for example, the Asians, i.e., most Malaysians here are Chinese like those from Hong Kong and Chinese is their mother tongue; English is only a second language learnt at school. West Indians, however, have English as their mother tongue though it has been pointed out that the idioms differ from ours. Understandably, all the trainees coming to the U.K. are at least bi-lingual.

Most children in these countries are brought up with strong extended family ties, because "A large family is valued for its own sake for the social pleasure of living among a large group of people." The Asians' family in particular is closely connected with ancient social customs and religious practices and has a very complex system of family relationships. Family organisations are very much like those of the Victorian period in the U.K. with extended kinship relying upon each other for co-operation. For example, many of these trainees' parents, in particular the Chinese, own small retail business and their survival depends very much upon

1. Dr. Helen Ware; Reported in the Times 22/7/75 (48)
   (This observation could be well generalised to other countries under discussion.)
the free family labour as the small farmer owners do for their livelihood in other developing countries. In addition, in these countries, the family, not only is it the basic social unit in the grouping, but creates the basic conditions for social and cultural adjustments. From parents, the children learn most of the norms and values which affect their behaviour.

Thus, a child is dependent upon his father, who as a senior member of the extended family has control over everything. His mother who has brought him up continues to exercise authority over him in domestic matters even when he may be many thousands of miles away. Parental attitudes towards their children are sometimes excessively strict and even punitive when compared to those held by British parents. On arrival here, the trainees are confused by the segmentation of family welfare and care, e.g. parents when old are cared for away from home. By contrast they are brought up in a culture which traditionally welds grandparents, parents and other members of extended family into a very close-knit one. At the same time, the grip of western culture had the desired effect of uprooting these trainees and of creating estrangement and conflicting values at the same time.

On the one hand these trainees aspire to western values, yet on the other hand their nurtured values fight against this aspiration by the feelings of guilt. It is conceivable that these situational conditions
could present the trainees with serious conflicts including misunderstanding, tensions and barriers between their traditionally educated parents' and themselves, drenched in the western values which allow them far more personal freedom than they could dream of had they stayed home. Consequently, they behave very much like marginal men holding two different loyalties, leaving them in a vacuum. This is the seat of alienation. Socio-psychological insecurity and difficulty to adjust adequately to the U.K. because they become aware that their beliefs and values do not fit into the advanced urban societies which emphasize individual pursuit of own interest and competition to get on in life.

So far, the analysis reveals that these trainees' self-expression is very much submerged by their parents, societies who demand submissiveness, i.e., to respect the elders, seniors, the authority and parents. To many whose aspiration in the U.K. is to be qualified as a nurse and whose family tie is very strong will keep a low profile and will find it easier to accept the restrictive atmosphere of the British hospitals. To a minority whose aim is "to be independent" or "to see the world" will soon notice that their behaviour differs from their indigenous peer groups with whom they wish to identify. They become critical and more aware of the hospital's autocracy. The hospitals, on the other hand, may find the former group of trainees (in particular some nationalities like Asians are more docile) more
adaptive to their administrative needs and norms, or do they? Any "deviants" may have to be removed.¹

Could this be the reason for low morale, high drop-out rates?

Culturally, most of these overseas trainees are brought up to hold the teacher in high reverence as they do towards their parents. The social values place upon the warm and informal associations in their own family and social groups. Ours, however, is upon strict style of formal politeness in social intercourse. We consider that the British cool and carefully preserved formal relationship could dampen these overseas trainees' liveliness and distort their attitudes and could also play an important and crucial role in their interpretation of their character and behaviour.

All these countries lay great emphasis on free and compulsory education except Hong Kong, owing to lack of school buildings, she is not able to enforce it. Nevertheless, there is a great undercurrent which reminds us that literacy is increasing everyday and school enrolments have increased and are still increasing by many

¹ One S.N.O.(T) indicated that there are several ways to "get rid of bad trainees" irrespective of their origin. One of them is "my boss would reject applicants of (a certain surname) because (the boss) believes that through past experience those persons make bad nurses."
times since 1950.\textsuperscript{1} At the same time, unemployment figures are swelling and has reached a point where it is politically explosive (perhaps this explains the laxity with which young educated are allowed to emigrate). Singer\textsuperscript{2} identified four important causal factors, (1) the population explosion, (2) the revolution of rising expectation, i.e., "an intense desire for cash earnings and for wage employment in particular, and a rejection of subsistence farming within the traditional system."\textsuperscript{3} (3) Urban explosion, i.e., more young people drift into the towns, (4) the technological explosion - employment of sophisticated machinery (mostly suitable for industrialised countries) instead of using the pool of labour available for production.

There is also strong competition for salaried jobs like teaching, government posts and in this particular instance, nursing. Many will meet the minimum academic entrance qualification, with increasing free education, but more and more applicants are applying for nursing training with better academic qualifications, like 'A' levels thus squeezing out those with the minimum academic

2. IBID
3. IBID
qualifications. The status of nursing is further
enhanced creating an euphoric atmosphere of prestige
and respect. The emphasis in all those countries looked
at is domestic and dirty jobs are being carried out by
another group of personnel – the Amahs, the maids or the
nursing assistants.

It appears that the nurses in the developing countries
are better equipped after their training to carry out
skilled tasks. Tasks which would have been normally
carried out by doctors here, like intravenous injections,
drawing blood samples, doing superficial sutures after
episiotomy in midwifery. No doubt we can argue that
circumstances force upon them owing to lack of doctors
in the hospitals. We must therefore not decry these
trainees claims and expectations.

These countries present the picture of a veritable
melting pot of races and cultures. Ignorance of these
often breeds an attitude of indifference, callousness
and suspicion towards each other or produces an elab-
orate paternalism or paternalism towards these trainees.

said paternalism because hospitals are very fertile
grounds to breed this sort of perception. Mason
described how various colonial systems have influenced
the contemporary perception and treatment of colonised
people. 1 For example, in the hospitals, the nursing

administrators see their overseas trainees as eventually maturing sufficiently to take responsibility and on occasion a SNO(s) sees fit to tell the trainees that they shall be allowed to receive visitors provided that she (SNO) receive a written permission from their parents. In other words, in the absence of their parents, this SNO(s) thought she should take over "maternal" care. Or during my informal discussions with the nursing administrators, many of them suggested that "these young girls and boys look upon me as a father (or) mother figure" or "Their parents are so far away and these young men and women are not used to our customs, we must protect them from harm." "Some others pointed out that "some of them (trainees) become very naughty and I need to shout at them."

This lack of mutual understanding gives rise to inter-group tensions and hostility while the trainees tend to group themselves by their nationality. This association will only keep alive the old cultural norms and practices they had learnt. They communicate with their native language and this further strengthens their traditional ties and resists any attempt to integrate them. On the other hand these are potentially undesirable to the quality of care delivered to the sick.
This chapter will look more critically into the following questions which are also the central part of this research study. It is also necessary to have a knowledge of the process which ends with arrival in the U.K. and the pressures preset these trainees prior to their arrival.

Why do so many overseas trainees choose to come to the U.K. for a nurse training course? Why do they not go to some other host country or stay in their own country instead? How do they apply to come here? Are there any guidance officially or unofficially in their own country as to the selection procedures U.K. has? Having "selected" a particular hospital, how do they finance themselves for the passage? Are they given enough information both the course and the types of nursing and social life in the U.K.? Perhaps, most important from the view point of the recruiting hospitals, what are the trainees' desires and aspirations, their motivations and expectations? How much do they know about British hospitals and how do they experience the selection process? Perhaps a more complex question which confronts many nursing personnel connected with training and staffing is, why do so many fail to complete nursing education once started? This question is relevant to both British and overseas trainees. Therefore, are
there any discriminating factors which are likely to force these overseas trainees to drop out of nursing profession? It has been suggested that those who withdraw do not like nursing, or like it less than something else, that these overseas trainees having no alternative route whereby they can come through the immigration office at the U.K. ports, use nursing as a camouflage for their other cherished aspirations and desires – which have been pin-pointed down to higher education; that education as a nurse is a good form of insurance, since "one can readily get a job should the unfortunate necessity arise" like having difficulty with renewing permit to stay. The suggestions are however inadequate without empirical data to back them up. We need to look more closely at what trainees are hoping for.

Why does a person leave his home for a foreign country? and how does he set about doing it, i.e. where is the address to write to obtained? People who migrate are generally more enterprising and ambitious and are unable to reconcile themselves to the lack of opportunities at home. They usually have initiative and drive and with an ability to leave a poor and difficult situation to find something more promising elsewhere. (See footnote) *

* "Most of the Indians who come here are like me, village people in need of work, and they come here to earn money, not just for the fun of the trip. If any says he is here for a holiday, he is telling a lie. Would anyone work in another's house if he had plenty to eat in his own? Why else should we leave the country where we were born and where we have our land and kin?"

1. U. Sharma, Rampal and his Family; Collins 1971 P109. (41)
Are the trainees caught in the same web as Rampal had? This question is easier to ask than to answer. The question, "why do these trainees choose to enter nursing?" can nevertheless be broken down into two sub-questions of equal importance; what alternative choice are rejected? Accepting that these trainees' intrinsic desire is nursing, why did they decide to come here to do the nursing course? Could it be that these trainees' choice had been previously influenced by the presence of the colonialists and their styles of life in their own country? (see Footnote).*

Many of us have been led to believe that there is a government sponsored agency in the trainee's own country, that these trainees approach it for practical advice concerning types of hospitals or training available and

* "When we looked at the English people, there was not one poor man amongst them...What sort of place could this England be that everyone who went there came back a rich man and lived in such luxurious case? We began to realise that there might be places in the world free of drudgery and poverty which we saw around us, we had something to compare our own environment with and we saw that there must be a world of difference between India and England."....Therefore we began to pray in our heart, 'Oh Bhagwan (God), if only you would send us to England also, then we might see for ourselves the life they lead there.' If someone had told us at that time, 'Rampal, someday you will indeed go to England and you will suffer much unhappiness there.' We would not have believed it but at least what we saw first awoke in us the wish to see England for ourselves. That desire was never to leave us in the years to follow, until at last we arrived here." 1

1. U.Sharma: Rampal and his family, Collins 1971 Pp 55-56 (41)
to obtain addresses of hospitals for training. In actual fact, only 12.5% of them had approached the government sponsored organisations and 12% used private agencies.

The trainees were then asked where did they obtain the hospital addresses to write to. The answer to this question was that some applied to come to the U.K. through government or private agency, some of them also replied because they too had written to hospitals themselves. For this reason there were 879 cases, nearly half of them (43.2%) obtained the hospital addresses from friends in the hospitals in the U.K., 9.1% from relatives already here in the hospitals while 42.7% of them had used the nursing journals (mostly Nursing Times and Nursing Mirrors), addresses from the government or private agencies, and newspaper advertisements in the order of importance. Writing directly to hospitals was not always fruitful and sometimes one met a lot of frustrations. Many trainees abandoned the queues at their government sponsored organisations when they found that they could insure a place by paying a fee to the private agencies. There were also many who persevered even if it meant writing over 100 letters before a vacancy was obtained. When they were asked to, about half, as shown in table 5.1 replied that they wrote to between one and five hospitals and the rest to more.
Table 5.1 No. of Hospitals written to

<table>
<thead>
<tr>
<th>No. of hospitals</th>
<th>1 - 5</th>
<th>6 - 10</th>
<th>11 - 15</th>
<th>16 - 20</th>
<th>21 - 25</th>
<th>26 - 30</th>
<th>31 - 50</th>
<th>51 - 100</th>
<th>100+</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>429</td>
<td>173</td>
<td>70</td>
<td>73</td>
<td>48</td>
<td>77</td>
<td>57</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>%</td>
<td>44.6</td>
<td>18.0</td>
<td>7.3</td>
<td>7.6</td>
<td>5.0</td>
<td>8.0</td>
<td>6.0</td>
<td>2.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>961</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Extensive mail survey.

Data on the British trainees in this area are not available for comparison. It may be assumed that the indigenous trainees do not need to go through the pre-entry trauma, the pressure and frustration of writing to so many hospitals. It would indeed be surprising to learn that they would spend much time to write to more than five hospitals. The obvious result will be that the prospective indigenous applicant will reject the idea of becoming a nurse and fortunately it does not appear that British trainees will ever need meet this sort of situation. PEP's survey showed that among the Irish nurses, fifty percent applied to only one hospital.1

1. PEP: Overseas Nurses in Britain 1972 P.19(33)
As indicated previously, these overseas trainees experienced a "very demoralising and frustrating" pre-entry period. Four types of problems were identified in the extensive survey and two reasons were given by those who experienced "no problems." (See Table 5.2). The figures come to more than 1101 because more than one comment was given by the trainees as the question was open-ended. They found the following four groups in ranking order as most pertinent problems, (a) worrying and time consuming, (b) no response from the hospitals, (c) waste of postage, (d) own government created difficulty. Quite a significant proportion did not experience many problems. On the one hand the trainees had friends/relatives already in the hospital in the U.K. and on the other hand they had to pay for the peace of mind. Before we give some excerpts from the extensive survey to illustrate the types of problems. We wish to point out that earlier on we have suggested that many

<table>
<thead>
<tr>
<th>Problem Type</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Worrying and Time Consuming</td>
<td>460</td>
<td>41.8%</td>
</tr>
<tr>
<td>2. No response from the hospitals</td>
<td>324</td>
<td>29.4%</td>
</tr>
<tr>
<td>3. Waste of postage</td>
<td>269</td>
<td>24.4%</td>
</tr>
<tr>
<td>4. Own government showed difficulty</td>
<td>156</td>
<td>14.2%</td>
</tr>
<tr>
<td>5. No problem - friends/relatives here</td>
<td>426</td>
<td>38.7%</td>
</tr>
<tr>
<td>6. No problem - used agency</td>
<td>178</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey

* Percentage of total sample population for each answer.
trainees may have quit from the long queues at their government sponsored organisations because they could obtain a hospital place quicker from the private agencies for a fee. This was further probed in the interview and the result confirmed such a situation because 30.8% of them now confided that they had used and paid an agency in their search for a hospital place.

The following excerpts illustrated the nature and quality of the problems facing the training during the period they applied for a hospital place:

"I never got a reply from the hospitals I wrote to."

"I have suffered a lot. I have to wait patiently until after writing to the tenth hospital."

"The present hospital took over six months to give a decision after inviting me to re-apply. Frustrating and nerve-wrecking."

"As far as I remember, one general hospital situated in London assured me that I shall be accepted in a very short period. Accordingly, I prepared a lot of things for my travel, but they left me in vain. After all my efforts in corresponding with them, sending the necessary documents, they sent me a "No VACANCY" note later. They should not have sent me any acceptance letter. It is so unfair to let somebody hope for nothing."

"Although the hospital was willing to accept me when
I applied in 1970, I had to fill several forms which were required by the government in Malaysia. The government was then to send these forms to the Malaysian Students' Department in London which would in turn send the sponsorship form to the hospital. But the hospital never received the documents. Those forms were "mislaid" so I was told later and the PG0(T) here could not accept me without those forms. So I filled the whole set of forms again. It was only in November 1971 when I finally succeeded to secure a place in this hospital.

"The anxiety of waiting for a reply and the disappointment when I was turned down after getting the necessary papers and referees' letters."

"No vacancies, no accommodation for males. That I must be a resident before I could be accepted. Some hospitals asked for "A" levels. Some put me on a waiting list."

"Had to wait for 4½ years and nearly gave up. Usually got a refusal when applying to hospitals."

"I applied since 1970 and was only successful in obtaining a place in June 1971. The Entry Permit to the U.K. was hard to gain access to because the BHC in Guyana just simply withheld it."

"(1) difficulty in obtaining a place in the hospitals.  
(2) Expenses through correspondence with hospitals and home government in obtaining placing certificate sponsor-"
ship and visa. (3) Fee paid to agency in obtaining this hospital."

"I have encountered many problems and the worst of all was having to wait for a terribly long time for my sponsorship and visa. Another problem was the expenses through correspondence with the hospital and home government."

"I really got a hard time in applying for a hospital place. I was working in Singapore and had to return to Malaysia to solve my problems whenever I received a letter from either the U.K. or the agency. I spent nearly a year's time before I was finally given a place and I was asked to approach the head-mistress for a letter of recommendation and the Ministry of Education. Besides, I had to produce a bank account from the bank as a guarantee. It was indeed a long channel I had passed through before I got this post and a large sum was paid to the agency. Anyway, I am quite satisfied for I've got what I wanted."

"Most of the problems were long and futile waiting; corruption within our own government organisation. Discrimination in terms of nationality. Accepting payment of fees .... It's a real agony."

"I would like to say something for those who are still waiting for a place. I was very behind in the queue. But because of nationality and of the influential backing from someone in the Civil Service, I was able to jump the queue. Many of other nationalities were left to wait or they have to pay to the officers to speed up the process. This is an accepted mode of living for anything even jobs at home."
"Although it was through government organisation I had to apply myself. It was a very long and protracted process of waiting for about two years before the Mauritius High Commission here sent me a letter of offer from the hospital. Through meeting Mauritian fellows here, many told me that they had to pay "thank you money" to someone who could influence selection at home."

"Even though I applied through the agency, I regret to say that it did not live up to my expectations. I always had to remind them if they have sent this or that yet. They all could not care less, and they were not furnished with correct information."

"One of the two hospitals that I had applied would only accept candidates who had been interviewed by one's own governmental organisation which demanded a good knowledge of the Malay language and the ability to converse in that language instead of English!! irrelevant!

This hospital on the other hand, places more emphasis on educational qualification and more important still, the ability to pass the GNC entrance test."

"I wrote to more than 50 hospitals, I think, and only a few have had the decency to reply. Then, my father heard of somebody who would guarantee a place for £50. I did not wish him to spend this kind of money but he had already paid it when I was informed. A month later I was called and told that there was a vacancy. I accepted it without question and I was told not to tell anybody where I obtained the vacancy. I was very surprised to realise that this is a psychiatric and not
a general hospital."

"Because of the difficulties, I paid about £500 (£40) to an agent in order to get a hospital place."

"I think it is a disgrace to exploit (pay fee to the agency) a person in despair to leave the country which politically does not offer us a secure job."

"Each time I applied I sent in the photostat copies of my testimonials so that I could get the replies as soon as possible and the replies were no vacancies or they would let me know as soon as a vacancy arises but all in vain. It cost all my pocket money because of photocopying and registration of letters fees. Some did not reply and some by sea-mail."

"Well, in my case, I first wrote to the GNC and I was told that with my experience in nursing, my period of training as SRN would be reduced by six months and that I should write to any hospital. But when I reached here I was asked to sit for a test which I failed and the result was I have to take the two years pupil nurse course or go back home. My nursing certificate was shown to them but was of no help."

"I am lucky, my father knows someone in the Ministry."

"As I went to the agency, I did not face any special problems in getting a place in this hospital."

"It was the agency that taught me how to apply for a place in the correct manner. It was my first application for a job so I did not have any idea at all."
Why Nursing in U.K.?

Earlier on suggestions like colonial experience, that grass on the other side of the mountain is greener, that home difficulties had forced the trainees to leave their home country, that these trainees, in conformity with the general migratory history, were ambitious, more educated and independent. In the extensive survey, the trainees were asked why they had to come to the U.K. to do the nursing course and their replies were many and very diverse as presented in Table 5.3. As already pointed out, the reason "I always wanted to be a nurse" or on similar lines, was deliberately omitted out. 1

Almost everyone in five of the trainees made a point, that although the other six pre-coded replies may have influenced him to decide to come here for the nursing course intrinsically "It is nursing that I love most." "I always wanted to be a nurse." "I like nursing people especially the old people ... Because I am interested in nursing and wish to be a qualified nurse and be able to do nursing. Since it is difficult for me to obtain a place in my own country's hospital. Any hospital overseas will do as long as the training provided is good enough and it is recognised in every country too." To many, nursing may....be a cherished dream as expressed by a female Hong Kong student nurse in psychiatric nursing who was able "to realise my most cherished dream - to be

1. See Chapter on Methodology.
a Nurse." It is a reality also as this pupil nurse (in general nursing) from Philippines who knew what nursing is like. "Nursing is quite a rewarding job because it involves close contact with people and it is a satisfying job as well."

Table 5.3 Why U.K. for Nurse Training (... survey)

<table>
<thead>
<tr>
<th>Reason</th>
<th>U.K.</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better pay here than being trained at home</td>
<td>42</td>
<td>47%</td>
</tr>
<tr>
<td>Better career prospects than at home</td>
<td>501</td>
<td>45.5%</td>
</tr>
<tr>
<td>A prestige for young persons to go abroad</td>
<td>275</td>
<td>24.9%</td>
</tr>
<tr>
<td>A job that pays while being trained</td>
<td>233</td>
<td>21.1%</td>
</tr>
<tr>
<td>Difficult to obtain place in own country's hospital</td>
<td>637</td>
<td>57.8%</td>
</tr>
<tr>
<td>Lack of employment opportunities</td>
<td>652</td>
<td>59.2%</td>
</tr>
<tr>
<td>Other reasons: (a) Want to be a nurse</td>
<td>229</td>
<td>20.8%</td>
</tr>
<tr>
<td>(b) Like to travel</td>
<td>63</td>
<td>5.7%</td>
</tr>
<tr>
<td>(c) Like to be independent</td>
<td>7</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

There was also some evidence that foreign education or simply to go abroad (in particular the U.K.) is regarded as one of the ways of improving one's social status in a developing country as shown in Table 5.3. "Lack of employment opportunities at home" was the leading motive for the overseas trainees to travel thousands of miles in order to train as a nurse in the U.K. But pecuniary reasons came out very low among 6 or more alternatives
with only 4%.

Did pre-coding answers to the question - "why did you decide to come here to do the nursing course?" affect reliability of the questionnaire in measuring aspirations and motivations? To answer this we included among the interviews an open-ended question. The answers were categorised into frequency counts and Table 5.4 presents the eight alternative answers and shows a greater variation when compared with the answers in Table 5.3.

| 1. Nursing ambition          | 57 47.5 |
| 2. Difficult to obtain a place at home | 46 38.3 |
| 4. To be independent/to help parents | 26 21.7 |
| 5. Lack of employment opportunities | 30 25.0 |
| 6. No prospect with job at home  | 29 24.2 |
| 7. Like to travel              | 59 49.2 |
| 8. Being paid in training/a secure job | 20 16.2 |

The interesting point here is "Nursing ambition" has more than doubled against the replies in the extensive survey, Table 5.3. On the other hand, the reason "lack of employment opportunities" has lost its lead to "like to travel." It could be that the trainees were allowed to amplify what they meant by lack of employment.
opportunities and many explained that the job they were holding was not up to their expectation for a career. This would suggest that the pre-determined and pre-coded answers are not flexible enough to allow for ramifications. In this particular instance many trainees had been cornered to tick boxes as it was easy and convenient rather than to write other reasons. Similar argument could be put forward to explain why "difficult to obtain a place at home" has slipped from 57.8% to 38.3% in the interview.

Despite further probing, it appears that trainees were not very willing to open up on certain subjects - to admit that they came here because there were fewer employment opportunities at home especially in Mauritius and Philippines. But when asked earlier during the interview if there were any employment opportunities in their country, 49.2% then said "no" but the Malaysians were most emphatic to point out that there were opportunities in private firms but not in the government services because of the government's pro-Malays policy and that they did not wish to work in private firms because of insecurities. være critical of the validity of the claim to wish to be a nurse. However, there is sufficient evidence to suggest that what the trainees had ticked and written were comparable. Personal experiences and contacts with overseas students in higher education have further reinforced this conviction.

Similarly, most Philippines agreed that being paid while
in training was an added incentive to venture abroad.

The following excerpts from the interview will perhaps illustrate how the data have been enriched in this particular field and how pre-coded answers reduce diversity.

"I like to be a nurse and also the idea of earning a living while in training appealed to me very much" said a male Mauritian student nurse who had been a full-time teacher before coming here, earning about £20 per month.

"I like nursing, have many friends here. It is a secure, good and rewarding profession. Also there is not much jobs around at home." An unemployed male Mauritian student.

"(1) Unemployment at home, (2) I came here to study at college but I gave it up to do nursing. (3) My sisters are here and they wanted me to come. (4) I also like to be independent. I was fed up with study because I have to work part-time as well. So I went to see a friend to help me to get hospital addresses." A male Mauritian student who came here as a full-time student in a college.

"There is more prospect in nursing than being assistant E.E.G. technician, as one qualification in that field
has little promotion prospect. Nursing has better pay at home if I can obtain another certificate like ENT. A male Ghanaian student who was an assistant E.E.G. technician.

"It is difficult to get a job at home even with nursing. It is also an opportunity to travel because I was told England is a paradise and beautiful." A female African student who came here first as a visitor.

"I always wanted to do nursing, helping people to get better. When I applied to train at home, I was refused because of the government policy. Therefore, I have to come here in order to realise my goal." An unemployed female Malaysian student. Her male compatriot said that "no jobs are available at home. I was always interested in medical field but owing to financial difficulties, I did not take up medicine."

"My sister influenced me and she did all the application papers otherwise I would have stayed home to do nursing because I am sure I could get a place, since I was already doing some kind of training." A female Malaysian pupil who was a full-time nursing assistant at home.

"Coming outside is a big opportunity especially for Asians. Most of us want to go abroad because it is good and it is a prestige also. Nursing means that I can earn a living while getting another profession."
A male pupil from Philippines who was a full-time teacher at home. His female compatriot who was a nursing assistant at home both said, "I wanted to help my parents. My ambition is to be a nurse. The U.K. offers both to me.

A female West Indian student who was unemployed before she came explained that "I could not get into the course at home and there is a long waiting list." Her female compatriot who was in full-time education at home decided to come because "there is no job prospect for Indians, because Negroes with primary education can get better jobs than I could. It is also an opportunity to travel." Another male machine operator from the same group packed up his job to be a pupil nurse because of his "ambition to travel for adventure and to raise my own standard as well." Another male West Indian student who was a policeman at home said, "I wanted to do mental nursing. At home it is impossible to get in. Also it is better training here. I find the ones at home are too backward now. I disliked the regimentation in the force because there are too many barriers between personal relationship."

A male student from Sri Lanka saw the U.K. as a second chance because "I was doing 'A' levels and I could not get good grades for university at home, so I came here to see if I could get a better chance to go to university."
This part-time teacher from Mauritius who is now a student explained that "I wanted to leave my country to be independent and just to be on my own." Another female pupil nurse from the same country "wanted to do nursing in the U.K. because it is a better qualification than at home."

A Malay girl typist saw that in a private firm there is no good prospect as Malays receive special privileges against us (Chinese, Indians)." "I was doing nursing assistant's job in a private hospital and the pay was low. More important, I like nursing and wish to get a proper training first," explained another female Malaysian pupil. A Malay girl who was doing a student's course was "fed up with studying and my friends are in nursing so I decided to go abroad as there are few training schools at home - with Malays getting all the chances. I felt that I might as well use my 3 years wisely and nursing was my first choice after all."

A West Indian female pupil nurse packed her full-time school teaching career simply "because I wanted to go to England and I was told...there is a lot of money to make." Her fellow compatriot came because "I tried at home to get a nursing course and it was taking very long. At the same time, I had given my name to the Ministry of Health for training in the U.K., though I did not particularly like nursing but I like the nurse's
uniform and it is prestigious."

Somehow fate is not always on your side when you are unemployed and desperately seeking a post in your own home. A female African student had this experience because she "was already prepared to come to the U.K. when a place to train in my own country was offered and I had to reject it regretfully." Another compatriot of hers "had waited for four years to get a place to do nursing at home" before she decided to look outside her country. A male African bank clerk explained that "I wish to get a profession, that is to better myself so that I shall be higher than I would have been," or as expressed by a female compatriot of his "I could not get a job at home because it is very difficult especially for girls to have a good and secure job. Going abroad means prestige for the parents as well as for myself. Coming to do nursing I can earn more than any job would pay at home. And now having been in nursing for sometime, I quite like the work and it is enjoyable."

A Filipina came because "I was challenged to come and learn about nursing because my father did not want to pay my college fees as he felt that it would be a waste once I got married." She further explained that she had to take up teaching if she were to stay home while all her elder sisters have gone into higher education. Another girl explained that "because of martial law at that time I could not go abroad as a tourist...the U.K. offers the best opportunity to become a nurse, there are so many requirements like height, age, weight, etc."
It is also a very long training and very expensive.

In some cases, the particular type of nursing desired is not available at home therefore it is necessary to look further afield. One African student preferred psychiatric nursing and there is "none at home." Another female student from Africa wanted "to see what England is really like because I was told so much. Going abroad gives prestige to the person."

Why did not the trainees stay behind and do the training home? Over half of them (57.8%) said that it was difficult to obtain a place in their own country and to some it would mean a long period of waiting. This male Mauritian psychiatric student nurse explained that he "would have had to wait for two years before I could be accepted to start my training at home. I took the opportunity to use those two years." While some nursing is a job that pays while being trained though it also has an appeal like this Filipina pupil nurse in general training: "I want to study as a nurse and I want to earn money so that I can help my parents" and another of her compatriots argued that "because I want to be a nurse but I cannot afford it at home and and at the same time I can see places."

Some trainees did not want to stay and be trained at home because of political discrimination as this male
Malaysian student nurse in psychiatric training pointed out, "I always wanted to become a nurse, a SRN, that is because of the difficulty in getting a place at home as preference is only given to the Malays owing to the Five Year Malaysian Plan, I could not get into nursing there. So when I was accepted, I did not even give a thought to the problems I may face here."

Another Hong Kong girl looked upon doing nursing away from home as self-disciplinary because she "kept changing jobs at home. If I had done this nursing course at home, I could easily resign but feel quite stuck here, but I'm glad that I have come here. It has made me feel a bit more independent and mature. I like nursing anyway."

43 also had the wish to travel and 7 wanted independence from their parents. For example, one female African student nurse in General training use this nursing course as "an opportunity to travel because I was told England is a paradise and beautiful," while a male Mauritian pupil nurse in mental handicap training came "out of curiosity to know what is happening in the other parts of the world." Another wish to be "independent of my parents" or "I'm independent of my parents."

We noted too in the Table 5.3 that "lack of employment opportunities at home" was ticked most, i.e., 59.2%, and this suggests that this factor is the leading motive for
the overseas trainees to travel thousands of miles in order to get a good job when he or she goes back. "I also wanted to be a nurse just like the missionary nurses we have back home. They look lovely." A male African woman "to find out the difference of an education in an advanced country. Having gained rich knowledge (if any) to let my country benefit from it."

A pupil nurse from Sri Lanka sought a better future in nursing but first "I had family troubles. Dad wanted me to stay in his business but I did not want to because I wanted a more secure future than the fluctuating worries of a business. I think nursing offers a better alternative."

When interpreting the foregone data to unravel the overseas trainees' motivations for choosing a nursing course in Britain, care and caution must be taken. Even if evidence suggested that they were very motivated to follow the nursing course here it must be borne in mind that answers like "I've always wanted to be a nurse" at best indicates a vague, non-specific set of motivations and could even be an eye opener, since it is extremely unlikely that a young person, given the opportunity to follow another vocation at home, would not stay back. Can we then give any credence to their other answers? In general, we are dealing with statements which reflect many kinds of things and motivations. To be a nurse is
one of them. Similarly, answers were so given because they were "safe" from criticism, because they were fair and for other reasons which could have nothing to do with their motives for applying for a nursing course in the U.K. On the whole, the answers were pragmatic, interpersonal as well as intrapersonal.

What alternatives were rejected by them? Would they do something else had they the opportunity to choose? Thus, given a free choice, nearly half had considered no other opportunity as shown in Table 5.5.

Table 5.5. If you could start afresh, what career would you choose?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nursing</td>
<td>55</td>
</tr>
<tr>
<td>2. Full-time education</td>
<td>39</td>
</tr>
<tr>
<td>3. Vocational</td>
<td>13</td>
</tr>
<tr>
<td>4. Clerical</td>
<td>2</td>
</tr>
<tr>
<td>5. Doctor/Dentist</td>
<td>4</td>
</tr>
<tr>
<td>6. Others</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
</tr>
</tbody>
</table>

Source: Interview data.

Another Host Country than U.K.?

Why would such a person travel so many thousands of miles and leave their parents, kins and peers in order to be a trainee nurse? One of the most interesting point brought to light in this study is that a majority of the trainees wanted to be a nurse and some persevere to with great patience and waited for two years — four.
years in order to become a nurse. Two-thirds of them (68%) were even prepared to go to another country if the U.K. had not offered them a place. This declaration of intent is an indication that most trainees were strongly motivated to follow a course of nursing. These two-thirds of the trainees were then asked the country of their preference should their application to the U.K. have fallen through. The answers were recorded in Table 5.6 whose evidence also showed that they had very limited choice—could it be that choice of alternative country is very dependent upon the following three factors: (1) proximity of the country to one's own, (2) historical contacts, (3) language? Thus, more Mauritian would say that they prefer France and Canada because Mauritius was occupied by France before Britain and Canada offers training in both French and English languages. In fact, there are many Mauritian students in higher education in France. For some time, Malaysia and Singapore have been sponsoring their own qualified nurses for tutor's courses in Australia, hence this explains why there were so many who would go there for training. The West Indians and the Filipinos, on the other hand preferred U.S.A. and Canada. Both had historical contacts as migrant labour to U.S.A. and at the same time they are near to the U.S.A. and the Philippines had been a U.S. colony and is still under her wing economically. The Africans selected France, Germany and Canada and a few the U.S.A. as the former two had been their colonial rulers.
The obvious next question to ask is why did not they go to the other country of their choice instead of the U.K. Those who were prepared to go to another country were asked this question and their replies are in the Table 5.6 below and it appeared that the constraints were from the receiving end.

Table 5.6  Why not to other country of choice?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Training there has to be paid for</td>
<td>117 15.6%</td>
</tr>
<tr>
<td>2. Difficult to obtain a place</td>
<td>363 48.5</td>
</tr>
<tr>
<td>3. Pay is less than in the U.K.</td>
<td>4 0.5</td>
</tr>
<tr>
<td>4. No friend/relative there</td>
<td>130 17.4</td>
</tr>
<tr>
<td>5. Less career prospects</td>
<td>29 3.9</td>
</tr>
<tr>
<td>6. Other reasons (a) U.K. offered a place first</td>
<td>47 6.3</td>
</tr>
<tr>
<td>(b) No trainees allowed</td>
<td>22 3.0</td>
</tr>
<tr>
<td>(c) prefer British qualification</td>
<td>37 4.9</td>
</tr>
</tbody>
</table>

| Source: Extensive Mail Survey | 749 100.0 |

The question of choice of hospital has also been raised during the preliminary and informal discussion with the trainees. The general feeling was that many of them had embarked on a type of nursing other than that they had expected. This does not necessarily mean that the feeling is exclusively among the trainees in psychiatric and mental handicap training. Several questions had therefore been incorporated to measure the extent of the trainees' say in the selection procedures. These data are presented in Table 5.7.
Table 5.7 Why did you choose to train in this hospital?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A friend in this hospital</td>
<td>198</td>
<td>18.0%</td>
</tr>
<tr>
<td>2. A relative in this hospital</td>
<td>95</td>
<td>8.6%</td>
</tr>
<tr>
<td>3. A friend here heard this hospital is good</td>
<td>113</td>
<td>10.2%</td>
</tr>
<tr>
<td>4. A relative here heard this hospital is good</td>
<td>19</td>
<td>0.2%</td>
</tr>
<tr>
<td>5. Only hospital place offered</td>
<td>565</td>
<td>51.3%</td>
</tr>
<tr>
<td>6. Other reasons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) first to answer</td>
<td>144</td>
<td>13.1%</td>
</tr>
<tr>
<td>(b) preferred this one</td>
<td>65</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey (multiple answers)

Compared with PEP's findings, it would suggest that more overseas trainees in the present study had little say even if we accept their friends' or relatives' recommendation or being near the latter, as a free choice, we are still left with 64% of them to be accounted for. The finding reflects the general opinion of the trainees expressed in informal discussions that they had no choice as to where and which type of nursing or for this matter which hospital they wished to go to.

The data also lent support to the PEP's findings and conclusions that "it is in the hospitals that are most short of staff that overseas nurses are most likely to be able to find places to train." Sifting through the trainees' replies revealed a deep anxiety on their part to obtain a hospital place by whatever means or blindly as long as it is a hospital place, rather than to

1. PEP Overseas nurses in Britain  p.19  (33)
2. " " " " " p.17  (33)
select carefully which type of nursing and training to aim for. A Mauritian pupil nurse in mental handicap training remarked: "When I wrote for admission, I did not have in mind any type of nursing. I just wanted to be a nurse in a hospital. So the earliest offer was first accepted." Are there any other evidence to support what has already been said?

In the (mail) extensive survey, the trainees were also asked to tick which training course they first applied to, which type of nursing they hoped for. Over three-quarters (76.9%) of them had applied for a state registered course (3 years) and only 12% had applied for a state enrolment course (2 years), while the rest had no choice but to accept what was on the plate. But only two-thirds (64.2%) had hoped for general nursing (less than PEP's findings) 1 22.6% for psychiatric training and only 5% mental handicap training, while over 8% had no choice. Asked if their present choice was the one they had first hoped for, only 57% replied positively. Of the rest, 38.8% were either "very disappointed" or "disappointed", 32.8% felt that "it did not matter" but only 8.5% were "not disappointed at all".

Among the trainees who came to a hospital different from the one they expected, nearly half (49.9%) had received

1. PEP. Overseas nurses in Britain. P.19. (33)
No clear information from their hospital as to which type of nursing course they were going to do before leaving home. Some of their comments suggested that the responsible authority in their own country was as ignorant as themselves. One male Mauritian student nurse in mental handicap training blamed his High Commission, "I was informed by the Mauritius High Commission that this is a general hospital." Another female psychiatric Malaysian student pointed out that Information was given "but no specification about the type of work I'd encounter, I thought it was same as the general one."

Despite their "frustration" to realise their first hope only one-third of them wanted to change to the nursing course they had first hoped for. (It must be pointed out that the trainees did not know that they could change to another course if they so wished, as soon as they found out that that particular nursing course does not suit them but nor had the hospital authority informed those trainees of such a possibility). Thus, those who did not wish to change were not necessarily happy where they were. They felt bound to stay put as this Malaysian student in mental handicap training explained "I did not know I could change the hospital." Another frequent side remark was "because if I do so now I will lose 6 or 7 months of training" or "too late and a waste of time." Some facing the inevitable reduced the dissonance between their aspirations and the reality of their situation over-time like this Malaysian student's
remarked "Frankly, I thought this was a general hospital, that's why I accepted it. But now after having worked with all my patients, I somehow don't regret it as this sort of nursing brings the best in you." Another group was powerless to do anything because somebody else had made the application for them. Said one female Malaysian pupil nurse: "Actually, I did not know what type of hospital I would be in because I applied through an agency. It was not until the very last few days when I was leaving that I was told this is a mental handicap hospital but I could not do anything because it would disappoint my parents after all the money they had spent on me and moreover, I am not in a very well to-do family. And I have heard from many friends that next year (1975) no one would be allowed to go overseas. So I decided to seize the first opportunity that I have had." Those who did try to change did not get very far and were met with barriers; "I have no choice (to stay), I wanted to leave when I was a nursing assistant but the Matron refused to allow me. I applied to several general hospitals but was not accepted because the Matron here refused to give me references." Or "As soon as you step into the hospital and realise that you are not happy with the environment, your chances of going to another are nil because the P.N.O. refuses to give any references for the post you apply for."

Just over half (in fact more than we expected) had received information about nursing when they applied to
the hospitals here and the responses in Table 5.6 revealed their feelings about the information on nursing pre and post entry to Britain. A fair number of them (37.9%) felt that the information given was promising, but then post-entry shows a dramatic drop to only 10.3% or less than 5% of the sample population.

Table 5.6 Feelings of the Trainees about the information on nursing pre and post entry to the United Kingdom.

<table>
<thead>
<tr>
<th></th>
<th>Before %</th>
<th>Now %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Too brief and vague</td>
<td>172</td>
<td>124</td>
</tr>
<tr>
<td>2. Doubtful, no facts</td>
<td>55</td>
<td>51</td>
</tr>
<tr>
<td>3. Promising</td>
<td>210</td>
<td>57</td>
</tr>
<tr>
<td>4. True</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>5. Too many facts</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>6. Picture too rosy</td>
<td>56</td>
<td>197</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey.

The evidence suggests that there is a great need to provide a clear and uniform information about nursing life and the profession, to provide an accurate picture of nursing in different types and their values within and outside the U.K. as a career. There was also a certain degree of disorientation at the realisation that nursing was not as "rosy" as it had been painted.
"I expected the social status of a nurse to be as high as in my country. I also expected that there were very few male nurses. I did also expect the standard of nursing to be very high in the U.K."

"A lot to learn and more days in the school and a lot of theory. Modern equipment and also good informal and personal relationship."

"I did not really expect a bed of roses knowing that most careers concerned need initiative and hard work to reach the goal. The only worrying thing at that time was the attitude of people in the Ministry towards me. Frankly, I did not have much ideas what it was all about except wearing a nice looking uniform and feeling smart and learning some diseases."

"I have heard a lot about nursing in the U.K.; that the U.K. trains nurses in hard working conditions in a pre-historic stone building under the command of sergeant majors (matrons and ward sisters). In spite of all I was told, I was not discouraged by them. On the other hand I prepared myself to face it because nursing is what I really wanted to undertake."

"One expected new, highly impressive buildings with a spotless interior, a home from home with someone kind and understanding to whom one can turn to in time of need. More outdoor life, visits to other hospital schools,
inter-hospital activities."

"Well, I didn't really expect it to be very pleasant or easy as I had heard from friends what it is like and the things I'd have to face. So I prepared myself to face the worse so that I would not feel disappointed, or anything like that, if things happened to be not as I had expected."

"Especially being in psychiatric nursing, I expected it would be very interesting and on the other hand frightening as well, like; how the mentally-ill people behave ran through my mind and how should I react.... I thought most patients were locked behind bars."

"Nursing duties only; no washing of bed-pans, washing floors, dishes etc., but unfortunately nursing here is not up to my expectations. I am quite demoralised to see some of the patients being ill-treated even by their own kind."

"Like a team of co-operative colleagues working joyfully with one another, helping in every way that is possible to make the patients happy and well."

"I thought there would be very advanced methods of treating the sick. A career where I could learn more about health science from medical professors and also about the types of drugs, etc. I should be trained to give injections, to dress wounds etc. The hospital
where I would work, I would meet a lot of accident cases and a place where I would be reassuring patients and their relatives."

"Much more pleasant, much more rewarding and therefore providing more prospects for one who really wants to do nursing. I expected nursing to be held in high esteem in the U.K. . . . . I did not expect so much of non-nursing duties as nurses perform here. I thought the nurse would be more concerned about the patients in general rather than seeing the sluices clean ... that the authorities would be more concerned about our welfare. I thought it would be more family, like with a lot of encouragement from Matron and tutors but I soon found out I stood alone."

In fact, at the time of applying for a place here, the trainees had conjured up a picture of nursing life mostly reflecting the conditions of this profession in their own countries. Many too were in fact set to get on with the nursing and did not allow expectations to discourage them should the former be shattered. They were asked to assess their anxiety on a three-point scale about six items, while they were still at home. One would expect the most anxious to be those with little motivations to follow the nursing course or who had unrealistic expectations of nursing life in particular, items 1, 3, 4, 5. As it turned out, their replies contradicted this expectation. (See Table 5.10).
Table 5.10 While still at home how much did you worry about ....?

<table>
<thead>
<tr>
<th></th>
<th>Very much</th>
<th>Much</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life in a hospital?</td>
<td>149 13.5</td>
<td>278 25.3</td>
<td>674 61.3</td>
</tr>
<tr>
<td>Living with people of</td>
<td>115 10.4</td>
<td>224 20.4</td>
<td>762 69.2</td>
</tr>
<tr>
<td>different nationality?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The dirty articles one</td>
<td>89 8.1</td>
<td>244 22.2</td>
<td>768 69.8</td>
</tr>
<tr>
<td>would have to handle?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether the work would</td>
<td>112 10.2</td>
<td>286 26.0</td>
<td>703 63.8</td>
</tr>
<tr>
<td>be hard?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What kind of patients one</td>
<td>180 16.4</td>
<td>358 32.5</td>
<td>563 51.1</td>
</tr>
<tr>
<td>would meet?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether people would be</td>
<td>273 24.8</td>
<td>347 31.5</td>
<td>481 43.7</td>
</tr>
<tr>
<td>friendly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>average</strong></td>
<td>13.9</td>
<td>26.3</td>
<td>59.8</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey.

Nearly three-fifths of them were not at all worried while still at home about the six items. Among items 1, 3, 4, and 5, there is marked variation ranging from 51.1% to 69.8% or an overall of 61.5% who were not perturbed by them.

Item 6 showed that over half of the trainees were either very much or much worried whether people would be friendly. One could only suggest that:

1) these trainees had little or no contact with British people at personal level.

2) As they had once been under the British colonial rule so the British were seen in terms of the ruler and the ruled position.
(3) They knew beforehand that the British ways of life were different from theirs.

The next step in this analysis was to inquire whether there were any differences between sex, country of origin and status, though we expected that, in general female trainees would be more worried than the males, no differences between student and pupil nurses. This question has significance because in general it is male who is more likely to emigrate, therefore psychologically better prepared.

As expected 45.1% of the girls against 29.6% of the boys were either very much or much worried on all the six items, and 60.8% against 56.2% who were not worried at all were students and pupils respectively. On the other hand, it was very difficult to generalise on the variable - country of origin. For example, more trainees from Malaysia group and Philippines were either very much or much worried about items 1, 5 and 6, while trainees from West Indies and Africa were more worried about items 2, 3, 4 and a high proportion of the trainees from Mauritius group were worried about item 3.

Knowledge of British Hospitals and Recruiting Systems

Another possible explanation to the causes of anxiety among the trainees before their departure could be lack of general knowledge of British hospitals, the type of nursing and training available and their educational
entrance requirements. The interview data confirmed our
doubt, only 28.3% knew the difference between the two and
three years course. 67.5%, 13.3% and 35.6% of the trainees
knew what is general, mental handicap and psychiatric
nursing respectively. These numbers were nevertheless
higher than PEP's. 1

The knowledge of minimum educational qualification for
either the two or three years course was measured by
their replies to "Do you know what is the minimum
entrance qualification for the two years course and the
three years course?" If their answer to the two years
course was at least a formal education with or without
'O' level qualifications or less than three 'O' levels
(allowing the fact that only overseas persons with
formal 'O' level qualifications would be considered for
training here), it was then considered that they knew.
Any other higher educational qualifications would put
them under the "Don't know" category. Answers to the
three years course were similarly based except that it
should be three 'O' level with pass in English or pass
in the G.N.C. test. Thus only 17.5% and 9% of them
knew and 67.5% and 37.7% did not know what the minimum
entrance qualifications were for either course. The
remaining 15% and 54% respectively gave higher academic
requirements. Higher academic requirements for the
three years course was usually given because these
respondents learnt by their own experience since they
were accepted with high academic qualifications. It also

1. PEP Overseas Nurses in Britain. P.19. (33)
suggested that the recruiting officers had offered no more than a mere statement of whether they were accepted or not. Usually, an overseas applicant sent in an application letter with a curriculum vitae and the recruiting officer at the receiving end would vet his suitability. There was plenty support for this: as FNO(T) explained: "we rely most of all on personal letters of applications and copies of G.C.E. results, i.e. 5 'O' levels or equivalent with English for students and two 'O' levels for pupil nurses."

Every person coming to the U.K. must obtain an entry permit from the British High Commission (BHC) or the British Embassy (BE). It is also understood that both would scrutinise every nursing applicant for their suitability and spoken English and would provide necessary information to the applicants about nursing in the U.K. Similarly, most hospitals here expected that those procedures were automatic. It was surprising to learn that only 68% of the trainees in the interview sample had been interviewed by either BHC or BE when among the sample population only 6.4% came as tourist or under "other" category. A similar proportion (65%) thought that the interview was "useless, not informative," "waste of time" or "just one of the red-tapes", "too quick." One Filipina student explained that "it was too late because the interview was arranged on the morning of my departure and I could not make it because of my departure on that afternoon." The contents of the interview were dry and monotonous and could reinforce the
trainee's attitude that the interview was but a "fix". About 70% of the respondents being interviewed said that the following four items were usually asked: (1) personal background, (2) why do you like nursing in the U.K.? (3) Will you return after your training? (4) Do you have any relatives in the U.K.?

One typical interview a Malaysian student nurse recalled was at the BNC. She was asked: "How many brothers and sisters do you have? Why do you want to go to England to do the nursing course? Will you come back? Which hospital has accepted you?" One Mauritian's reaction to the interview he had with the Nursing Selection Committee: "It was not informative at all because it was a very quick session. We queued up for about one to two hours and then when we were called in it lasted only a few minutes, almost like going to Woolworth to buy some sweets. They could have asked for my photograph." Another reaction was "like buying 'fish and chips', in and out."

Much of the data pointed out that many came here in complete ignorance about the country and the types of nursing and training they were going to, that the BNC or BE ought to have played a more positive role in disseminating information about nursing and the courses available and life in the U.K. This study substantiated the findings of PEP, that "a considerable lack of information and advice available to the overseas nurses and a
disturbingly random approach to selection of a hospital and course based, it would seem, in ignorance of conditions in Britain and anxiety above all to get a place to train almost regardless of other considerations."

Other evidence suggested that many trainees relied very heavily upon their friends or relatives to say a few recommending words to the recruiting officer here, or for hospital addresses. It was therefore not surprising that this "bush telegraph" method of recruiting overseas trainees led to concentration of a particular national in one hospital or within one particular RHA. One could not possibly blame the recruiting officers to have relied upon references of the applicants' friends already in their hospitals. Like this tutor intimated to me: "Good Lord," he exclaimed, "it is better to see what you are getting than offering a post to a person you don't know"—responding to my query why this hospital relied so much on informal recommendations, i.e., from overseas trainees or trained staff already in the hospital. This meant that if a recommending friend was seen as "good" by the recruiting officer, the applicant would certainly be offered a post. Psychologically, an insurance against bad recruits?

1. PEP Overseas Nurses in Britain, 1972, p.18 (33)
Consequently, a high proportion of trainees found themselves in and around London. There are also other arguments, London, as a world business centre, competes for labour for its various offices etc. Nursing could not compete successfully for indigenous labour because nursing is advertised as a dedication. On the other hand business firms offer week-ends off and regular 9-5 hours as well as financial incentives.

Who pays these overseas trainees' fare? Murmurs have been echoed that they are usually from poor homes and this was already refuted. Further empirical data from the personal interview suggested that 67.6% of them had their fares to the U.K. paid by their parents and over one-fifth paid their own fares. Two of them received a scholarship and only 9.2% borrowed money to pay the fares. The scholarship is not governmental and it was in operation in Malaysia to help people of any nationality of little means who were selected for a nursing course abroad. Four percent in addition to the 9.2% who borrowed money, needed to repay the fare money. This was in fact less than the expected 16.9% who came from manual work parents who were manual workers. Thus:

(1) It is generally a very costly business.

(2) Lower socio-economic people would find difficulty in obtaining loans because they would not have much surety even if they could show that a place is available here.
(3) More were motivated to achieve the goal and were willing to defer their gratifications for immediate rewards like refusing a dead-end job. Poor people cannot wait for the one year or more that many have to endure.

(4) Less pressure from parents to enter employment among better socio-economic origin.

(5) Better-off parents were more inclined to send their children abroad to study or train because of the social prestige they would gain in the eyes of their community and among friends.

(6) Those from poorer families might not have the required minimum education owing to their parents' inability to pay for their education beyond free education grades.

A substantial number (38.3%) of the respondents also revealed during the interview that they sent money to their parents regularly but 40% of them also commented that they sent the money out of love for their parents; it was and still is a custom to send money to one's parents merely because society expects this filial gesture. An excerpt may illustrate this point: "I do not need to support my parents financially but I was brought up in a social custom in which children who work either at home or abroad, give some money to their parents as a gesture of love and affection, to remind the parents that they are not forgotten. This will give them a sense of security against old age."

Summary

The findings clearly pointed to the disadvantages the overseas trainees faced compared with their indigenous fellows when applying to do nursing. They had very limited knowledge of the British hospitals, their recruitment procedures, of different types of nursing and values of different courses for future careers, either back at home or should they decide to stay in the U.K. Not only had there been a failure from this end to provide basic and clear information to the prospective trainees, the BHC and BE in their own country had failed to be diligent in disseminating nursing information to the applicants as already shown, nearly one-third of the trainees had not had an interview before they came here. Those who were interviewed found the contents irrelevant and the information not useful. In fact, it appeared that luck more than anything played a very important part. For example, we knew that many overseas applicants applied to more than five hospitals at a time and this could be compared to buying as many lottery tickets as one could afford and then praying to God that one of them would be drawn out. Failing this, a very large proportion, in particular, Malaya, Mauritians and Philippines bought "help" from private agencies to gain admission to a hospital here, or bought their way in their government sponsored agencies. This kind of corruption was not limited to one particular country but it was and still is a power-
ful tool for the rich. Hospitals which could not attract indigenous labour were most willing to accept overseas trainees from whatever source and this was particularly true in the psychiatry fields including mental handicap and also in the non-teaching general hospitals. Obviously, in the absence of correct information what choice had these trainees and could they afford to be choosy?

This study agreed with PEP that overseas trainees tended to be pulled in and around the London area. Since records were kept in 1967, an average 57.7% of the trainees coming to the U.K. found their ways in the four Thames R.N.A.'s as shown in Fig. 5.A. The cause of congregation pointed to the fact that these hospitals

Fig. 5.A. Percentage of trainees from overseas in 4 Thames R.H.A.'s since 31 December 1967*

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>59.6</td>
</tr>
<tr>
<td>1968</td>
<td>54.3</td>
</tr>
<tr>
<td>1969</td>
<td>57.2</td>
</tr>
<tr>
<td>1970</td>
<td>53.0</td>
</tr>
<tr>
<td>1971</td>
<td>57.7</td>
</tr>
<tr>
<td>1972</td>
<td>53.2</td>
</tr>
<tr>
<td>1973</td>
<td>59.1</td>
</tr>
<tr>
<td>Average</td>
<td>57.7%</td>
</tr>
</tbody>
</table>

* Figures from DHSS Statistics and Research Division's publications for the years mentioned.
had to compete for labour against the business world whose field is more glamorous than nursing and they could not compete. In addition, they have another serious competitor of their own kind, the teaching hospitals.

On the other hand, findings indicated that many of these trainees were highly motivated to follow a nursing course but in the absence of comparative data with indigenous trainees we must be wary to treat the data as defacto. The approach to motivations and expectations was only one particular kind and it needs further testing. At the same time, the range of occupational choices considered by these overseas trainees were very limited and among the reasons given to for their choice of nursing in Britain, "lack of employment opportunities" was a very predominant factor as well as "like to travel." Their expectations of nursing, in view of the absence of necessary information did not appear too high or exaggerative. There appeared to have been several points which were causing discontent and frustration; they felt they were bound by the hospital to stay even though they realised that that particular type of nursing was not the one they had hoped for merely because to them, the hospitals concerned did not appear willing to release them.

Political and economic factors were the mainspring behind the large numbers of overseas applicants but the U.K. was
not the only choice and 68% of them would have been prepared to go to another country if Britain had refused their application. Closer analysis did not produce significant differences among the overseas trainees about their anxiety in coming to do nursing in Britain in the three-point scale, in different types of nursing and training and from different countries.
Chapter 6

Arrival Perception: The Transitional Period

Psychological studies argue that the way a person perceives and defines a situation is one of the important determinants of how one will behave and interact in a particular situation the person is in. Perception is part of a process to "make sense" of experiences. The perceiver and the perceived are constantly changing in the course of interaction. But the first impression is very important and is very resistant to change. In the nursing profession, first impression as well as an accurate social perception are very important.

This study regards the overseas trainees' first impression of their reception into an "alien" society and more important still, of their reception into the hospital organisation as principal determinants of their subsequent behaviours and attitudes towards hospital staff, patients and towards the profession and the training as well. Therefore, in both the extensive survey and the interview, views were elicited to determine these overseas trainees' first impressions and the induction services available for them in the hospitals.

Coming to the U.K. is an expensive enterprise and takes
much effort. Most of the trainees were given farewell dinners and parties, and gifts from relatives, close school friends or workmates if they were in employment. Family members living in other places came to say "good-bye" to them and to wish them "good fortune." In many cases they made hurried trips to bid "farewell" to those members to whom it was their duty to pay their respects because they could not come or were by custom their parents' elders. On the day of departure, many orthodox parents, particularly among the Asians, made elaborate rituals and offered special prayers to ensure their children's safe journey, good health and success in their studies. The airport would usually be packed with friends and relatives; an emotional scene by which trainees were less affected as they were looking forward to their future in Britain. They were in fact exchanging active social relations with their established interpersonal network for letters only. Their life would start with much more strain, they would have to form a new web of relationships in a culturally different society, eat new food (maybe against their religious conviction), read more liberal newspapers, observe different ways of doing things and different attitudes to life; speak a more or less strange language. (See footnote).
Footnote:

The scene is best described in the following excerpts from Rampal:

"All the members of my household came to see me off at the airport. All the friends I had made at work turned up also... They even put a garland of flowers round my neck before I boarded the plane... And so I set off, full of hopes, it never occurred to me to think how far I was going from my family, or whether I should miss them or not when I arrived. My mind was filled only with optimistic thoughts for my future." 1

1. U. Sharma: Rampal and his Family, Collins, 1971 P.73. (41)
1. The Welcome

Full of hopes and aspirations, these overseas trainees took off and travelled almost half-way across the world. On reaching the British airport they had their first realization of what leaving home meant, however much they may have disliked it.

* Footnote:

"When I arrived in the evening at London Airport I looked around to see who had come to meet me.... Everyone seemed to have some friend or relative to meet them. Surely some government official must appear at any moment and take me to wherever I was to be accommodated?......At all events, they are sure to send someone to meet us from the plane. I did not understand that the voucher was only a permit to work in England and did not assure me of anything more than the right to enter the country......I kept on waiting and still no one called....We had not even any idea of the customs of the place, where we could go to buy a meal....We did not know London and had no idea that it would be such a long way from the airport (To East London)...We began to get worried..... Where was the man taking us? Perhaps he intended to take us to some lonely place, then beat us up and rob us." 1

1. U. Sharma: Rampal and His Family, Collins 1971. P. 73-75. (41)
Many overseas trainees claimed that very few hospital staff were at the airport to receive them or in some cases no-one was there as shown in Table 6.1.

Table 6.1 Who met you at the Airport?

<table>
<thead>
<tr>
<th>1. Friend/relative</th>
<th>447</th>
<th>40.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. A hospital staff</td>
<td>6</td>
<td>0.1%</td>
</tr>
<tr>
<td>3. The British Council staff</td>
<td>219</td>
<td>20.0%</td>
</tr>
<tr>
<td>4. No one</td>
<td>429</td>
<td>39.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1101</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

When asked to describe how they spent their time at the time of their arrival in the U.K. until they started their training, over two-fifths (42.4%) claimed to have started work in the ward on the day after their arrival. Some excerpts may illustrate their initiation into the N.H.S. hospitals and the kind of induction they went through.

"I came in the evening and after a rest I started to work next day in a psycho-geriatric ward."

"I was working the next day until four months later when I started the training."

"I started duty the next morning in a maximum security ward, not a very pleasant experience. Then I spent the
rest of the week in geriatric wards."

"I was required to start work in the ward next day. I worked for 10 days before I went to school."

"I started work next morning in a geriatric ward. It was a shocking and tough experience, especially when I had to lift old patients on my own most of the time without any experience... Patients swore at me but I used to laugh as I did not know that they were swear words."

Fourteen percent started training the very next day after their arrival: "I had only one night on my own before I started my study the next morning which I spent sleeping owing to the long distance I had travelled."

"I arrived on Sunday night and next morning I took the G.N.C. test at 9 a.m. and then I was told to start training immediately." Or, "I started training 16 hours after my arrival. I did not do much."

The rest had some time off. 16.3% of them took their own time off to stay with their friend or relative for a few days before heading for their hospitals. Some stayed in their own country's government residential halls like Malaysian Hall or Hong Kong House. Twenty (1.8%) had orientation course, mostly of one week's duration, 24% were given a few days free to wander about. 17.5% on the other hand claimed that their few free days were not particularly happy ones. They were "lonely
and homesick."

"I stayed with my relatives and they gave me a clear picture about life in England."

"I went to visit relatives for two days then worked as a nursing assistant."

"I spent a few days in London with a friend and met a few friends from my home-town – I did a bit of shopping for necessities concerning food and nursing."

"I stayed one week in the Malaysian Hall with a few colleagues. We wandered as far as Oxford Street as we did not know where to go sight-seeing....I went sight-seeing with a neighbour. I had a fantastic time."

"I stayed for two weeks at my aunt's place in London. Then I came to the hospital to start the training."

"I had orientation courses organised by the hospital. My batch was lucky as the hospital only started it when we came. Quite interesting I suppose....we were told about England and the people and then we were introduced to English families."

"I wandered a bit on the hospital ground and was shown around the hospital....I familiarised myself with the environment...trying to learn how to find my way about."
"My training started four days after my arrival, so I just had enough time to be shown briefly around the nurses' home and the town. At the same time, I made a few friends too and we exchanged our experiences on our first arrival in a strange country."

"I arrived here several days before the course started so I stayed in the nurses' home until then....I was looking around the hospital and dared myself to see London all by myself."

"I spent half the day unpacking my things and half the day sitting in my room till I slept without switching off the light. I felt very lonely and I cried from time to time, till I met my next-door girl. I did not know where the canteen was and I was afraid to see the patients (psychiatric in this case) walking along the corridor. So I spent most of my time in my room until I met the P.N.O. next day and started work that afternoon."

"I just stayed in my room, crying and thinking about my parents back home....I felt very depressed and homesick. I had no appetite at all. I felt as though I really wanted to return home for good. My friends were good, kind and helpful, but I just could not appreciate anything or anybody."

"Homesick...I spent my time shedding precious tears, wishing I had bought a return ticket, regretting, completely
disillusioned.

Through casual talks with the nursing administrators we learnt that many hospitals had not yet started any orientation courses at the time of the survey. The aim of the orientation course is to alleviate the "cultural shock" and to "make sense" of the society in which the overseas trainees have come to stay, at least for a couple of years.

Footnote: Other groups of immigrants also experienced similar difficulties as shown by Sharma.

"Those early days in England were most miserable for me...... I looked about me and thought how different this house was from those I had been used to in India. The chairs, beds, doors and windows were all of unfamiliar design and seemed very strange to me...... There was no one to whom I could tell my pain yet nor could I hold it back in my heart. All day I would spend working hard, and when I came back at night I would just lie down and pull the quilt over my head. I would take sleeping draught and somehow struggle through the night, hoping to find some relief in unconsciousness until it was morning and time to go to work again. That is how the time passed with me for many months." 1

In the early 1970's, the DHSS encouraged the hospitals to provide a two-day orientation course. The idea did not seem to have spread as desired. By the middle of 1974 only twenty trainees out of 1101 claimed to have had an orientation course of up to one week's duration when the sampled hospitals were supposedly to have recruited more overseas applicants than the others. The twenty trainees were from two general and one psychiatric hospitals among the four Thames R.H.A.'s and the rest did not seem to provide. However, from those overseas trainees' comments, most hospitals usually gave the general introduction to their lay-outs. Thus, "we were brought round to different sections of the hospital." Their comments also indicated that more thought should be given to the problems facing an uprooted person. In this case, these overseas trainees could be easily transplanted as they were young and amenable to adapt. Such an evidence came from a trainee who explained that "during the first two days, it was terrible; everything was different, the food, the way of living. Going down to the cafeteria was like being sentenced to execution not knowing what to eat but fortunately later on I met some girls who told me what to do. I got a week's orientation which proved to be very useful because we then knew more about places, people, etc."

Further evidence to corroborate what those overseas trainees' transitional experience were like came from the replies to this question: "How long after your arrival in the hospital did you start duty or training?"
Their answers were recorded in Table 6.2, column A. Similar proportion claimed to have started duty or training within 48 hours of arrival at their hospital.

Table 6.2 When started Duty or Training, on what status?

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B%</th>
<th>C</th>
<th>D</th>
<th>E%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same day</td>
<td>104</td>
<td>9.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 day</td>
<td>522</td>
<td>47.4</td>
<td>ST/N</td>
<td>472</td>
<td>42.9</td>
</tr>
<tr>
<td>2 days</td>
<td>204</td>
<td>18.5</td>
<td>D/N</td>
<td>160</td>
<td>14.5</td>
</tr>
<tr>
<td>3 days</td>
<td>64</td>
<td>5.8</td>
<td>N/A</td>
<td>465</td>
<td>42.2</td>
</tr>
<tr>
<td>4 days</td>
<td>35</td>
<td>3.2</td>
<td>Domestic</td>
<td>4</td>
<td>0.4</td>
</tr>
<tr>
<td>5 days</td>
<td>18</td>
<td>1.6</td>
<td></td>
<td>1101</td>
<td>100.0</td>
</tr>
<tr>
<td>6-7 days</td>
<td>107</td>
<td>9.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 weeks</td>
<td>39</td>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ weeks</td>
<td>8</td>
<td>0.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1101</td>
<td>100.0</td>
<td></td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Source: General mail survey

In the same table above, column C and D, we learnt that 57.4% started the training and the rest worked as nursing assistants and domestics until their training started. This group was further probed to find out how long they had worked before they started training. Nearly half of them, as shown in Table 6.3, worked for one month or less or the overall mean number of months each trainee had worked was 2.4. The importance of this finding is to point to the consequences of initial impression by way of induction into the hospital life may have on their social adjustment later.
Table 6.3 Length of time as N/A or Domestics

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one month</td>
<td>22</td>
<td>48.8%</td>
</tr>
<tr>
<td>One month</td>
<td>33</td>
<td>7.0%</td>
</tr>
<tr>
<td>Two months</td>
<td>72</td>
<td>15.4%</td>
</tr>
<tr>
<td>Three months</td>
<td>43</td>
<td>9.2%</td>
</tr>
<tr>
<td>Four months</td>
<td>36</td>
<td>7.7%</td>
</tr>
<tr>
<td>Five months</td>
<td>15</td>
<td>3.2%</td>
</tr>
<tr>
<td>Six months</td>
<td>16</td>
<td>3.4%</td>
</tr>
<tr>
<td>7-12 months</td>
<td>15</td>
<td>3.2%</td>
</tr>
<tr>
<td>1+ years</td>
<td>10</td>
<td>2.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>469</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Mean months worked = 2.42 months

Source: Extensive Mail Survey

2. G.N.C. Test

Three-quarters of the sample had applied for a three years course and when compared with the actual number of trainees doing the three years course it would appear that only 15% of them did not achieve their aim. At the same time, the numbers in the two year course more than doubled from 132 to 271. Did this suggest that all the overseas trainees under the "no choice" category were pursuing the two year course? Evidence did not substantiate the suggestion. Instead, many of these pupil nurses were over qualified and many claimed that they had been unfairly given a pupil nurse course after being initially offered a student course; that they should not have sat the GNC test because they had more than their minimum requirements or had been accepted as students.
"unconditionally" (see letters of offer, Appendix D).

One pupil with seven 'O' levels pointed out that "I have already had my required qualifications. I had just left home and I was really homesick. I failed the test and was asked to do the pupil training."

"We were not informed that we were to sit for the CNC test and all five of us were put on the SEN course."

In the course of administering the extensive survey we learnt that Q21A (see Appendix B) should have been asked to all trainees instead of students only because many pupil commented that they too had taken the CNC test and this explained for the low, 34.2%, respondents said to have sat the test. At the same time, the proportion of overseas trainees who felt that the test was "fair" substantiated PEP's figure while 28% refrained from commenting and ticked "don't know". The 44% who felt that the test was "unfair" thought the test was unnecessary because they had the required qualifications for the 3 years course; they were not warned of such a test, the timing of the administration of the test was inauspicious, they questioned the partiality of the test. Table 6.4, their replies, showed a centrifugal tendency along a pole. Thus we had 62% claimed to have sat the test within 48 hours and at the other end 33.7% did it one week or more after

1. PEP Overseas Nurses in Britain, Broadsheet 539, 1972 P:30. (33)
their arrival. On the other hand over one-quarter did so after a week of their arrival and this finding would imply a refutation of PET's finding which did not have any respondent in this particular group. 1

Table 6.4 When was GNC Test taken?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Same day</td>
<td>29</td>
<td>10.3</td>
</tr>
<tr>
<td>2. One day</td>
<td>166</td>
<td>44.0</td>
</tr>
<tr>
<td>3. Two days</td>
<td>29</td>
<td>7.7</td>
</tr>
<tr>
<td>4. Three days</td>
<td>12</td>
<td>3.2</td>
</tr>
<tr>
<td>5. Four days</td>
<td>3</td>
<td>0.8</td>
</tr>
<tr>
<td>6. Five days</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>7. 6-7 days</td>
<td>31</td>
<td>8.2</td>
</tr>
<tr>
<td>8. 1-2 weeks</td>
<td>20</td>
<td>5.3</td>
</tr>
<tr>
<td>9. 2+ weeks</td>
<td>76</td>
<td>20.2</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>377</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Exclusive mail survey.

"From what I have observed, I don't think it's fair because I don't understand why we need a higher qualification to take the same course as them (the indigenes)... The GNC requires a minimum of three subjects with English but I have 7."

"The letter never mentioned any test or anything like being sent on a SEN course in the event of failure. The sudden announcement and knowledge of it in itself reduces

a high level of concentration. The tutor did little to help to allay any anxiety but simply 'here you are, get on with it and you have 20 minutes for it.'

"I was under the impression that if I had 5 'O' levels I did not need to sit for any test and it was a shock to learn otherwise and I was scared lest I failed and could not do my SEN training and have to do SEN instead."

"I was not told anything about this test in my correspondence and the test was too soon after my arrival. I was still recovering from the long journey, tiredness, anxiety, homesickness. After all, I have 10 'O' levels and 2 'A' levels."

"We have the required qualifications they need, why subject us to these tests? and when fail we will have to do pupil course which is not what we came here for."

"Before coming to this country, I was already accepted on the merits of educational qualifications."

"It was an insult to me and to others who are highly qualified."

"I had five 'O' levels plus English. It was a waste of time and money and against the CNC rules."

"The test was done by pencil. The test result was never shown to those who had taken it. There is no fixed figure, i.e. what is the pass mark ....you never get to know the results and it is only known to you if you had failed
It is really a matter of whether your face suits them... for all I know it could have been erased."

"Many of those taking the test were not used to speaking English in their own country. They were not given time to acclimatise themselves. Many of them who failed have proved later to be more capable than those who initially passed the test. It is unfair to overseas trainees, many of whom have never seen such a test paper. I feel they should have more preparation before taking such a test."

It was also suggested that many overseas trainees had forced those tutors to impose the test indiscriminately because few overseas applicants had falsified their educational certificates. The GNC test as we understand it, is only intended for prospective applicants who do not have the minimum three 'O' levels with English language or the equivalent formal educational questions. Several respondents as well as a local secondary teacher alluded that it is all part of the bureaucracy to make most use of the manpower at the least outlay in terms of salary. Is this true? The rules of the Canadian and American Hospital Authorities are analogous to the above allusion because they stipulate that a foreign trained nurse, SRN, must pass an examination before he can be recognised as a Registered Nurse. In the meantime, he is paid lower salary while doing the same work as his Canadian and American fellow Registered Nurse does.
In fact, many do not bother to take the examination while the hospitals are getting their qualified nurses cheaply. Is this suggestion true and how applicable is this to the overseas trainees?

The not impression given by the overseas trainees in this section was they catechised the validity, equitability of sitting the GNC test, the value of an offer for a particular course when they were put into another one once in Britain. At the same time we do not have empirical data elsewhere to refute or to confirm their claims.

3. Settling down in the hospital environment

Most, if not all of these overseas trainees came from a very complex network of family life and enjoyed the security of a warm close-knit family structure. As would be expected, there were several factors of a personal and situational nature which influenced their adjustment including the extent of contact with the British people, previous contact with other culture, personality, characteristics, language facility and unofficial guidance, or "orientation." Adjustment took place not only in a new and complex situation but also within an abnormal situation - the hospital environment. There are several ways of adjusting to this specialised institutional community taking into account the factors already mentioned. We asked them about their experience of life in the hospital environment.
First, they were asked to describe their likes and dislikes and life in general in the place they were living. Their responses were recorded in Table 6.5. The main reaction suggested that they were finding bridging two entirely different cultures very demanding and were failing.

Table 6.5: Likes and Dislikes – Life and the place trainees lived

|                                | No. comments or O.K. | 513 | 47.0% |
|                                | Complaints against residents | 136 | 12.4% |
|                                | Complaints against home wardens/ Domestic | 201 | 18.3% |
|                                | Lack of facilities for the home | 427 | 33.8% |
|                                | No sleep on night duty | 293 | 18.9% |
|                                | Boring and lonely | 552 | 50.1% |
|                                | Lack of recreational facilities | 457 | 41.5% |
|                                | Lack of care to sick | 194 | 17.6% |

Source: Extensive mail survey

Of the 47% in "no comment or O.K." group, 40% were positively satisfied. Were the rest very satisfied or very dissatisfied? A very large section were quite negative of the place they were living; they felt that the residents were irresponsible and noisy; the wardens and the domestics were difficult to come to terms with; they felt bored and institutionalised owing to lack of recreational facilities; they felt that the care they received when they were sick was inconsistent to the care they delivered to the sick.
"How glad and relieved I was to see him! There is no doubt that, however deep a man's distress, some peace comes from seeing someone he can call his own. It does not matter whether they are his from being of the same family, through coming from the same district, the same caste or the same village." 

The large number of overseas trainees who felt lonely and bored was unexpected, because it was thought that the presence of their own nationals would reduce both loneliness and homesickness, because 87% of them lived and grouped in the nurses' homes on the hospital ground or in other accommodation provided by the hospitals. Some excerpts may illustrate their reactions to a situation outside their home environment.

"Extremely fast pace of living, definitely higher standard of living, but lack the basic primary relationships. Nurses seem to keep to themselves. They do not mix much, despite the fact that the nurses' home is comfortable, it is a lonely life here. I miss the parental affection which I have been used to since childhood."

"It is quite a dull life. Not much facilities offered in the nurses' home, especially domestic appliances. The kitchen is small and untidy and has no fridge. No visitors allowed in the rooms and friends of the same sex are not allowed overnight or to spend a few days with us."

"Too far from the centre of entertainment. Bingo, Bingo

1. U. Sharma - Rampal and his Family, Collins 1971 P.91. (41)
and Bingo all the time. We are all Bingo maniacs. It looks like we are more English than the English. No other forms of entertainment except for occasional discos - a dull life all round. I would like to see more social activities other than nursing life. The T.V. in our sitting room is never in working condition despite several complaints."

"Too much noises, no sitting room. The present one was a bedroom converted to a T.V. room and it can only accommodate 4 or 5 people comfortably otherwise the room gets stuffy and smelly with only one small window. The nurses' home houses forty nurses."

"We would prefer a writing table to the dressing table. Nothing is conducive to study or to impress on you that you are a student and you must study. We have to write on our knees or sitting on our beds. This is worse than yoga especially when you have to bend your head to write. It is not surprising many of us take sick leave for backache or aches at the back of the neck."

"The residents are inconsiderate. They mess the kitchen and never try to tidy up a bit for the next users. Their music is always at full volume. When you are on night duty and want some peaceful rest, you pray God that both the domestics and the residents would not shout or talk along the corridor. The residents tend to group among themselves, like Malaysians, with Malaysians; Mauritiens with Mauritiens, West Indians among themselves.
There is no real friendship among foreigners themselves."

"The conditions are not bad, but some overseas nurses make their own life miserable; they do not put things back after use. Nor do they keep their place tidy; they are going to stay here for two or three years. This is a fact!"

"The warden never stops walking up and down the corridor peeping into people's room on pretext. She is very nosy and likes to interfere. Other than that we have most of the facilities and could be contented if the warden were not here."

"The idea of being sick and still being asked to work is too much. There is hardly a time when a nurse falls ill and is not told off. You cannot be sick if you have no temperature. The first thing they do when you report yourself sick, is to take your temperature. If it is not high then they will say you are all right. You can go to work after you have taken two aspirins."

There are also much personal and situational satisfactions to be derived. "I am quite happy with the facilities..... I like my room though it is a bit small but it is comfortable.....I enjoy having so many Asians in our nurses' home but miss mixing with English and other nationalities.....Life is quite all right for me because I enjoy anything offered to me; transportation and market area are very convenient around our hospital; we
have facilities like lawn tennis court, recreation room, comfortable rooms, kitchen and T.V. in each block, it is convenient and cheap compared with a bedsitter outside. Friendly atmosphere and rules are very lax."

"Life here is just like life elsewhere, as you make it. I very much enjoy my life in this hospital also working for and helping the patients."

"In general life seems rewarding though there are obstacles at times but the advantages outweigh the latter."

"I don't miss anything. I am very comfortable and settled down. I have no dislikes about anything probably because I am not really fussy or fastidious."

When their answers were computed against year of training reached, to see how differently they answered, we found that there was a gradient. The third year trainees were most likely to give positive comments or to offer no comments followed by the second year trainees and the neophites were most critical of their situational and personal environment. This would imply that overseas trainees tended to come to terms with their differences or that they were more adjusted. Among the unstandardised opinions, the indicated conclusion would be adjustment required two parties to give and to take and time was an important factor to settling down, as they progressed through their vocational education, these overseas trainees would shift their opinions on their immediate physical
environment from evaluative to descriptive terms.

4. Adaptation

The very moment these overseas trainees stepped out of the plane, their expectations of life in Britain were shattered. Loneliness and homesickness seeped in and accentuated when they were expected to accept the customs and routines of this country almost overnight. It appeared that the hospitals expected this sort of change-over; almost every other trainee stepping into the hospital grounds started either training or duty within forty-eight hours. Is it fair to impose? What are the expectations of the receiving hospitals of these trainees? Whatever facilities there were to cushion the cultural shock or to allow gradual absorption of alien customs, seemed inadequate. What this means is beyond our comprehension if we have not travelled thousands of miles and come to a totally unfamiliar country leaving behind all family and friendship ties. Many overseas trainees did not have a close friend let alone relative here. During occasions like Bank Holidays or festivals these trainees experienced most intense homesickness and loneliness. In their countries, people came out in masses to celebrate any festivity. The festive mood is in the streets and in the sea-side resorts. Participants are clad in their best attires. In the U.K. by contrast, festivity is very home centred. To the unaccustomed overseas trainees, it would be a depressing sight - not a soul in the streets. It is during those moments that
they long for home. These feelings of loss, fear and isolation would be a shadow to them and may cause long term psychological damage unless something is done swiftly. Their only means of communication would be through letters which can be very infrequent especially if their parents are illiterate or unable to communicate because they do not know other written language than their maternal tongue. To take an example, with increasing western education, it often happens that in a Chinese family for example, parents can only write Chinese while their children, though they can understand spoken Chinese, cannot. Consequently the absence of news from home serves to increase apprehension and anxiety.

The unfamiliarity of the way of life here, the physical constraints and unfamiliarity - not so much of the skyscrapers, the apparent honesty as shown in the open-shop, supermarkets, the self-service, the methods of transport and its complexity, the worst was of course the weather, the severe cold which forces people to stay within for most of the year, all amounted to strangeness and sense of isolation. In addition, the English are reputed for their passive tolerance which means that reception is "cool"; to the newly arrived trainees, it appears as hostility, contempt, aloofness or snobbishness. It was not surprising then to learn that most of their friends came from overseas or from their own country (58.7%). Another two-fifths (41%) had a mixture including indigenous people but only three claimed to have most
British friends.

Is this surprising? "Birds of a feather flock together." Do we need other explanations? In the personal interview, the respondents were asked "Why do overseas students and pupils generally choose people from abroad as their friends?" Table 6.6 described their replies and column C displays the frequencies one particular reason had been mentioned. More attributes were given to the overseas persons than British. Thus, people from abroad were perceived as more approachable because "they are very helpful in getting you settled down in a new country. I was very homesick and they know my difficulties and problems. I suppose we are in similar situations."

"Most foreigners have similar cultural and social back-
ground beliefs. These make them seek out each other's companionship. They come forward and talk to you when you are new here. Most of us have experience of living in a multi-racial country, therefore we understand each other better and hence are readier to help. Some of the English are very pretentious and insincere. They smile and laugh with you as long as you are there but once you turn your back you are being criticised."

"I feel that I can get along better with most overseas persons than with English because I feel secure in their company."

"English student nurses feel that most overseas students are dull. They are misinformed about overseas students' cultures. They believe all negroes are slave workers in sugar cane fields. Hence, I become sensitive to their attitudes, I do not therefore choose English for friends. Some English are friendly some are not and this makes you have an inferiority complex and you get worse over time. This makes you seek friendship from foreigners."

All evidence implied that the overseas trainees still need a long time to adjust themselves in Britain and that they respond to their unhappiness, loneliness, homesickness and personal as well as situational problems by apathy and withdrawal from active social life; recoil into ethnic groupings to seek solace and continuity of their childhood culture and customs. They may temporarily regress in their behaviour as a result of cultural shock and the accumulation
of social and mental strains. Determined to get on in order to save their "face", they put further strains on themselves without revealing overt signs and symptoms. There was further evidence of withdrawal behaviour in the extensive survey.

The overseas trainees were asked "with whom would you discuss a problem of any kind you may have?" Only 14% would consult a nursing official as shown in Table 6.7. We had expected a high number to consult their tutors because the latter were regarded as more understanding. In fact, only seventy-one trainees would do so or 6% of them which suggests the need to build a better relationship between the trainees and the tutorial staff, a more positive model for the trainees to identify. These findings confirm those in Table 6.6 that these overseas trainees were socially introvert. Among the "other", many mentioned boyfriend or girlfriend, fiance or fiancee, husband or

Table 6.7 Discuss problems with whom?

| 1. Class-mate | 362 33% |
| 2. Other hospital staff | 49 4.4% |
| 3. Nursing Officers | 36 3.2% |
| 4. Tutor | 71 6.4% |
| 5. Relative here | 243 22.1% |
| 6. Other | 340 30.9% |
| **Total** | **1101 100.0** |

Source: Extensive mail survey
wife and "write home for advice."

What are the trainees like off duty? How do they occupy their free time? To what extent do they participate in the organised activities of the community in which they live and work? Replies from the extensive survey indicated that the majority of them had spent most of their free time in own nurses' home. Thus, to 92% and 99% "most of my off-duty time is spent in the nurses' home, in my room - sleeping, in the sitting room reading the newspapers or watching the T.V. Sometimes I go out shopping."

"I don't have many friends here and off-duty is irregular. Therefore you really feel lonely most of the time."

Not all free time was spent within the building because some 87% "sometimes go out for a walk with friends. May be I go somewhere else or go to visit friends, places of interest or doing overtime." It also appeared that they did not elect to spend their off-duty in this fashion but were rather forced by the situation.

"Do some shopping and the rest spent in own or friends' room provided they are off-duty too. Since the work is heavy, the two days off are spent mostly on 'housework' and complete rest."

"Sleeping in the nurses' home. I was very energetic once, and now all I want is to sleep. I've come to a point
where I dread being off-duty. There is nothing offered. Even the T.V. room is like a sardine box, with old T.V., crammed with chairs and stuffy.

Similarly, during their annual holidays, in an open ended question, in which more than one answer was possible, in one group 81.5% stayed in the nurses' home, i.e. "just stayed here in the hospital and sometimes doing overtime, mostly doing overtime....I went out with a friend for a day or two and spent the rest of my leave in the hospital grounds....In the nurses' home watching telly and it was hell." In another group 77% had also spent sometime away from the hospital to see places of interest. Very few took part-time jobs. Another group 34% went abroad on package holidays.

This syndrome of social isolation is not only among the overseas trainees but also among the indigenous trainees.\(^{1}\) In this particular instance, the overseas trainees' isolation seemed more intense and that their social activity was very limited to the most basic, technically necessary in order to fulfill their own needs. They appeared to maintain a symbiotic relation rather than a social one with their host society. The trainees played one role and the host another with very little intermingling.

In summary, the description which these overseas trainees

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1. D. Sayle: Nurses' use of leisure (occasional papers) June 22 1972 Nursing Times. (37)
gave, showed the inevitable element of marginality, of forced dual membership rather than adapting themselves. The trainees put up with it in order to get the nursing qualification therefore they participated minimally in the host society. At the same time, they, as culture carriers, tried to maintain their loyalty to their home. Therefore, when they "shifted" their allegiance they sought a kind of modus vivendi in their host society but the degree of their involvement also depended very much how far the host society would go beyond their passive tolerance to a more intimate understanding. As culture carriers, they also felt insecure because their customs and modes were different from those of the host society. Their contact with the new culture acted as an eye opener and they began to question their former customs and traditions. Many found their attempt to re-arrange their mode of living very frustrating and they themselves gradually become more or less without direction and control owing to the lack of acceptable models here for them to follow.

Some possible overt manifestation of loneliness, sense of frustration, the incapacity to reach across a cultural distance are, unexpected failure in their studies, bizarre social behaviour, resenting attitude, frequent illness, negativism and pessimism. But very often these manifestations are hidden unless allowed to express like in the following two incidents occurred during the interview. Both were Filipinas in two different mental handicap
hospitals. Their reactions reflected very much the feeling of powerless to order one’s life. The incidents also underlined the need for a more constructive approach to avoid these situations. If not, to allow the trainees opportunities to discuss their problems with someone they could trust and confide. Similarly, they pointed to the need for a more "planned" type of recruitment of overseas trainees in the future to allow wider spread in order to avoid formation of cliques. The formation of cliques are harmful to the nursing profession and the 'dispense of care' profession, at the same time such formation will stalemate any efforts the hospitals make to assist these overseas trainees to adapt themselves in their new social environment.

In the first incident, after several minutes of interview, the girl started to sob. On query she bemoaned that she was "very miserable, lonely and fed-up with everything." Probing further, the girl commented that: "The hospital takes too many Filipinos and many are not suitable for this type of nursing. I applied here because my boyfriend is already working here. Everything was all right at first. But slowly things got worse. Many Filipinas are very jealous of us, so they gossip and tell lies about me having an affair with another boy. My boyfriend believes it and now he does not want to go out with me anymore." Apparently, there were strict rules about visiting in the nurses' home.

This girl had been here for only about four months.
Obviously she had emotional and personal problems and needed very careful handling, like a trusted shoulder to cry upon - and someone to give her a friendly and warm hug. Unfortunately, according to her, no such person she could trust was available. She commented that: "This hospital is old-fashioned and treats us like small children. We are not allowed to have male visitors to female rooms (and vice-versa). Then, when you are on duty, they expect you to be responsible for the patients' welfare. If I am so irresponsible as they (nursing administrators and home warden) think I am, my parents would not have allowed me to come here in the first place."

To err on the off, in one general hospital, the overseas trainees requested the matron's permission to let their boyfriend visit them in their own rooms because the visitor's room - only one for over one hundred residents - was very small with no privacy, ie no curtains. The matron pointed out that if they wished to bring their boyfriends into their rooms, she would first have to write to their parents explaining their daughters' request and if their parents agreed she would then grant the permission.

On the question of over-recruiting trainees from one particular country, there were many comments both during the informal discussions and during the administration of extensive survey and interview schedule. One West Indian
student nurse felt particularly isolated because she was the only one from the West Indies in that hospital. She remarked that: "I feel bloody lonely and the other students have groups of their own country to go with. I am an outcast to them." Another Filipino was very critical too, "we have too many Malaysian girls here and they speak Chinese or Malay even in the wards, in front of the ward sisters."

In the second incident, the girl began to cry as she recounted her experiences which she had to go through twice when she was asked whether she was satisfied with her training. "I was in ward (A), an English SEN was in charge and there was another English student nurse with me. We had to take the patients to the swimming pool for the physiotherapy. On that week I had backache but I still went on duty because the nursing officer did not believe me. She said I could go on duty as I did not have a temperature. On that morning, the SEN asked me to take the patients to the swimming pool and I refused. I told her that my back is painful and I could not possibly go into the pool. She did not want to listen to me. She did not ask the other student nurse to go instead either. I implored her and I cried but she simply said that if I do not she will report me to the office. Well, if this SEN cannot understand me, what chance do I have from the nursing officer, especially when you are a foreigner? Of course, the nursing officer will believe her. And the next day I was asked to go again. Oh, I was really mad. When I finished my duty, I locked myself in my room and simply cried. I could not write home about this because if I do
my parents would be worried and would ask me to go back
immediately. They were against my coming here to do
the nursing course and I love to be a nurse." Apparently,
this girl had no-body to turn to because the incidents
according to her were about six months old and she was
bearing her bitterness and frustration with her all the
time. This illustrates the need for counselling services,
that hospital attitudes should aim for quality with
humanistic approach and logic; that nurses like patients
are individuals and even more sensitive to their peers
and officers.

Summary

The evidence of this chapter suggested that the overseas
trainees were continuously being placed into alienative
situations from the moment they stepped into Britain.
Many, if not all, felt bewildered and disillusioned with
the drab buildings, the featureless attires of both
sexes who surrounded them. If they were unfortunate, they
would be greeted by the grey pull of the English winter.
That was the beginning of disillusionment and also the
beginning of realising that their expectations were let
down. Arriving at the hospital, they moved further into
a strange environment which they had to come to terms with
for the rest of their training period - (the hospital, a
total institution).
Many had to sit unexpectedly; the GNC test within 24 hours as well. Their adaptive mechanisms were dwarfed with a sense of loss superimposed, i.e., the severance of close-knit family ties which were a source of emotional support they had known from birth. Facing the hospital's cold and impersonal nature of authority, these overseas trainees became more and more alienated and they recoiled to seek out their own kind, creating adaptive problems, both for themselves and the nursing administrators.
Chapter 7

Social Adjustment in the Hospital Community

So far, evidence suggested that our trainees came ready to follow the nursing course despite their somewhat incongruent expectations of nursing in the U.K. Many were influenced by lack of employment opportunities, some with political reasons like discrimination in the employment field and many came because of the shortage of nursing training in their own country. In this chapter we assess how the trainees see the nursing situation and how they cope, their job satisfaction and dissatisfaction, their career intentions after completing their present training. The data came from both extensive survey and personal interviews.

How contented are the trainees in their training? How do they relate themselves to the nursing profession? Do they feel secure with the nursing qualification they will obtain? The last question also throws some light on their motivations.

If the trainees lack factual information about what is to be expected of nursing the result will be to perpetuate myths. If their expectations are not forthcoming, disillusionment and dissatisfaction with the job would result. The myths were of self-directing independence, prestige and association with worthwhile people like doctors, glamorous travel and financial rewards. A trainee would
be very likely to be resentful and dissatisfied, should the job turn out to offer only hard physical work and little prestige. This has already been demonstrated.

We know that the motivations which impelled these trainees to come to Britain and directed their choice in nursing were social in origin, that the satisfactions they experienced were largely social as were the anxieties and conflicts which plagued and distressed them. These motivations, satisfactions, anxieties and conflicts were consequences of their interaction with other members of the nursing profession. Therefore where do these trainees stand? How far are they adjusted to the hospital community?

**Job Satisfaction**

In the extensive survey, the subjects were asked "how interesting do you find your present job as a trainee nurse?" Few found the traineeship uninteresting (12% said "not interesting" and 2% very uninteresting). The rest thought it was either interesting or very interesting. Some of their remarks may help to illustrate their thoughts when they gave their negative answers;

"Actually, I love nursing very much, the only thing is that the ward sister is horrible and our tutor is the same."

"It is the job, it is the attitude of one's contemporaries. We did not have any tutor when we started our P.T.S."
We were asked to do personal study ourselves. We hardly did any practical work."

Over two-fifths (41.3%) felt that "training in the school is good but poor on the wards. We should be provided with better tutors with new ideas. There is a lack of qualified tutors and clinical instruments."

"Sometimes, we do not need to be in school because anybody else can do what nurses do in a subnormal hospital. I think we are taught a lot of clinical nursing that we shall never need to use with subnormals. Instead we need more teachings about the individual, personality and mental development and other social aspects." As expected, there was a definite relationship between the trainees' status and their feelings about the training system and a relationship between types of nursing and their feelings about the training system. That is, students were more negative than pupils and students in psychiatric and mental handicap nursing were more likely than those in general training to find the training system bad. Similarly, pupils in psychiatric and mental handicap training were more prone to be negative than those in general nursing. Sex, as a variable had no positive correlation.

The trainees were asked again during the personal interview how satisfying was their training. Their replies are presented in Table 7.1 below. Over half (62.5%) were
very spontaneous and felt that the training was satisfactory. But when they were asked to elaborate their answers, more they gave a medley of opinions. Some excerpts may exemplify the point, but it was very clear that 30% of them were dissatisfied because they were doing the wrong type of nursing and a similar proportion felt that there was insufficient teachings.

Table 7.1 How satisfied are you with present training?

| 1. Not the right type of nursing | 36 | 30% |
| 2. Tutors are not helpful | 17 | 14.2% |
| 3. Bad working atmosphere | 23 | 19.2% |
| 4. There is not enough teaching | 36 | 30% |
| 5. Good working atmosphere | 77 | 64.2% |
| 6. Not enough qualified tutors | 17 | 14.2% |
| 7. General attitudes to us are not good | 18 | 15.0% |
| 8. Learning new skill and new things | 74 | 61.7% |
| 9. It is a special kind of nursing | 63 | 52.5% |

Source: Interview.

"The training itself is very interesting and the officers' attitudes are too old fashioned, very strict and demoralising. They don't trust you on the wards because you are coloured. They think of you only as a pair of hands. I suppose it is because of our past history, like slavery."

"I have just completed my training and I feel I am a different person. I have more responsibilities and I enjoy the work. Looking back, the training itself had its ups and downs. At one time we had a very good group of
tutors and you learned a lot and then they all left. What was left behind was a bunch of rubbish; they could not teach. They bored you with repetitions."

"I enjoy working in the wards, helping the patients and teaching is good but there are not enough clinical tutors to help us in the ward. Everything is luck in this world, and it all depends upon whom you work with."

"I feel very empty although I try my best. We had a constant change of tutors. They are not very helpful and they lack understanding. There is no ward teaching from the tutors. If you do not go and ask for something to do like past examination questions, they forget you are in training."

"Some staff do not co-operate. The nursing officers make you feel that you are only here to do what they ask you. They do not provide any recreational facilities, instead we simply vegetate mentally."

"Everything is new to me especially subnormal nursing. Meeting many different people and I enjoy working for these patients although this is not the type of nursing I was hoping for. One real frustration is the charge nurse or ward sisters would not back your initiative because they feel threatened that they will not get the praise."

"It is not satisfying because I wanted to do the general nursing and I was hoping to go back home at the end of the
training. Otherwise I enjoy the work and also I learn things which I don't think I shall learn in the general. I suppose the idea that I cannot go back home after 3 years has made life less interesting. There is too little teaching to stimulate interest."

"I have learned a lot of things I never knew before. I understand more about human relationship and mental illness. I enjoy helping the patients......But we do too much domestic work and there are not enough tutors to help us. There is no encouragement or incentive to study. You go to school for a day and all you do is sit down like stupid fools. Most of the time is spent in repetitive talk."

"We spend too much time in geriatric wards. We have four such wards to go through during our training. We have twenty-nine other type of wards. Is this necessary? The teaching is not very challenging and sometimes it gets very boring."

"I like to help these patients but on the whole I do not enjoy it because my initial experience has made me prejudiced against this hospital, ie, it did not let me know exactly the type of nursing I would be in for. Some of the charge nurses and ward sisters are bossy and push you around, and they do things the wrong way round to what was taught. For example, they ask us to change all patients before dinner and then after dinner they are not changed just because they want to have an easy time and go
home early."

During the construction of the interview schedule, it was decided to follow up the previous ideas to see if the "wrong" type of nursing and training would also affect the trainees' future outlook. Forty percent felt that their present training would eventually offer them a secure future. Of those who felt otherwise, 40.8% were pupil nurses (13 in mental handicap, 19 in psychiatric and 17 in general nursing). The rest were 18 students in mental handicap training, 4 students from psychiatric and one from general nursing. The one general trainee came from the Philippines and she thought her future insecure because "if I stay in England, any hospital will accept me but not back home where this STN is not well recognised. I need to take another examination and only then will my future be secured."

Several studies have already pointed out that a recurrent complaint of trainees is the discrepancies between theory and practice, between what is taught in school and what they have to do in the wards.\(^1,2,3\) Do overseas trainees differ? The training programme is divided into two overlapping fields; the practice and theory of nursing. The former is carried out in the wards after the initial theoretical teaching in the training school. In the

1. Huty, H.E.: Student Nurses: 1st year Problems, 1965
2. J.M. MacGuire: From Student to Nurse Pt. 1) All mentioned
extensive survey, the trainees were first asked if what was taught in school was being similarly carried out in the wards. Only 9% were positive and 56.7% complained it was slightly and 34.3% as totally different. The findings not only corroborated the earlier studies on the indigenous trainees, they also raise a serious question. Are the trainees taught to deliver health care as required of them in everyday life? Is what's being taught hypothetical? Where does the fault lie, i.e., in the school or in the wards? Evidence from other studies 1,2 showed that there was little difference between overseas and local trainees regarding the opinions on theory versus practical training.

When the trainees were asked to judge the amount of practical and theory they were taught, the proportion of trainees who found the theory "too much" was less than those against the practical by 3% as shown in Table 7.2, columns C and F below. Nearly half felt that both were "just enough" while more complained of the "too little" theory than practice by almost 5%. Who are those trainees behind the figures, that is from what type of nursing?

and of which status, students or pupils? We would expect more students and pupils in psychiatric and mental handicap nursing to mention that theory was taught "too little as well as the practice because academically the curriculum

1. J. MacGuire: Threshold to Nursing 1969 (16)
was not demanding and on the wards practical or clinical
nursing was wanting owing to the greater emphasis on
care and socialization, rather on "curing" sense as in
general nursing. We also expected pupil nurses in general
to say that the theory was "Too little" because of their
earlier expectations and academic backgrounds. Thus,
they were hoping to have deeper understanding of nursing
and at the same time high educational qualifications
would not do justice to their status because in general
pupil training has little emphasis on theoretical nursing.
It is more or less an apprenticeship, learning the
nursing procedures as one goes along.

The results as shown in Tables 7.3 and 7.4 did not wholly
confirm the expectation except among students of
psychiatric and mental handicap nursing and among pupils
of mental handicap who claimed that the theory taught was
too little, and this was further confirmed by the small
proportion of pupils who said there was "too little"
practicals (Table 7.4).

Similarly, on the practicals, the results confirmed the
expectations that a larger proportion of students in
psychiatric and mental handicap nursing would find there
was too little practical. The results did not confirm
the expected behaviour of the pupils in psychiatric
training while substantiated those in the mental handicap
training, also the expectation of overall request for more
Table 7.2  Theory Versus Practice by status

<table>
<thead>
<tr>
<th>What do you think</th>
<th>Theory Stu pupils</th>
<th>Total</th>
<th>Practice Stu pupils</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>of the amount of theory &amp; practice given to you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Too much</td>
<td>71</td>
<td>13</td>
<td>84</td>
<td>85</td>
</tr>
<tr>
<td>2 Just enough</td>
<td>406</td>
<td>122</td>
<td>528</td>
<td>360</td>
</tr>
<tr>
<td>3 Too little</td>
<td>325</td>
<td>114</td>
<td>439</td>
<td>320</td>
</tr>
<tr>
<td>4 Don't know</td>
<td>28</td>
<td>22</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>Totals</td>
<td>830</td>
<td>271</td>
<td>1101</td>
<td>830</td>
</tr>
</tbody>
</table>

Source: extensive mail survey

Table 7.3 The amount of Theory by Status and Type of Nursing

<table>
<thead>
<tr>
<th>What do you think of the amount of theory given to you</th>
<th>Students General Psychiatry- Mental handicap</th>
<th>Pupils General Psychiatry-Mental handicap</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Too much</td>
<td>47</td>
<td>18</td>
</tr>
<tr>
<td>2 Just enough</td>
<td>167</td>
<td>160</td>
</tr>
<tr>
<td>3 Too little</td>
<td>104</td>
<td>139</td>
</tr>
<tr>
<td>4 Don't know</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>331</td>
<td>327</td>
</tr>
</tbody>
</table>

Source: extensive mail survey

Table 7.4 The amount of Practice by Status and types of nursing

<table>
<thead>
<tr>
<th>What do you think of the amount of practice given to you</th>
<th>Students General Psychiatry- Mental handicap</th>
<th>Pupils General Psychiatry-Mental handicap</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Too much</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>2 Just enough</td>
<td>171</td>
<td>132</td>
</tr>
<tr>
<td>3 Too little</td>
<td>99</td>
<td>139</td>
</tr>
<tr>
<td>4 Don't know</td>
<td>26</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>331</td>
<td>327</td>
</tr>
</tbody>
</table>

Source: extensive mail survey
theoretical teaching from the pupil nurses generally.

How satisfied are the trainees with their nursing course? When the trainees were asked "Are you satisfied with your present nursing course?" we anticipated a hotch-potch of answers. I have tried to present them in a more congruent picture in Table 7.5 below. In column C of the table I have ranked the replies by frequency. Very few trainees were dissatisfied with their jobs; more than double, 35%, obtained job satisfaction. Dissatisfaction with the small amount of teaching or bad teaching ranked first. Some selections of the trainees' explanations

Table 7.5 Satisfied or dissatisfied with present training?

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No staff co-operation</td>
<td>19</td>
<td>16%</td>
<td>7</td>
</tr>
<tr>
<td>2. Divergence in Practice &amp; Theory</td>
<td>25</td>
<td>21%</td>
<td>5</td>
</tr>
<tr>
<td>3. Job satisfaction</td>
<td>42</td>
<td>35%</td>
<td>4</td>
</tr>
<tr>
<td>4. Too much domestic work</td>
<td>48</td>
<td>40%</td>
<td>3</td>
</tr>
<tr>
<td>5. Like school because it is a nice break</td>
<td>23</td>
<td>19%</td>
<td>6</td>
</tr>
<tr>
<td>6. No job satisfaction</td>
<td>17</td>
<td>14%</td>
<td>9</td>
</tr>
<tr>
<td>7. No particular reason</td>
<td>18</td>
<td>15%</td>
<td>8</td>
</tr>
<tr>
<td>8. Bad teaching/not enough teaching</td>
<td>80</td>
<td>66%</td>
<td>1</td>
</tr>
<tr>
<td>9. Too much geriatric/heavy wards</td>
<td>56</td>
<td>47%</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Interview data. Does not add to 120 as more than one answer is possible.

might elucidate the varied opinions:

"I mean I don't need to be trained in this kind of nursing (mental handicap, pupil course). I feel a misfit. I think pupil nurse training is more of a domestic training."
My ambition is to be a nurse that is why I sacrifice leaving my family and permanent job at home. But I never thought the training I shall undertake is like the work of hospital helpers in our country, called "domestics." It is totally too easy for examination purpose. There is no co-ordination between what are taught in school and what we do in the wards. The difference is poles apart."

"It is very boring to be a pupil nurse because there is very little teaching, a lot of geriatric nursing and domestic work. Whatever teaching there is, is repetitive. This type of training is not enough and I would like to go further."

"It is the best course in nursing and in general I am fairly happy although I feel that the teaching method could be changed with more school days and employ more qualified tutors."

"Student nurses are being used for the bare routine work and we get too tired afterwards to study. There is also a lot of geriatric nursing while we still have to do domestic jobs. The tutor is not good. She shouts and tells you off. She sits in her office and asks you to read books. All we do in the classroom is talking. I much prefer to go to the ward than to school because it is so boring."

"As trainees, we are left on night duty in charge very early in our training. I was in charge in my first year.
It is still too much responsibility. Night sister simply comes and asks you 'everything all right?'

"I don't know what it is like in other fields, I think I learn here and I am satisfied with life in general although more could be done to make our stay more interesting than mere circular events, ie, sleep, eat, work."

"Bad nursing atmosphere, a cat and dog's life especially between the nursing officers and ward sisters or charge nurses. Each fighting one another behind their backs. The nursing officers shift us around too often and make you feel that only your pair of hands is needed and that they don't care about your needs as a trainee. We don't get much from the teachers, they have no subnormality qualification to teach us; too superficial most of the time. On the other hand, we look forward to school blocks because there is little demand in there."

"You tend to get used to it. There is a lack of support from those above, like nursing officers upwards. All the training programme is only a showpiece. The schooling is a waste of time and eighteen months would suffice to register for psychiatric nursing. In the ward, there is too much gossiping about other persons."

"I would like to see more team work, to have more theory in mental illness, more clinical tutors to come to the wards to teach us practicals."
All the evidence pointed to the uncoordinated nursing curriculum, course design. This unbalance was further enhanced by lack of qualified tutorial staff. Consequently, the skeleton staff found the demands made by the trainees more and more taxing. It was no surprise therefore to learn that many, especially among psychiatric and mental handicap trainees found their time spent in school "boring," "a break from heavy ward load" or a "resting or recuperating period." Similarly, the evidence highlighted the sense of insecurity, apathy and ambivalence among these trainees in their new environment, in particular in the specialised institutions like hospitals.

Table 7.6 When would you be contented?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Better working atmosphere</td>
<td>635</td>
</tr>
<tr>
<td>2. Attitudes of officers need changing</td>
<td>569</td>
</tr>
<tr>
<td>3. Better training programmes</td>
<td>262</td>
</tr>
<tr>
<td>4. Closer link between school/ward</td>
<td>319</td>
</tr>
<tr>
<td>5. Raise the nursing standard</td>
<td>219</td>
</tr>
<tr>
<td>6. Improve staffing situation</td>
<td>304</td>
</tr>
<tr>
<td>7. More specialisation opportunities</td>
<td>287</td>
</tr>
<tr>
<td>8. More money</td>
<td>452</td>
</tr>
<tr>
<td>9. No comments</td>
<td>293</td>
</tr>
</tbody>
</table>

Source: Extensive Survey data.
Table 7.7  Further comments, if any

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. More tutors/more ward teaching</td>
<td>58</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>2. Improve working atmosphere</td>
<td>80</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>3. More concern for sick nurses</td>
<td>52</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>4. Orientation course</td>
<td>44</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>5. Better information on nursing and conditions</td>
<td>44</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>6. Others</td>
<td>82</td>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>

Source: Interview data.

The trainees' suggestions (Table 7.6) for changes were further echoed during the interview as shown in Table 6.7. The two tables present a range of problems and difficulties which could be remedied, creating a more receptive and adaptive atmosphere in the hospitals, the changes would probably be also beneficial to the indigenous trainees.

The first step was in April 1975 when the reorganisation was introduced to democratize administration. Similarly, "Salmonisation" was another attempt to replace archaic administrative procedures. We may have an insight of the hospital if we look at some of the trainees' comments, criticism and suggestions.

"Staffing situation must improve to an ideal point so that the standard of nursing can be improved and the public

1. Counselling (24), better nurses' home (20), more recreational facilities (22), provide hospital transport to go to other hospitals (16).
will get a better image of nursing. Better working
conditions and better staff relationships with the seniors."

"I want fair treatment, to be treated as a student and not
as a labourer. We should be assigned only to carry out
nursing duties and not domestic, clerical and porter's
chores."

"The present administrative system is very old fashioned
and prejudiced against overseas nurses. The school and
ward practice must be brought closer to avoid apathy
from the trainees. More theoretical approach to mental
illness is urgently needed to fulfil our expected
interest in psychiatric nursing."

"Free from worry of being liable to be terminated from
our training for merely having failed a block entrance
test throughout the three years of training. Better study
facilities and friendly atmosphere offered by the nursing
administrators. There must be more concern over our
health because it is terrible to get told off for being
sick and not given attention."

"Good and fairer tutors. Reasonable administrative staff,
happier atmosphere in the wards, ie, team-work. Considera-
tion from senior staff is essential and fair treatment
from everybody especially from the top; tutors, ward
sisters and charge nurses. We must be allowed privacy
in our own room and freedom. To have the furnishing we
wish provided we take care of hospital belongings. I
suppose that is too much to ask for."

"There should be more communications between ward sisters
and charge nurses and nurses. Everyone should do their
fair share. Ward sisters/charge nurses should work in the
ward and get to know their individual nurses, not sending
us on relief all the time."

"Perhaps if I had a very friendly, tactful and intelligent
tutor and administrative staff, I would do nursing for ever here."

"Recognising that overseas nurses have same potential. More theoretical lectures on nature and care of mental subnormality. At present this very lack of deeper level of understanding creates frustrations and leads us to a semi-threshold of interest."

"No prejudice, co-operation with all grades. Respect for overseas nurses' intelligence and ability. No favours especially in the class-rooms. Someone to whom overseas trainees can go for help. More overseas nurses in higher positions."

"No moral blackmail, i.e., always reminders that your passport needs renewing by them every year, especially when you refuse to do an overtime or to change shift without due notice. Better recreational facilities."

"More informal and personal relationships. Similarly for the patients since we are trying to rehabilitate them and life outside hospital community is less authoritarian and less formal.

Earlier, we have suggested that the nurses' industrial action may have influenced these respondents perception of their work environment, e.g., "more money," "improve staffing situation."

The Trainees' perception of Nursing Functions and their part within

The nursing profession like any other occupation has its own culture, with certain belief patterns, value system, personality traits and behaviour characteristics. These
exert an important influence upon the new entrants. How do they respond to those pressures which are alien to them up to their arrival in Britain? Their responses could be measured by the degree of satisfaction they felt towards their training at the same time this satisfaction is related to the degree of social and personal adjustment they had achieved within the work group they were part of. Morale, therefore, is not only affected by bad teaching since the number of weeks spent in school during the training period is small compared with the time spent on the wards. For overseas nurses, most of their working hours were to be spent with nurses of different nationality. How do they perceive themselves in the nursing hierarchy? In the extensive survey, they were asked if they felt that they had an equal chance with other people for promotion. Only one-fifth gave a definite "yes" compared with 36% who said "no"; still more ticked "don't know." During the coding stage it was noticed that 69 respondents had ticked "no" and then crossed off and left a tick in "don't know" box. This could be because they were subsequently asked to explain their negative reply. The reasons and comments behind their replies should give valuable information to both the nurse educators and administrators, i.e., man-power and planning. They are tabulated below in Table 7.8. Their answers indicated that they had a definite opinion on this question and there were four categories only.
Table 7.8  Why no equal chance of promotion?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No chance for SEN</td>
<td>59</td>
<td>14.9</td>
</tr>
<tr>
<td>2. Favouritism</td>
<td>83</td>
<td>21.0</td>
</tr>
<tr>
<td>3. Being a foreigner</td>
<td>215</td>
<td>54.3</td>
</tr>
<tr>
<td>4. Not stay for promotion</td>
<td>39</td>
<td>9.8</td>
</tr>
</tbody>
</table>

One-half of those who felt that they would not have equal chance with other people for promotion argued thus:

"The racial prejudice is too obvious. No matter how well and hard we work we are always by-passed."

"There is very much colour prejudice in this hospital. They consider us to be 'daft.' No further than charge nurse. They usually employ British for nursing officers or higher post."

"Because we come from overseas and we stand less chance than their own people. Very few of us get promotion if they can promote the local staff."

"I know from experience that they want their own people to head most of the departments; therefore my chances are very slim and I shall not get a fair chance."

"You have to be a favourite with persons in charge of the hospital. You have to be white and to bow the people at
the top before you are promoted. If you speak the truth you are black listed."

"There is too much racism and favouritism."

"I say 'no' because I feel that here you are promoted if the superiors like you. If you try to bring some working order when in charge, you become very unpopular with the staff especially the 'white' staff."

"There is no chance for promotion for SEN. As it happens in the ward I am working, a coloured SEN (full-time) is not given the chance to take charge, instead an English part-time SEN is taking charge!"

"Many overseas staff nurses who had been here for a while have not had promotion yet and as I am still in training and shall be just: an SEN, I shall not stand any chance at all."

How can we explain this resignation? Could it be linked to their ward experience? Because of the significant number of trainees who felt disadvantaged in their future career, and because during the informal and preliminary discussions, many trainees and qualified overseas staff pointed out that different procedures were being practiced for trainees on the wards. It was decided to explore any possible link to their ward experiences. Theoretically, a trainee is entirely under the ward sister's/charge nurses'
authority as he walks into the ward. During the interview the respondents were asked "Do you feel that you have the same chance as other students and pupils to learn on the wards?". Two-thirds of them were positive of having an equal chance. When they were asked to elaborate both their positive and negative opinions however, they sketched a very different picture compared with their clear-cut replies of "yes" or "no" as shown in Table 7.9 below. That there was a positive equal chance to learn in the wards showed a very significant drop in the table unless we attribute the same meaning to the category "up to individual to help oneself" as same meaning.

Table 7.9 Equal chances to learn in wards? (interview)

| 1. Very fair charge nurse/ward sister | 22 18% |
| 2. Favouritism | 38 32 |
| 3. No ward teaching | 58 48 |
| 4. Up to the individual to help oneself | 28 23 |
| 5. Pupil nurses have less chances to learn | 28 23 |
| 6. Juniors are neglected in favour of seniors | 6 5 |

Their comments were clear like: "no ward teaching as such" or "we have no teaching sessions."

"This depends a lot upon the individual, but the students have more chances than us (pupils) simply because we are inferior to them by status. They never find time to teach pupils in the wards."
"It is very difficult to answer because it depends very much on yourself because they don't know what you want to learn. If you ask you get answers."

"We do not have teaching sessions but you can ask if you want to learn."

"More preference to students. If she is an English pupil then she gets priority over other students, then I get the 'chicken' chance to learn. Most English trainees are allocated to easy wards and workload and we are doing the heavy ones. But some do help."

"Some ward sisters show a lot of favouritism and charge nurses are better than them. Pupils are not well regarded in the wards. A lot has to do with the person in charge and is also up to the individual."

"Some of these students and pupils are 'Tripodstands' (meaning those who seek favours). They pretend, they make tea for charge nurses and ward sisters and for others in order to get their friendship. All this merely because they want to spend time chatting then working."

"There is a lot of favouritism and the white ward sister/charge nurse will teach the incoming trainees procedures which I did not get, simply because they are English or Irish. I am a third year student, yet for anything of interest or special, I shall be ignored in favour of a first or second year European nurse. They (Europeans) can
take extra time for break and ward sisters simply close their eyes. If we do it we get a telling off or may even be reported to the nursing officers. Not much ward teaching as well."

"You notice the favouritism going on. The charge nurse will teach even a junior simply because he likes him or her, while as a senior, I am asked to clean the sluice, the treatment room and mop floors."

"As a first year student, the ward sister tends to neglect you and regard you as one of the nursing assistants and you do all the mental and routine tasks. The senior trainees have all the chances to give medicine, any injection there is."

This finding further endorsed what have already been discussed earlier on that there is a clear lack of ward teaching to bring out interest and to maintain let alone to raise morale. This also supported our earlier finding of the chasm between school and ward teachings.

In view of the large number of trainees perceiving the discrepancies of equality in the nursing profession, one wonders how this would affect their career expectation (perceived) against career aspiration should they stay in Britain to practise their nursing profession, holding other factors such as prejudice, favouritism as constant. The career expectation would be the number of rungs of nursing
profession ladder the trainees thought they might mount in the present condition and career aspiration would be the number of rungs the trainees would like to climb given the opportunity to do so — an ideal situation. It was possible to interpret from Table 7.10 that career expectation and career aspiration ran divergent routes and the trainees perceived them poles apart. Thus, in their replies to their career expectation only four trainees felt they could reach above charge nurse's/ward sister's position, i.e., clinical tutor or nursing officer either in teaching or service, in column A of the Table 7.10.

<table>
<thead>
<tr>
<th>Table 7.10 Career expectation (A) and Career aspiration (B)</th>
<th>Column C</th>
<th>Column D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ward Sister/CN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Clinical Tutor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Nursing Officer (T)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Nursing Officer (S)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Senior Nursing Officer (T)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Senior Nursing Officer (S)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Principal Nursing Officer (T)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Principal Nursing Officer (S)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When looking at the figures in Table 7.10, it must be borne in mind that a person on passing his state final examination (the three years' course) and when he has registered with the GNC, automatically becomes a staff nurse. In Column B we noticed that no trainee aspired to
be staff nurse and that the proportion of the trainees aspiring to be charge nurse/ward sister had also dropped very significantly. One very interesting point emerging from the table was the fact that over three-quarters of the trainees saw their career in the service side of nursing rather than in the teaching side. This should be of valuable information to the manpower and planning section when they formulate future policies.

Passport versus nursing ambition

What holds these overseas trainees to nursing once in Britain? Could the yearly passport renewal have a very strong-hold on these trainees in staying in nursing? Is passport an important determining factor in keeping trainees from leaving their training? The student visa issued to trainees appeared to have bound them to stay because withdrawal from nursing before the conditions of their stay have been satisfied which is usually four years, they may be forced to return to their own country. It is also a disgrace to be afflicted this way and will be looked upon as such on their return home. On the other hand a trainee may withdraw and still be permitted to stay in the U.K. if he transfers himself to another type of nursing course or if he goes to follow a full-time study in higher education. The latter requires the person to show evidence that he is self-supporting financially for the length of his study. Usually, he needs a bank statement of his account. In many cases, this is not possible to realise because of the prohibitive cost
especially of maintenance. Only in very rare cases parents consent to undertake such a heavy commitment to share the financial burden. This may sound contradictory to the earlier argument that a large number of overseas trainees came from middle class or upper middle class background. The mitigating factor is their parents also have large family to look after and indeed many of their children were still in either primary or secondary education at the time of these trainees' departure. What then is holding back overseas trainees in the training? Could there be other factors more potent...? Could it be the nursing ambition?

If the passport or student's visa is a contract binding the trainees to stay put, large numbers of trainees would be expected to mention spontaneously that removal of student's visa or revocation of the conditions of their stay would send them packing their luggage, to the question in the extensive survey: "Apart from ill-health (and maternity for girls) under what conditions would you think of leaving the nursing profession all-together?" Instead, over half of them reaffirmed their determination to stay in nursing as shown in Table 7.11 below. The potent discouraging factor appeared to be the conditions of services which would eventually drive them away. Perhaps, the use of excerpts would bring out the thoughts of these trainees more cogently. They also illustrated some of the informal and unwritten procedures of the hospitals.
Table 7.11  When to leave nursing?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No intention to leave</td>
<td>588 52.4%</td>
</tr>
<tr>
<td>2. No prospect of promotion</td>
<td>194 17.6%</td>
</tr>
<tr>
<td>3. Poor working atmosphere</td>
<td>344 31.2%</td>
</tr>
<tr>
<td>4. Sacked or visa not renewed</td>
<td>105 9.5%</td>
</tr>
<tr>
<td>5. After marriage</td>
<td>152 13.8%</td>
</tr>
</tbody>
</table>

"If no promotion acquired after some years."

"If I thought that instead of going further afield and gaining promotion, I am making no progress, then I suppose I would try to seek for better opportunities somewhere else outside the nursing profession."

"I would not leave the nursing profession because a career in nursing is more important than anything else."

"Never had that thought in my mind."

"I don't know because I have come to love nursing."

"When the prevalent 'looking down' attitude from the nursing officers does not change soon. Unfriendly attitude of the ward sisters as well."

"After getting married."

"If there is no improvement in the ill-regard for overseas nurses especially in the promotion field and also in allocation of wards. Lack of satisfaction. Insult to overseas nurses' intelligence by treating us as idiots when in fact we are more qualified than they are."

"Unless sacked which is a prevalent feature in this hospital or if they keep on black-mailing us. When they want you to do an overtime, they hint at the same time:"
"Oh yes, when you do need to renew your passport - let me know, I shall see what I can do."

Why did the working atmosphere attract so much criticism?

We also know that job satisfaction is a pre-requisite to a high level of morale. Can we identify which divisions in the nursing hierarchy are not conducive to good morale or are deterrents? Is the hospital as an institution receptive and adaptive? or antagonistic and rigidly structured? How does one measure this? The first step is obviously how much these trainees like or dislike working in their respective hospital.

Table 7.12 Overseas Trained Likes of the Hospital

<table>
<thead>
<tr>
<th>1. Nothing I like</th>
<th>521</th>
<th>47.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Friendly people from different countries</td>
<td>238</td>
<td>21.6%</td>
</tr>
<tr>
<td>3. School block/good tutor</td>
<td>51</td>
<td>4.6%</td>
</tr>
<tr>
<td>4. In nice area</td>
<td>57</td>
<td>5.2%</td>
</tr>
<tr>
<td>5. Comfortable nurses home</td>
<td>26</td>
<td>2.3%</td>
</tr>
<tr>
<td>6. Type of patients/nursing</td>
<td>240</td>
<td>21.8%</td>
</tr>
<tr>
<td>7. Shift allows more free time</td>
<td>49</td>
<td>4.5%</td>
</tr>
<tr>
<td>8. Facilities &amp; opportunities for special interest</td>
<td>22</td>
<td>2.0%</td>
</tr>
<tr>
<td>9. Good working atmosphere</td>
<td>140</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

Source: Extensive mail survey

As shown in Table 7.12, about half of them did not like anything in their hospital. When they were asked what they disliked most in their hospital, they more or less repeated what they had already indicated earlier on, in particular, Tables 6.6 and 6.7, with working conditions ranked first again. They also described their nurses home
as "institutionalised" and "sparsely furnished" with little or no recreational facilities. The atmosphere was "dead - no life and miserable through facing four walls during off-duty....Nurses keep to themselves and relationships among the nurses are casual, a hello, nothing more unless you are very good friends." It lacks "privacy, our room is being inspected when we are not in and visitors coming from long distance have been chased from the block." The room was like a "prison cell - too small and poorly furnished."

The nursing administrators were described as "unreasonable and unfair" and they called for "fairer promotion scheme on seniority instead of skin colour; better staff relations, better chance to voice our complaints without fear of victimization." Table 7.13 illustrated their feelings towards their colleagues and those in the hierarchy. 36.7% and 75% indicated that they found ward sisters/charge nurses and fellow trainees were respectively most helpful. Among the groups the trainees felt to be least helpful were INC(s), Nursing Assistants, SNO(s), SEN and NO(s) in descending order.
Table 7.13 Which Group most and least helpful? (Interview)

<table>
<thead>
<tr>
<th>Role</th>
<th>Most Helpful</th>
<th>Less Helpful</th>
<th>Not mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ENO(s)</td>
<td>6</td>
<td>97</td>
<td>17</td>
</tr>
<tr>
<td>b. ENO(T)</td>
<td>24</td>
<td>54</td>
<td>42</td>
</tr>
<tr>
<td>c. ENO(T)</td>
<td>34</td>
<td>28</td>
<td>53</td>
</tr>
<tr>
<td>d. ENO(s)</td>
<td>7</td>
<td>77</td>
<td>36</td>
</tr>
<tr>
<td>e. Allocation Officer</td>
<td>13</td>
<td>30</td>
<td>77</td>
</tr>
<tr>
<td>f. HC(s)</td>
<td>15</td>
<td>59</td>
<td>46</td>
</tr>
<tr>
<td>g. HC(T)</td>
<td>34</td>
<td>14</td>
<td>72</td>
</tr>
<tr>
<td>h. Clinical Tutor</td>
<td>85</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>i. V.S/C.N</td>
<td>104</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>j. Staff Nurse</td>
<td>66</td>
<td>13</td>
<td>41</td>
</tr>
<tr>
<td>k. SEN</td>
<td>15</td>
<td>68</td>
<td>37</td>
</tr>
<tr>
<td>l. Senior Student Nurses</td>
<td>60</td>
<td>14</td>
<td>46</td>
</tr>
<tr>
<td>m. Fellow trainees</td>
<td>90</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>n. Nursing Assistants</td>
<td>11</td>
<td>89</td>
<td>20</td>
</tr>
</tbody>
</table>
Future Career Intentions

All the evidence indicated that the hospitals are very authoritarian, the administrative approaches were antiquated with least emphasis on the importance of human relations. They appeared antagonistic and rigidly structured to the eyes of our trainees. Despite the frustrations and stumbling blocks they had encountered, they appeared happy to follow the nursing courses, were motivated to complete and stay on after the course. Much could be done to change the prevalent authoritarian attitude or in their own words, "Sergeant Major's" approach both in the nurses' home and in the hospital.

There is already evidence which showed that qualified overseas nurses do not leave the NHS hospitals and in fact more overseas nurses stayed on than indigenous qualified nurses.¹ The present study clearly corroborated this. In the extensive survey trainees were asked: "when you qualify what do you hope to do?" Their replies were

* We have personally witnessed this type of approach during our field work. One nursing officer we were with shouted at a trainee along the corridor: "Eh you, come here! I want you!

¹ O. Gish: Nursing and Midwifery Migration in Britain. Occ.Papers, Nursing Times, 1 May 1969 (17C)
precoded and tabled below. The proportion of trainees wishing to stay to further their nursing career was comparable with Gish's findings which were "about three-quarters of these non-British nurses remain in Britain after completion of their nursing training course." 1

Table 7.14 When you qualify what do you hope to do?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Go back home to practice as a nurse</td>
<td>123</td>
<td>11.6%</td>
</tr>
<tr>
<td>2. Stay here and then seek for promotion</td>
<td>72</td>
<td>6.5%</td>
</tr>
<tr>
<td>3. Stay here for further training in nursing</td>
<td>323</td>
<td>74.8%</td>
</tr>
<tr>
<td>4. Stay here to get another job outside nursing</td>
<td>34</td>
<td>3.1%</td>
</tr>
<tr>
<td>5. Stay here to study other than nursing</td>
<td>44</td>
<td>4.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1101</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Source: Excessive mail survey

Less than one in ten wished to go back home to practise nursing while during the interview we noticed a reverse situation. In fact, over half (51.7%) of them indicated that they would like to go back home after obtaining their training. This may well refute the finding in the extensive survey. What had actually happened was that most of them who indicated a willingness to go back had one condition in mind, that is if opportunity arises for them to go. It appeared that many would not have this opportunity for many years to come, in particular the

1. Op cit. (17c)
Malaysians, because many of them would have a serious handicap by the time they became qualified nurses. They would in fact be in the same position as this one who liked very much to go "but I don't have much command in Malay and also it is not easy to get a job unless somebody pulls strings." Another explained that his handicap was "this qualification, RMMS is not useful at home and I must do another two years for SRN before I can contemplate about going home."

Summary

The trainees have come into an established organisation with established patterns of behaviour, with its own rules, learned communication patterns, power structure, rivalries and fierce loyalties. There is also a strong informal pecking order with seniority status. As novices, they found that they functioned in a highly complicated environment in conjunction with many persons. In addition, in contrast with social attitudes outside the hospitals, the latter proved to be inflexible and insensitive. Asked how interesting was their traineeship, 36% found it either very interesting or interesting but they felt dissatisfied with their functional position in the nursing hierarchy; they had to be both trainees and domestics or nursing assistants at the same time. They mentioned factors like, wrong type of nursing, unhelpful tutors, insufficient qualified tutors and teaching, bad working atmosphere, bad attitudes from above, lack of care when
they were sick and lack of recreational facilities, as incapacitating their motivation to follow the nursing course.

These trainees were disoriented by apparent conflict between teaching and service needs with consequent gross differences between what was taught in school and what they did in the wards. They felt that deeper knowledge of nursing and in particular in the special fields of psychiatry and mental handicap as very desirable in order to meet their expectations. In practice, they noticed recurrent preferential treatment on the wards by the persons in charge and felt that they were prevented from obtaining proper ward training. Many of them felt insecure and disadvantaged because "we are foreigners." Their insecurity was further corroborated when we found distinct differences between their career expectations and career aspirations. The highest grade they believed they could reach in the former was nursing officer and only one had mentioned it. Two-thirds thought charge nurse/ward sisters' level the limit and another third believed they would have no opportunity to progress from staff nurse position. Compared with their career aspiration, many had principal nursing officer's rank in mind. This demonstrated a deep resentment towards the policies of the administrators. They felt they were being used for their "pair of hands." The accusing fingers appeared to point at the administrators in the manpower and planning section. They also indicated that they were unjustly treated by insensitive, arbitrary and
unreasonable supervisors, both in the nurses homes and in nursing.

On a happier note, nearly three-quarters of those trainees wanted to gain further nursing qualifications after their present training and in addition 62% had the immediate intention of staying in the NHS hospitals and working for promotion.

Without empirical evidence from the hospitals, the nursing administrators, it is very difficult to justify the overseas trainees' view. This is further hampered by the approach of this research which concentrate in this group. What is the other side of the coin? e.g., the expectations of these trainees by the hospital? How do the hospitals see them, as a group with special problems or as any other candidate seeking a nursing course?
Chapter 8

Conclusions

This study showed that overseas trainees felt disquiet in their hospital environment whose administrative approach to human relations was very archaic in their eyes. They likened a hospital to a cloistered world which is very resistant to outside pressure. They were dissatisfied with their training which had not lived up to their expectation and consequently they were not adapting themselves to their new environment. This chapter summarises the main findings of the study, discusses their implications and puts forward some recommendations.

Summary of the Findings

A. Personal Characteristics

1) In general, the overseas person would start a nursing course older than their British counterparts at about 21 years old.

ii) More males than females tended to come from Mauritius, Ceylon and Africa.

iii) More females entered general training than males, most of whom were in psychiatric and mental handicap nursing.
iv) The overseas trainees in the general nursing were slightly younger than those in mental handicap training who were in turn younger than the psychiatric trainees.

v) Nearly all overseas trainees came as single persons.

B. Educational Aspects

i) Three in every four overseas trainees stayed in full-time education until 18 or over.

ii) At the time of departure 81% possessed O level or equivalent qualifications and 5.6% had A level or equivalent as well, while the hundred and twenty one Filipinos had BSc. or B.A. in Education, technology etc.

iii) When the number of O levels was crosstabulated by country of origin, sex, status, there was insignificant difference between sexes for Malaysia and Mauritius but males from West Indies and Africa had more O levels than the females (82.2% against 69.1% and 95% against 85% respectively). The general trend is the other way round, the females had higher mean O levels than the males. Wide ranges of educational attainment existed among trainees of different country of origin. The following countries were ranked in order of highest percentage score with at least one O level subject; Malaysia, Mauritius, Africa and West Indies.

C. Family Background

Most trainees had left living parents and a large family
unit with an average of 5.5 siblings and they were usually from the middle of the birth rank among their siblings. Very few of their parents were manual workers.

D. Pre-Nursing Experience

i) Very few had any nursing experience prior to their training in the U.K. (5.8%) but as many as 90% had either relatives or friends as qualified nurses. 30.6% had also lodged an application to train in their own country's hospitals.

ii) At the time of their application for training in the U.K. 30.5% were still either in full-time or part-time education. 46.2% were working either full-time or part-time and with an average of 2 years with 1.5 jobs in their employment record. The rest had been unemployed for a mean duration of six months.

iii) Of those in employment, 44.2% were in non-manual work.

E. Socio-Cultural and Economic Background

Looking briefly at ten major donor countries we noted that:

i) These countries are plural societies with very diversified ethnic groups.

ii) With the exception of the Philippines which was an American colony, all were once British colonies, while
Hong Kong still is. They had inherited both her legal, educational and governmental systems and the English language had been imposed upon them to allow common understanding among a people with very diversified languages and very varied dialects. It also welded the different nationalities together. English is also the medium of instruction in their schools whose educational qualifications are equivalent to British ones. All their primary education is free and among some, secondary education too is free. Most of the countries have a high literacy rate.

iii) These countries have sub-tropical or mild climates disturbed only by natural disasters like typhoons, earthquakes. Their festivities are crowd orientated while those in Britain are home centered.

iv) With the exception of Hong Kong and Malaysia, all other countries are still very dependent upon an agricultural economy with more mouths to feed than they produce.

v) With the exception of Guyana, all countries are overpopulated and emigration is needed to strike a balance.

vi) Unemployment and underemployment are plaguing their economy.

vii) There is a wide spectrum of religious beliefs and practices but emphasis has been particularly paid to two kinds because of their possible effect upon these trainees.

a. Hinduism which prohibits pork and beef eating among its adherents.

b. Islam which requires its followers to say prayers.
five times daily if possible and to fast during the month of Ramadan. It also prohibits its followers from eating pork.

viii) Their family structure is very similar to the Victorian era i.e. large extended family ties, very authoritarian in raising their children. It requires from their children unquestionable obedience and demands respect for ancestors and requires the old and the sick to be cared for in the family circle. Old people's homes are unheard of.

ix) Their people are health orientated. Owing to the expense of medical treatment doctors and nurses as healers are held in high respect compared to the U.K. Owing to lack of sufficient doctors in the hospitals, their nurses do more clinical work than British nurses. For example, they give intra-venous injections, take blood samples, do superficial stitching, the midwives suture the episiotomy. Nurses are trained to carry out skilled tasks which here are usually carried out by doctors. Another group of workers carry out the "dirty" and domestic jobs i.e. giving bedpans, washing and cleaning sluices, floors etc.

x) Despite the shortage of nurses and doctors, it is not the lack of suitable candidates that limits recruitment. They can pick and choose among applicants with very high qualifications and their minimum educational requirements are higher than in Britain.

xi) Apart from the Philippines, they pay allowances to...
their trainees and their training systems are similar to the British pattern, providing general, psychiatric and midwifery courses. The Philippines, on the other hand, had inherited the American system and the trainees have to pay the training fees.

xii) Their national dietary and eating habits differ from the British.

P. Basis of Admission: Choice of the U.K.

Motivations and Expectations

i) The trainees had at least five routes whereby to come to the U.K. Apparently 75% wrote direct to the hospital, 12% used private agencies, 12.5% signed up with government agencies, 4% came as tourists and 2.3% as full-time students in higher education, as dependents, domestic. Of those who wrote direct 46% obtained the address from their relatives or friends already in a hospital here. On average each applicant had written to 14 hospitals.

ii) Trainees gave a variety of reasons for coming to a nursing course in the U.K. Some of the reasons were positively linked to motivation to nurse.

iii) While accepting nursing training opportunities in the U.K. 68% had also considered another country. The majority had thought of enrolling for a nursing course in Australia, U.S.A., Canada. Half of these had found it difficult to obtain a training place; others were put off by the training fees or lack of relative or
friends there.

iv) Motivations. Most of the trainees saw nursing as their career because they would still choose this profession should they have a free choice. On the other hand, they did not have much say as to which type of hospital, training to go to. Most showed a high degree of motivation to follow the nursing course having not worried about nursing working conditions before they came.

v) Expectations of Nursing. The majority had no idea of what to expect of nursing in the U.K. though half of them anticipated it to be the same as at home; i.e., prestigious and respected with high social status, hard and interesting but with no domestic work. Another quarter had hoped that nursing would be better here than at home with a friendly atmosphere. One important aspect of nursing here they did not expect was the fact that trainees and qualified nurses are required to carry out a certain amount of domestic or "dirty" work, in particular giving bedpans, cleaning floors, sluice, washing plates etc.

G. Information and Knowledge of Nursing in the U.K.

1) In the absence of clear factual information, the trainees relied heavily upon the "bush-telegraph" — news from friends and relatives who possibly to bolster for their own egos painted a rather easy and rosy life. It turn
turned out that it was the hospitals which did the selection. On the other hand, a small group would come at any cost and let the type of nursing and course worry them later. Most of them had hoped to be general student nurses.

ii) Most trainees knew that there is a difference between general and psychiatric nursing but their notion of "difference" is unacceptable here. They in fact believed that psychiatric patients are "mad" and need to be "locked behind bars" but they were convinced that the nursing care would be the same as general nursing. Virtually, all trainees were unable to distinguish between psychiatric and mental handicap nursing and they were also ignorant of the value of the two and three years' course though they knew there is a disimilarity because S.E.N. is quicker.

iii) There was a serious doubt raised at the value of the information which was being given to the trainees as most claimed it to be too brief, vague and rosy. Very few knew the minimum entrance educational qualification for both the pupil and student nurse course.

H. Arrival Perception and Experiences of Nursing in the U.K.

i) Most trainees were satisfied to follow the nursing course but not happy with the nursing curriculum. Most students and pupils in psychiatric and mental handicap nursing wanted more theory while those in general nursing wanted more practicals. They found it difficult to follow the course consistently because they were required to adopt
different approaches to nursing procedures in the schools and in the wards. For these reasons, most trainees in the psychiatric and mental handicap nursing of both courses and the pupils in the general nursing as well, felt insecure because of the qualification they would get. Whereas, virtually all general students were happy with their future prospects.

ii) Many complained about their induction into the hospital and the various hurdles they had to clear during the first forty eight hours e.g. to take G.N.C. test to start duty or training. They felt that all this was more or less hurried through with little concern for the new entrants. The aloofness of the nursing administrators and their supervisors on the wards were heavily criticised but the G.N.C. test received most severe critical remarks. This test appeared not to be relevant to "0" levels as many who failed had more than 5 "0" levels.

iii) The trainees put a high value on cooperation and friendly atmosphere with their nursing colleagues and others in the hospital and their apparent absence attracted copious criticism. The overall working conditions of their respective hospital were felt to be very poor and the aspects of working conditions most trainees were critical of were: inadequate social life, being treated as a child in their private life, sparsely furnished rooms to stay in, no health care to sick nurses and the official abject attitudes to sick nurses, inadequate nursing staff, inadequate equipment and space to work in, particularly in the psychiatric and mental handicap fields. Similarly
there is a contradiction between their complaints about authoritarian discipline in the hospital and their authoritarian family structure. How can we explain this contradiction? or their complaints? Could it be that while it is authoritarian in the hospital, it is liberal in the society here and they prefer the latter?

I. Atitudes to Nursing Courses

Evidence showed a significant relationship between attitudes towards nursing and length of time in the U.K. (by the year of training). Newly arrived trainees were less critical of the course, theory and practice but as they progressed they became increasingly critical. On the whole, the hospital was not seen as receptive and adaptive.

J. Aspects of Nursing with which most Trainees were satisfied were:

1) To be a nurse of whatever type, they were in.

2) In some hospitals (particularly psychiatric and mental handicap), trainees were allowed some initiative concerning care of the patients and this was very much appreciated. Similarly they enjoyed the relaxed and informal atmosphere on some wards between the nurse in charge of the ward and themselves and the patients.

3) The trainees were happy with the training programmes which were well planned and intensive and were carried
out accordingly both in the school and in the wards. However, this was to be insignificant when compared with the whole sample as these very satisfied trainees belonging to one particular general hospital. This hospital has just received teaching hospital status and it had its full complement of tutorial staff. It was also in this hospital that trainees felt very satisfied with the arrangement in their nurses' home. 4)

4) Few who received orientation courses were very happy with them.

5) In the few hospitals that have equal numbers of local and overseas trainees, the latter were satisfied with their social adjustment.

What attracted the trainees?

1) Basically, home conditions and the inadequate supply of indigent applicants in Britain were the driving forces behind the yearly exodus.

2) The historical link of their country with Britain provided a favourable image to prospective applicants.

3) The world wide recognition of SRN qualification received in the U.K.

"This nurses' home we visited was new and was built with the clear indication that the residents were to be trainees i.e., learners and the rooms compared very well with the rooms of university residential halls for students. They have proper writing and study desks. They provided a very conducive atmosphere to study and relaxation."
4) Opportunity to travel abroad and to see for themselves the Britain they had heard so much about during their school days as well as from returning persons from Britain.

5) The training allowance played an important part since not only would they acquire professional qualifications but would also be paid while doing so. This also provided an opportunity to be independent.

6) The common language.

7) Easy access to the UK due to the increasing needs of the NHS hospitals for more nursing staff.

These findings suggest a number of hypothesis.

a) The supervising function is not perceived as having anything to do with their training.

b) Lack of proper pre-arrival information induces these trainees to have too high and unrealistic expectations.

c) Too high and unrealistic expectations over-ride their motivations or blur their intention which the nursing administrators interpret as lack of interest and motivations.

d) Human relations with colleagues in particular senior
members and work conditions are the basis of this group's perception of their job satisfaction.

e) Lack of proper pre-arrival information and induction procedures heightens these trainees' tendency to seek out their own kind for friends.

f) Equal promotion opportunities are integral part of these trainees' job satisfaction.

g) The degree of satisfaction a nurse feels towards his training is significantly related to his degree of social and personal adjustment he achieves in his new environment.

**Suggestions**

1) Pre-arrival information is essential to familiarise the prospective trainees with what to anticipate in terms of the English way of life, climatic and social customs, the great English attitude of passive tolerance, the different types of nursing and training as well as their value for careers. This is already in preparation by UKCOSA ¹ in co-operation with RCN.² DHSS has already instructed all hospitals to send a copy of its leaflet entitled "Living in Britain" ³ to all prospective trainees.

1. United Kingdom Council for Overseas Students Affairs.

2. Royal College of Nursing.
However, evidence suggested that this instruction was not always carried out. Perhaps the cost to a hospital which recruits almost 100% of their trainees from overseas, could prove prohibited. To avoid unnecessary expense to the DHSS, the Department could send sufficient copies to the offices of BHC or BS abroad, especially in the major donor countries. Once in those offices, the future Central Recruitment Centre (at present, the individual hospital) would then simply inform the applicants where to obtain the pre-arrival information. To ensure that the applicants read the information, they should be asked to complete their application form in their own hand and to write a summary of the different types of nursing and training and their values. At the same time, more information regarding nursing should be given, such as who is classified as a mental handicap or psychiatric person? and what type of nursing is involved or is it nursing or care? What are the career prospects in their own country or in the UK? We all know that such information is essential, we know too that very often little attention will be paid to it. (See footnote).

Footnote: "I have to admit that even if I had been given a truthful picture of life in London, I do not suppose I would have believed it. Suppose I were to go back to Delhi now and tell another; 'Over there life was very hard.' He would reply; 'Why do you chatter rubbish to us? You have been so prosperous yourself and you are jealous in case we may become the same. That is why you talk like that to discourage us.' But if the man were to come here and see things for himself he would no doubt complain to me, 'Why did you not warn me that life in England was going to be difficult?' And if I retorted, 'I told you so, but you did not listen,' he would say, 'Yes, but how could I understand? I did not believe the truth you told.'" 1

2. Our evidence demonstrated that these trainees went through a long process in order to obtain admission to a hospital. Some resorted to private agencies which demanded extortionate fees for their services, some of the parents resorted to personal influence and bribery. Many had to write to over ten hospitals and wait an agonizing period between their first application and an eventual offer of a training place. Most trainees did all these without any real knowledge of the different types of nursing and training, the location of hospitals etc. At the same time, in many developing countries the goal of attaining a foreign education is something in the nature of an obsession. The belief that overseas training will confer on them prestige and opportunity for more rapid promotion is not groundless, although in many countries there is growing pressure to leave through legalised discrimination of one ethnic group against another or through population pressure. The present selection procedures designed for the indigenous applicants are not practical because of the long distance involved and they are questionable on the grounds of reliability. The submission of personal references is not an accurate guide. How can we check that these...
references are not forged? Although there is very little divergence in the educational levels, can we rely solely upon academic references? Some hospitals require prospective applicants to write a long and supposedly "searching" application. How reliable is this method? As in the case of personal references it invites deception. Some malpractices like alteration of educational certificates were already found. A more effective method is imperative and a central recruitment centre is the first step. The King's Fund Centre has published a report in favour of a Nursing Admission System for Overseas Applicants (NASOA). Its mechanism, usefulness and desirability have been thoroughly dealt with in the report.

In the past, some hospital matrons had their own informal methods of recruiting potential trainees from Ireland. They went out to recruit them personally. Without prohibitive cost to the NHS, it should be possible to plan a brief annual or bi-annual visit by at least two experienced recruiting officers - tutors in particular would be most suitable - to the major donor countries. In some cases two visits may be necessary, thus concentrating recruitment to two intensive periods, for example, every six months. Such recruiting officers are to be selected annually to allow wider dissemination of

knowledge of widely varying overseas conditions among the nursing administrators as a by-product of the visits. They can fulfil two important aims. First, a direct and total appraisal of these overseas applicants personally both on academic and personal suitability for the nursing course. Secondly, to establish a better and closer understanding with the indigenous governmental bodies and the DHCS or DEs, as to what British hospitals require of their prospective trainees and what the former have to offer in return. The knowledge of the socio-cultural and economic varieties of the developing countries thus gained would be of incalculable value in future planning for overseas trainees for a smooth adjustment here. The knowledge will help the planning of the curriculum for the orientation courses. Unfortunately, co-operation from the other end is also essential and it may be wise to liaise with local agency, if any, or with the DHCS or DEs and this could also ensure wide publicity and an informed choice of candidates. The expenses could be partially met by a fund contributed by the hospitals here. The contribution should be based on what they would have spent on postage and secretarial expenses. Candidates should similarly contribute a token fee (about £3) which would have been spent on postage stamps and other liabilities. Successful candidates should pay an extra fee later but should not add up to more than £5 per candidate. This method should be explored as an alternative to the NASOA.
3. The above suggestion overlaps this one. The HIC or DC should offer information and advice on appropriate training, types of nursing available in the UK, the requirements for achieving them, the allowances paid, information about the location of British hospitals and climatic conditions. It should give film shows about nursing conditions, life in general in the UK, (the hospitals in the films should be selected at random and information should be factual).

What has been proposed above implied that Britain would maintain her present recruitment policy of trainees from overseas.

4. Reception at the airport

Since most trainees come by air and arrive at the London airports, an experienced person should be available at the airport's enquiry desk (perhaps a sign like "nursing students/student's enquiry", could be displayed). The person should be practical and sympathetic. This is possible as the British Council already does just this; sending a representative, if she is requested, to the airport to receive the students and then to direct them which route to take to reach their final destination.

In the next two paragraphs it will be suggested that the counselling service could encourage the hospitals' nurse trainees themselves to volunteer for this scheme.

5) Orientation

All trainees should come to Britain at least three months
prior to their training to allow them time to settle
down. During this period they should spend some time
on the wards and in the orientation courses. The
first week and then last week of each month should be
spent in orientation courses. Initially, the orientation
should be confined within the hospital and its
immediate surroundings. The first day may be best spent
in the nurses homes meeting other trainees; (A map of
the hospital should be made available) and in familiar-
is ing themselves with the routes to the dinning room,
cafeteria, nursing administrators office, etc., showing
them how to use a knife and fork will save embarrassment.
This can be best done discreetly by another overseas
trainee (if possible own national). The established
overseas trainees should be encouraged to participate
in the orientation course at least once.

Gradually, they will be introduced to different departments
giving more emphasis to the departments they will need to
know immediately. Perhaps from the third day onwards,
they may be shown around the hospital and in
particular to the post office, bank etc. It may be
useful to confine talks by different heads of departments
to a maximum of two per day to allow the information to
sink in. During the first few weeks of their arrival,
trainees (including indigenous recruits) should not be
put into high dependency wards, (or generally known as
throwing them into the deep end). Experience of these
types of wards is essential but should be delayed until
towards the end of their three months. Their use in the wards should be well thought out and be seen as ongoing orientation rather than as providing a pair of extra hands. Their move to another ward should also be in the same context. During the following weeks' orientation courses, the trainees should be encouraged to question about their work and talk about their experiences so far. The course could now branch into the community visiting English families, lectures on British socio-economic history and her contemporary society. Success in cushioning any cultural shock and of the orientations depends however very much upon informal guidance and genuine desire to help.

6. Loneliness

It appears that life is not particularly colourful in the nursing profession. Loneliness is a serious problem among nurses owing to the nature of work which involves physical and mental fatigue and makes work and sleep the order of the day. This loneliness is more serious among the overseas trainees because they have to live in the nurses' homes far away from one's family and friends (local trainees who leave one town to another experience similar problems on many aspects as well). It intensifies in time of distress, i.e., no news from home for a few weeks, problems with their training, colleagues, superiors and other workmates. Part of the loneliness could however be self-imposed through their ethnic and socio-cultural heritage which constantly reminds them that they
are different. Offers of help will therefore be repelled. We learnt too that only a handful would approach hospital staff to discuss their problems. Somehow, positive experiences are very desirable through socio-cultural activities, participation in volunteer work, e.g. receiving new arrivals, participating in the orientation courses. These will provide ample opportunities for leadership and will make them feel being accepted as one of them.

7. Counselling

All the findings suggested that counselling in the hospital is very urgently required. The counselling would have several functions. Some of the main functions would be, in addition to counselling;

(a) to assist the trainees in their adjustment in a new environment (for both overseas and local trainees);

(b) to maintain high level of motivation to nurse which was shown throughout the study because such a service will make them feel that they are being looked after while in a foreign country; the ultimate benefit is better delivery of nursing care to the patients;

(c) to provide assistance and co-ordinate suggestion.
Most important, counselling service must be independent of nursing administration. The counsellor is in the best position to plan the orientation courses and a further by-product would be closer identification and relationship of the trainees with the counselling service.

When such a service is established on a nationwide basis, closer co-operation between hospitals could be achieved specifically in the reception of trainees at the airport. Thus, if a hospital is too far to send someone, its counselling service can contact its counterpart nearest to the airport to co-ordinate reception.

We learnt that most trainees spent their sparetime indoors; this suggests that a volunteer committee could be set up within the counselling service, which both indigenous and overseas trainees should be encouraged to join to function in suggestion No. 6. Trainees would only be too pleased to contribute and many subjects welcomed the ideas because - "At least I can do something useful instead of wasting my time doing absolutely nothing." But many also felt that the hospital should lay the foundation stone first.

1. In one particular hospital, the trainees initiated a working party with aims of requesting their hospital to set up an orientation course and a counselling service. All their enthusiasms were dashed at the reporting stage. It was told that "although the report was praised, all the recommendations were rejected, mainly because the senior staff were not flexible minded and were against any innovation of personnel." (Minutes of the 17th meeting of the Nursing Sub-Committee at UKCOSA 5.8.75).
8. **An association to maintain own interest**

A Student and Pupil Nurses Association (SPNA) should be formed at district or area level depending on the size of students and pupil population. Membership should be compulsory on registration as a trainee and an annual subscription fee deductable automatically from their first training allowance pay for both local and indigenous trainees. A fee of £5 is reasonable to be used to establish and improve recreational facilities and equipments; to provide transport cost for inter-hospital games, to promote inter-hospital games. Further monies could be raised by fetes, dances etc, which incidentally encourage co-operation and assimilation. This association would first of all need to be given due recognition by the nursing administration and the latter would need to accept its representative as bona fide.

Because of the nature of its work, the hospital should grant reasonable request for time off to take part in the association's activities or to participate in competitions. The primary aims of the SPNA should be orientated towards socio-cultural and welfare activities, to promote integration and assimilation among varied nationalities. The Association could contribute valuable assistance to the counselling service in the running and informalisation of orientation courses and volunteers to the reception committees for new arrivals.
9. The Intermediate Bodies

The High Commission or Embassy of the overseas trainees in the UK should be brought to participate more actively in the welfare of their nationals. During the orientation period, the trainees should pay a visit to their High Commission or Embassy and this should be followed by an invitation from the High Commissioner or Ambassador to attend a social function to be organised. This official body must seek closer co-operation with training schools and also to provide the latter with leaflet of its future events. At present the Hong Kong Government Office despatches fortnightly a weekly newsletter free to all her nationals here in an attempt to forge a link. This is automatically sent to the new arrivals because she receives an early warning that such and such a person will be coming here in the near future. So far it has proved very popular and very much valued by the recipients. The newsletter purports to keep immigrants informed of the news and of the new developments in Hong Kong in their absence. It also carries some international news of the week.

This should be extended to all other foreign governments here, and the newsletter should also include future events. Similarly, the trainees' government should be aware of their responsibilities towards their people in foreign countries. One Malaysian student complained that: "The only time I hear anything about my government is when they want us to go back to practise nursing!"
10. Entrance requirements and course contents

Data suggested that an average trainee came with at least 5 'O' levels. This is in fact much higher than the official requirements. This also indicates that candidates of this calibre or even higher are available for quite a while unless their home situation changes drastically overnight which is unforseeable. This high academic entrance qualification should be maintained and will ultimately contribute towards the professionalisation of this "caring profession." This should also apply to the local entrants lest we should be accused of dual policies. The GNC test needs further research. However, with high academic entrance qualification, the GNC test would not be necessary. As it is suitable to local entrants it could be continued as it is now for the local entrants without the educational qualification as Briggs pointed out that; "suitability should not be determined by 'O' levels alone." However, it is not viable to admit overseas applicants without the formal education. For this reason, the GNC test should be confined only to local applicants without the formal education. What is working against the overseas trainees is the spoken English. Otherwise the educational levels of the overseas compared with the British are not very divergent — after all, they were a produce of British colonization. (A clause should be inserted in the
application form stating clearly that applicants with faked credentials will be returned home once discovered without further consideration. Differences in frames of reference and in values may mean that one does not really understand what the other is trying to communicate though virtually all the trainees have been taught in English. This could be easily rectified by an intensive course in spoken English during the first three months of ongoing orientation together with working on the wards. Hospitals should indicate their offers clearly and should not change their minds once the trainees have arrived.

Regarding pupils, it is well known that many well-intentioned organisations disapprove of recruiting overseas persons for pupil nurse course because most probably the SEN to be gained has little or no value at all in their home country, as would the three years' course in psychiatric and mental handicap nursing in particular. What is important here is to drop the official image that accepting overseas personnel for training is an "aid" to the sending countries and accept that NHS hospitals need their services. As a matter of fact, the Home Office encourages newly qualified nurses to stay behind by granting permits to stay. There is also evidence that most qualified overseas nurses stay in the NHS hospitals. ¹ All pupil trainees should have at

least two 'O' levels. This will benefit themselves because they will be able to adjust better than those without formal education.

Briggs modules when in operation, should reduce much of the medley in the present nursing curriculum. In the meantime, it is suggested that the contents for psychiatric and mental handicap nursing should be changed drastically and geared to the care demanded by these patients. (i) More theoretical teaching should be given with particular emphasis on mental and personality development, sociology of nursing, of mental illness and mental handicap, interpersonal skills, communication techniques and team concepts. (ii) Practical theory should include rehabilitation closely identified with the outside community. (iii) It is also difficult to fit pupil nurses in these two groups of care because they do the same thing as the students. We would rather question the utility of this rank here. (iv) More systematic teaching programmes in the wards with built in teaching sessions. Ward sisters should have refresher courses to keep abreast of new practices and be taught that questions from learners are not critics, but rather as groping for answers. (v), a liaison representative should be allowed through the SPNA, in the Nurses Education Committee to promote closer cooperation and better understanding between the tutorial staff and their learners. A meeting at the end of a study block would be most appropriate to hear the trainee's viewpoints and evaluations. Through this dialogue, much
could be done to improve training curriculum.

II. Democratization of hospital administration

Hospitals are often victims of emotional decisions making. This is so, perhaps mostly due to the very nature of the humanistic service they provide. Nursing has also followed very closely with the medical profession. Does the nature of work itself produce a hierarchy and almost autocratic institution akin to army or military institution? Most of the findings clearly indicated that the hospitals appear inflexible and autocratic to new comers who felt more or less compelled to conform, that nursing administrators exploit the submissiveness of the Asian trainees thus perpetuating rigidity and autocracy. The trainees are submissive because their social customs have indoctrinated them to submit to (more appropriately to respect) authority and their seniors. Democratization of the administration would increase the trainees' interest (trainees in general).

A weekly ward meeting would be very beneficial. Everyone should be involved in seeking solutions to problems, on a routine basis. Those meetings should provide the opportunity for listening to each other and for trying to understand different points of view. If the nursing staff resist the attendance of other or lower grades (on grounds that they do not have direct contact with patient care) the latter could be excluded but invited occasionally to discuss their grievances and contribute
their observations. Such a meeting on a regular basis would help to achieve stronger identification with the nursing organisation, develop stronger loyalty and high morale. High morale requires that all nursing staff and others, indirectly concerned with the patients' welfare, realise the work of each individual member and accept each other as equals irrespective of each other's education, skill, training and knowledge.

12. Better co-operation

Coming right down in the nursing status, nursing assistants and part-timers were accused of being incompetent, lazy, shirking and unco-operative. They were seen as neglecting their proper functions because "they sit around, smoking and chatting to the nurse in charge of the ward," in particular the old-timers. It is suggested that the nursing assistants and part-timers should be moved at regular intervals for professional progress, to lubricate the staff relationship on the wards.

13. Nurses' Homes

It appears that there is too much "supervision" or "snooping" —"not referring so much to disciplinary requirements in periods of duty, but more to the restraints imposed upon a nurse's freedom in her personal life when she is not on duty," 1 In 1972, another report

recommended further relaxation of supervision of nurses' residences. The administrative arrangements had received a significant criticism. They felt they suffered from unnecessary and childish limitations in their free time while in the wards they were trusted with human lives, i.e., they were put in charge of the wards sometimes on their own even in their first year or with a nursing assistant during either day or night duty. An additional writing table in their room and upgrading some of the old rooms, could be a first practical step to restore feeling of belonging.

One of the imperative of bureaucracy is ascension to next position in the office, must be through passing a prescribed course of training. Nursing as a profession should hold similar procedures, but should nursing be lumbered with bureaucracy.

14. More information like sex, age, country of origin, type of nursing and training, should be recorded and kept at regional level. These could be incorporated to the existing forms CIII 131 A and B.

15. The need for more qualified tutors appropriate to the type of nursing is a most urgent need.

3. See Appendix E
16. We all desire our nurses to think critically, show intellectual curiosity, empathy and compassion. These trainees are most likely to lack severely in the first two and a deliberate remedial work is very desirable to allow them to achieve satisfactory performance there. This may involve tutorial assistance, opportunities to see, read and digest examples of various kinds of written materials and projects so that they can draw inference.

Implications of the study

a) There is no evidence that overseas trainees are using nursing as a stepping stone to another occupation or to higher education. On the other hand there is clear evidence that most overseas trainees will continue to practise nursing not at home but in NHS hospitals here.

b) Motivation is very abstract and difficult to measure but ample evidence suggested that though unemployment might be the primary cause for mass emigration, these trainees were very motivated to follow the nursing course.

c) There is some evidence that length of sojourn is related to the attitudes of the trainees.

d) There is no significant difference between sexes, country of origin in the findings.
e) Many trainees felt unable to adjust happily in the pupil nurse courses because they held the qualifications for students' training. They were relegated to pupil training because they failed the GNC test.

f) Present recruiting policies as well as nurse training programmes tend to present an over dramatised and unduly romantic picture of what nursing really is like. Both these policies and programmes are unrealistic and dangerous because they create frustration and dissatisfaction with nursing among the trainees.

**Suggestions for further research**

1. Does contact between cultures lead to cultural diffusion and change, to a process of learning and adjustment? If so, what is diffused and changed?

2. A large survey into qualified overseas nurses in the UK, looking into the patterns of their moves in the nursing profession. Are the moves horizontal or vertical? What qualification have they obtained since their first one? What are their attitudes to nursing? Why do they stay behind after qualification? Are they satisfied with their present position?

3. Similar studies for those who have returned home since their qualification. Why did they choose to return home. How do they compare with their fellow nurses who
"prefer" to stay behind? Have they gone into nursing or other occupations?

4. A study into the returnees, about their experiences in the UK, the utility of nursing gained in the UK for their own country. How do they readjust themselves? What sort of problems do they meet? This information will be very valuable to the Counsellors and career advisors here.

5. How effective are the orientation courses as a means of helping the overseas trainees to adjust themselves in a totally different society?

6. A study into the ex-overseas trainees, what can we learn from them? Why do they leave? How do they fare in the community?
Please note that most trainees in the study had used more than one route
The person comes here as a tourist first and then makes an application which usually takes about two months before he starts at the hospital if successful.

1. Tourist visa is issued only to persons buying return ticket and with guaranteed self-supporting financially or being maintained by someone here. The visa grants permission to stay up to 6 months.

2. This visa is stamped special conditions to stay in U.K. that he stays in his employment. A fresh permission must be sought before he can go to another employment. The visa must be renewed every year in some cases in less time for at least 4 years.
The person, whilst still at home, applies and takes between 6-12 months for an application to be finalised.

Goes to BEC* for hospital addresses/ Given hpl. addresses by friend/relative already here/ Obtained address from nursing Journals, and writes with educational & personal details

Re-applies to other hospitals

if not considered

Receives application if considered. Fills and sends back all essential forms and documents.

on waiting list/ fails on medical or educational grounds

If successful, with passport & letter of acceptance from hpl., goes to his Min. of Ed. to obtain sponsorship

Goes to the BEC to apply for visa together with sponsorship letter & letter of acceptance from hpl.

Offered interview and visa granted

preparations to come here

U.K. Immigration office. Passport stamped with the student's visa.

* BRITISH HIGH COMMISSION.

1. Sponsorship is a form of Certificate of Recommendation(applicable Malaysian candidates mostly)
ROUTE THREE

Applicants from Philippines. Application takes about 6-12 months. Information about nursing is obtained from B.O.A.C.(B.A.C) agency where advertisement "England badly needs student nurses" is displayed.

First given three hpl. addresses to write by the agency. Letter sent with personal & educational details

Re-applies to other hpl addresses from agency if not considered

If not considered receives application form and returns it with necessary documents.

If considered receives application form and returns it with necessary documents.

If succeeds, offered a post and work permit

If succeeds, offered a post and work permit

Applies for a passport (letter of acceptance & work permit from hpl. are needed as proof)

Applies for visa at the B.E. (needs to show work permit)

Offered an interview and visa granted

Preparations to come here

U.K. immigration office, passport stamped with permit to stay and the student's visa.

*agency usually gives a sample of the application letter to help the applicants

+British Embassy.
ROUTE FOUR

Applicants using private agencies and takes similar length of time as by other routes except most administrative and paper works are carried out by the agencies while the latter are being paid a fee of varying amounts ranging from £25 to £75.

--- Diagram ---

1. Approaches a private agency for assistance to obtain a hpl. place in U.K.
2. Informed by agency to see Minister for sponsorship, the E.H.C. for visa. Pays fees.
3. Agency will try again as the fees are payable when the place is secured. Unless if fails - failure is due to educational or medical reasons
4. Preparations for departure if visa and other papers are in order (usually it is and no trainee has to repeat application.
5. Other stage same as previous two routes.

N.B. So far it appears that private agencies are wide spread in Mauritius and Malaysia. But according to the trainees bribery to the government officials are part and parcel of their life in their own countries.
ROUTE FIVE

Applicants using government sponsored agency e.g. (Nursing Selection Committee in Mauritius, Scholarship Secretariat in Ghana, Ministry of Labour in Jamaica) and takes similar length of time as other routes except that it is similar to route four i.e. all administrative and paper works are done for the candidate provided he is willing to wait.

Gives name, personal and educational details to the government sponsored agency in an application form.

Sometimes the candidate may be given hospital addresses to apply then it will be similar to route two. Otherwise he waits until the agency informs him of a vacancy.

Successful candidate attends an interview.

If succeeds, proceeds to apply for passport, visa etc and preparations for departure.

As previous routes.

Re-applies to other hpl.s., or takes route two at the same time.

if fails or usually in the meantime

Please refer to footnotes in route four.
APPENDIX B
Dear Respondent,

I am writing this letter to accompany Mr. Lee's request to cooperate with him in filling up his questionnaire. As he explains in his letter, he is a Research Fellow in this department and I am his supervisor.

As his letter explains, Mr. Lee himself came to this country as an overseas trainee nurse. He encountered a number of difficulties which he believes are avoidable and for this reason he has now chosen this area to study. In order to do this, Mr. Lee has really no other way than to interview as many people as he can and to supplement these interviews by a survey covering as many people as possible. But the survey also has to cover a very wide range of matters, some factual and some concerned with your own experience and opinions about your experience. The result is the rather bulky document which accompanies this letter. We have tried it out on a number of people and we find that it really does not take more than half an hour to fill up, and I am sure that you will find that half hour well spent.

You can be absolutely certain that anything you write in the questionnaire or say during interviews at a later stage will be kept absolutely confidential. No names or names of hospitals will be mentioned in his report. I think there is every chance that the outcome may be of help to student nurses coming in future from overseas and may even be of help to you and your present colleagues.

I do hope therefore that you will find the time to co-operate and that you will return the questionnaire in the stamped-addressed envelope provided as soon as you can. I am sure that your experience, like mine, is that it is best to fill in a questionnaire as soon as you receive it. If you put it aside you tend to forget or to become more and more reluctant to bother. So, if you can sit down and do it today or tomorrow, please do.

Yours sincerely,

[Signature]

A.B. Cherns.
Dear Respondent,

May I ask for your help in a survey I am making? I am trying to find out a few important facts about the problems overseas nurses are facing.

But first, let me introduce myself. I am a research fellow at the above university. I came to England as a student nurse in 1966 and was trained at Cell Barnes Hospital, St. Albans, Herts. I left the hospital in 1970 to read for a social sciences degree. Now I am hoping to read for a M.Sc. degree by research.

I have chosen for my research topic to study the problems of overseas nurses. During my own time as a trainee I had experience of problems of many kinds, both dissatisfactions and satisfactions. Because of the nature of the work you are involved in, it is very difficult for your problems to be known other than among yourselves. In the hope that I can make helpful suggestions to improve matters, I would like very much to know more about your own experiences, whether bad or good. For this reason, I am handing out questionnaires to a cross-section of overseas nurses in England, and I sincerely hope that you will be willing to co-operate in completing the questionnaire enclosed. To make sure that I hear all points of view, kindly post the questionnaire back to me after you have completed it. I have enclosed a pre-paid envelope for this purpose.

I would like to know your own views. Please do not ask anyone else to fill the questionnaire or I shall not have a true cross-section of opinions. Although the questionnaire appears thick and heavy I hope you will find the questions easy and straightforward to answer, requiring a tick (✓) or numbers in the appropriate box(es) beside each question. It should not take up more than 30 minutes of your time.

One important thing: this study is carried out by myself alone. Therefore you can be assured that everything you write down will be kept confidential.

In the event of publication of my findings, which is my aim so that the problems of overseas nurses can be highlighted in the proper channels, your name and the name of your hospital will not be revealed.

It is simply between you and me. My only connection with your PNO is to request permission to allow me to give you the questionnaire. I feel sure that you will realize the importance of this survey and the fundamental part that you can play in it, not only to help yourself but also future overseas nurses. Therefore, please return the questionnaire as soon as you have completed it. Without your co-operation and trust this research study cannot achieve its aims.

... / Because
QUESTIONNAIRE FOR PRE-REGISTRATION OVERSEAS STUDENTS
AND PUPILS IN TRAINING

To complete the questionnaire, simply tick (✓) opposite correct e.g. in question 1(D) you tick (✓) box 1 if you are female or in 1(B) write the number of years or months in the box provided.

1.A. WHAT IS YOUR COUNTRY OF ORIGIN?

1.B. HOW LONG HAVE YOU BEEN IN UK?

1.C. WHAT WAS YOUR AGE ON YOUR LAST BIRTHDAY?

1.D. WHAT IS YOUR SEX?

1.E. WHAT IS YOUR MARITAL STATUS?

2. HOW DID YOU ENTER UK? AS:

3.A. BEFORE YOU CAME TO UK WHAT WERE YOU DOING AT HOME?

IF YOU WERE IN NEITHER FULL- OR PART-TIME EDUCATION, GO TO Q.3D
3.B. WHAT COURSE OF FULL/PART-TIME EDUCATION?
   GCE 'O' level or equivalent 1
   GCE 'A' level or equivalent 2
   Other, please specify .... 3

   Other:

3.C. ARE YOU STILL PURSUING THIS COURSE HERE?  
   Yes .... 1
   No .... 2


3.E. IF EMPLOYED FULL/PART-TIME, FOR HOW LONG DID YOU WORK BEFORE COMING TO UK?

3.F. HOW MANY JOBS HAVE YOU HAD SINCE LEAVING SCHOOL AND BEFORE COMING TO UK?

4.A. AT WHAT AGE DID YOU LEAVE FULL-TIME EDUCATION AT SCHOOL?
   Under 15 1
   16 .... 2
   17 .... 3
   18 .... 4
   18+ .... 5

4.B. WHAT EDUCATIONAL QUALIFICATIONS DID YOU HAVE BEFORE YOU CAME TO UK?
   'O' level or equivalent 1
   'A' level or equivalent 2
   Sat no examination .... 3
   Other, please specify 4

   Other:

4.C. IF 'O' LEVEL OR EQUIVALENT, HOW MANY SUBJECTS DID YOU PASS?

4.D. IF 'A' LEVEL OR EQUIVALENT, HOW MANY SUBJECTS DID YOU PASS?

4.E. WAS ENGLISH LANGUAGE ONE OF THE SUBJECTS YOU PASSED AT 'O' LEVEL OR EQUIVALENT?
   Yes .... 1
   No .... 2

IF YOU ARE NOT ATTENDING ANY COURSE BESIDES NURSING, PLEASE GO TO QUESTION 6 OR 7 WHICHEVER APPLIES TO YOU

5.A. WHAT OTHER COURSE ARE YOU FOLLOWING BESIDES NURSING?
   'O' level ........... 1
   'A' level ........... 2
   Other, please specify 3

   Other:
5.B. HOW DO YOU PURSUE THE COURSE?

- At Technical College
- At College of Further Education
- At Polytechnic
- By correspondence
- Other, please specify

5.C. HOW IS THE COURSE STUDIED

- Evening class
- Day release (full day)
- Day release (half day)

6.A. IF YOU HAVE COMPLETED ANY GENERAL EDUCATION COURSES SINCE YOU ARRIVED IN UK, PLEASE STATE:

- SUBJECTS:
- EXAM(S) SAT:
- EXAM(S) PASSED:

6.B. WHAT DO YOU HOPE TO DO WITH THE QUALIFICATION(S) OBTAINED THROUGH PRIVATE STUDIES?

7.A. HOW DID YOU FIRST APPLY TO COME TO DO NURSING IN UK?

- Wrote direct to hospital
- Through agency
- Government organization
- Other, please specify

7.B. IF YOU WROTE DIRECT WHERE DID YOU OBTAIN THE ADDRESSES?

- Friend at hospital here
- Relative at hospital here
- Other, please specify

7.C. APPROXIMATELY HOW MANY HOSPITALS DID YOU WRITE TO?

7.D. PLEASE DESCRIBE AS MUCH AS YOU CAN REMEMBER OF YOUR EXPERIENCE OF APPLYING FOR A HOSPITAL PLACE, AND THE PROBLEMS YOU HAVE MET IF ANY:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
8.A. HOW LONG AFTER YOUR ARRIVAL IN THE HOSPITAL DID YOU START DUTY OR TRAINING?

8.B. ON WHAT STATUS DID YOU START?

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurse</td>
<td>1</td>
</tr>
<tr>
<td>Pupil nurse</td>
<td>2</td>
</tr>
<tr>
<td>Nursing assistant</td>
<td>3</td>
</tr>
<tr>
<td>Domestic</td>
<td>4</td>
</tr>
</tbody>
</table>

8.C. IF YOU STARTED AS A NURSING ASSISTANT OR DOMESTIC, HOW LONG WAS IT BEFORE YOU STARTED THE PROPER TRAINING?

8.D. DID YOU WORK AT A DIFFERENT HOSPITAL BEFORE YOUR PRESENT ONE?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

8.E. IF "YES", FOR HOW LONG DID YOU WORK THERE?

8.F. IN WHAT CAPACITY WERE YOU IN THAT HOSPITAL?

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurse</td>
<td>1</td>
</tr>
<tr>
<td>Pupil nurse</td>
<td>2</td>
</tr>
<tr>
<td>Nursing assistant</td>
<td>3</td>
</tr>
<tr>
<td>Domestic</td>
<td>4</td>
</tr>
</tbody>
</table>

9.A. WHAT IS YOUR STATUS NOW?

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurse</td>
<td>1</td>
</tr>
<tr>
<td>Pupil nurse</td>
<td>2</td>
</tr>
</tbody>
</table>

9.B. WHICH YEAR OF TRAINING ARE YOU IN AT PRESENT?

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year</td>
<td>1</td>
</tr>
<tr>
<td>Second year</td>
<td>2</td>
</tr>
<tr>
<td>Final year</td>
<td>3</td>
</tr>
</tbody>
</table>

10.A. WHERE DO YOU LIVE AT PRESENT?

<table>
<thead>
<tr>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses' home</td>
<td>1</td>
</tr>
<tr>
<td>Hostels</td>
<td>2</td>
</tr>
<tr>
<td>Private rented room</td>
<td>3</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>4</td>
</tr>
</tbody>
</table>

Other:

10.B. ARE OVERSEAS NURSES GROUPED TOGETHER IN NURSES' HOME?

<table>
<thead>
<tr>
<th>Answer</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

10.C. WOULD YOU SAY THAT MOST OF YOUR FRIENDS IN UK ARE:

<table>
<thead>
<tr>
<th>Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>From own country</td>
<td>1</td>
</tr>
<tr>
<td>Overseas persons in general</td>
<td>2</td>
</tr>
<tr>
<td>A mixture</td>
<td>3</td>
</tr>
<tr>
<td>British</td>
<td>4</td>
</tr>
</tbody>
</table>
10.D. PLEASE DESCRIBE WHAT LIFE IS LIKE WHERE YOU ARE LIVING NOW: WHAT FACILITIES ARE OFFERED AND MISSING; CONVENIENCES AND INCONVENIENCES; LIKES AND DISLIKES.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

11.A. WHY DID YOU DECIDE TO COME HERE TO DO THE NURSING COURSE?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better pay here than being trained at home</td>
<td>1</td>
</tr>
<tr>
<td>Better career prospects here than staying at home</td>
<td>2</td>
</tr>
<tr>
<td>A prestige for young persons to go abroad</td>
<td>3</td>
</tr>
<tr>
<td>A job that pays while being trained</td>
<td>4</td>
</tr>
<tr>
<td>Difficult to obtain place in own country's hospitals</td>
<td>5</td>
</tr>
<tr>
<td>Lack of employment opportunities at home</td>
<td>6</td>
</tr>
<tr>
<td>Other reasons</td>
<td>7</td>
</tr>
</tbody>
</table>

11.B. WOULD YOU HAVE GONE TO ANOTHER COUNTRY IF YOU HAD NOT BEEN ACCEPTED HERE? Yes .... [1] No .... [2]

IF "NO" PLEASE GO TO QUESTION 12

11.C. IF "YES", WHICH COUNTRY WOULD YOU HAVE CHOSEN?

11.D. WHY DID YOU NOT GO TO THE OTHER COUNTRY OF YOUR CHOICE INSTEAD OF UK?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training there needs to be paid for</td>
<td>1</td>
</tr>
<tr>
<td>Difficult to obtain a place</td>
<td>2</td>
</tr>
<tr>
<td>Pay less than UK</td>
<td>3</td>
</tr>
<tr>
<td>No friend/relative there</td>
<td>4</td>
</tr>
<tr>
<td>Less career prospects</td>
<td>5</td>
</tr>
<tr>
<td>Other reasons, please specify</td>
<td>6</td>
</tr>
</tbody>
</table>

Other reasons:

12. WHY DID YOU CHOOSE TO TRAIN IN THIS HOSPITAL?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A friend in this hospital</td>
<td>1</td>
</tr>
<tr>
<td>A relative in this hospital</td>
<td>2</td>
</tr>
<tr>
<td>A friend here heard this hospital is good</td>
<td>3</td>
</tr>
<tr>
<td>A relative here heard this hospital is good</td>
<td>4</td>
</tr>
<tr>
<td>Only hospital place offered</td>
<td>5</td>
</tr>
<tr>
<td>Other reasons, please specify</td>
<td>6</td>
</tr>
</tbody>
</table>

Other reasons:
13. **WHILE STILL AT HOME HOW MUCH DID YOU WORRY ABOUT:**

<table>
<thead>
<tr>
<th></th>
<th>Very Much</th>
<th>Much</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Life in a hospital?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>ii) Living with people of different nationality?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>iii) The dirty articles one would have to handle?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>iv) Whether the work would be hard?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>v) What kind of patients one would meet?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>vi) Whether people would be friendly?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

14. **WHILE STILL AT HOME, WHAT DID YOU EXPECT NURSING TO BE LIKE IN UK?**

15.A. **WHICH TRAINING COURSE**

<table>
<thead>
<tr>
<th></th>
<th>State registration (3 yrs)</th>
<th>State enrolment (2 yrs)</th>
<th>No choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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</tbody>
</table>

15.B. **WHICH TYPE OF NURSING DID YOU HOPE TO DO WHEN YOU FIRST APPLIED?**

<table>
<thead>
<tr>
<th></th>
<th>General</th>
<th>Mental illness</th>
<th>Mental handicap</th>
<th>No choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>4</td>
<td></td>
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</tbody>
</table>

15.C. **IS YOUR PRESENT COURSE THE ONE YOU HAD FIRST HOPED FOR?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td></td>
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</table>

**IF YOUR ANSWER IS "YES" GO TO QUESTION 16**

15.D. **IF "NO" WHAT WERE YOUR FEELINGS WHEN YOU FOUND OUT THAT IT WAS NOT THE NURSING COURSE YOU HAD HOPED FOR?**

<table>
<thead>
<tr>
<th></th>
<th>Very disappointed</th>
<th>Disappointed</th>
<th>Not disappointed</th>
<th>Did not matter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td></td>
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<td>4</td>
<td></td>
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</tbody>
</table>

15.E. **DID THE HOSPITAL MAKE IT CLEAR WHICH NURSING TRAINING YOU WOULD BE UNDER-TAKING BEFORE YOU CAME HERE?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15.F. **WOULD YOU LIKE TO CHANGE TO ANOTHER NURSING COURSE NOW?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16.A. **WHEN YOU APPLIED TO THE HOSPITALS HERE DID THEY GIVE YOU ANY INFORMATION ABOUT NURSING?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF YOUR ANSWER IS "NO" PLEASE GO TO QUESTION 17**
16.B. IF "YES" WHAT DID YOU FEEL BEFORE YOU CAME TO UK AND WHAT DO YOU FEEL NOW ABOUT THE INFORMATION GIVEN TO YOU?

<table>
<thead>
<tr>
<th>Before</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too brief and vague</td>
<td>1</td>
</tr>
<tr>
<td>Doubtful, no facts</td>
<td>2</td>
</tr>
<tr>
<td>Promising</td>
<td>3</td>
</tr>
<tr>
<td>True</td>
<td>4</td>
</tr>
<tr>
<td>Too many facts</td>
<td>5</td>
</tr>
<tr>
<td>Picture too rosy</td>
<td>6</td>
</tr>
</tbody>
</table>

17.A. FOR THE SORT OF WORK YOU DO WOULD YOU SAY THAT YOUR PAY IS:

<table>
<thead>
<tr>
<th>Very good</th>
<th>Good</th>
<th>Bad</th>
<th>Very bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

17.B. HOW INTERESTING DO YOU FIND YOUR PRESENT JOB AS A TRAINEE NURSE?

<table>
<thead>
<tr>
<th>Very interesting</th>
<th>Interesting</th>
<th>Not interesting</th>
<th>Very uninteresting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

18.A. WHAT DO YOU THINK OF YOUR PRESENT TRAINING SYSTEM?

<table>
<thead>
<tr>
<th>Very good</th>
<th>Good</th>
<th>Bad</th>
<th>Very bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>

18.B. WHAT DO YOU THINK OF THE AMOUNT OF PRACTICAL GIVEN TO YOU IN THE NURSING SCHOOL?

<table>
<thead>
<tr>
<th>Too much</th>
<th>Just enough</th>
<th>Too little</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

18.C. WHAT DO YOU THINK OF THE AMOUNT OF THEORY GIVEN TO YOU IN THE SCHOOL?

<table>
<thead>
<tr>
<th>Too much</th>
<th>Just enough</th>
<th>Too little</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

18.D. IS WHAT YOU ARE TAUGHT IN SCHOOL THE SAME AS WHAT YOU DO IN THE WARD?

<table>
<thead>
<tr>
<th>The same</th>
<th>Totally different</th>
<th>Slightly different</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

18.E. ON THE WHOLE WHAT DO YOU THINK OF YOUR NURSING COURSE?

<table>
<thead>
<tr>
<th>Too easy</th>
<th>Just right</th>
<th>Difficult</th>
<th>Very difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
19.A. WHEN YOU QUALIFY WHAT DO YOU HOPE TO DO

- Go back home to practise as a nurse .......... 1
- Stay here and then seek for promotion ........ 2
- Stay here for further training in nursing .. 3
- Stay here to get another job outside nursing 4
- Stay here to study other than nursing ...... 5

19.B. DO YOU FEEL THAT YOU HAVE AN EQUAL CHANCE WITH OTHER PEOPLE FOR PROMOTION?

- Yes ........ 1
- No ........ 2
- Don't know 3

19.C. IF "NO", WHY?

- 
- 
- 

19. B.

20.A. APART FROM ILL-HEALTH (AND MATERNITY FOR GIRLS), UNDER WHAT CONDITIONS WOULD YOU THINK OF LEAVING NURSING PROFESSION ALTOGETHER?

- 
- 
- 

20.B. WHAT WOULD YOU LIKE TO DO IF YOU LEAVE NURSING?

- 
- 
- 

20.C. UNDER WHAT CONDITIONS WOULD YOU BE CONTENTED AND LIKELY TO PURSUE NURSING AS A CAREER?

- 
- 
- 

21.A. IF YOU ARE A STUDENT NURSE, DID YOU TAKE A GNC TEST BEFORE YOU STARTED YOUR COURSE?

- Yes .... 1
- No .... 2

21.B. IF "YES", HOW LONG AFTER YOU ARRIVED AT THE HOSPITAL DID YOU TAKE THE GNC TEST?
21.C. WHAT DO YOU THINK OF THE TEST?

Fair ..... 1
Unfair ..... 2
Don't know 3

21.D. IF "UNFAIR", WHY?

____________________________________________________

____________________________________________________

____________________________________________________

22. DOES YOUR PASSPORT NEED RENEWING EVERY YEAR

Yes ..... 1
No ..... 2

23. WHO MET YOU AT THE AIRPORT IN THE UK?

Friend/Relative .......... 1
A hospital staff .......... 2
The British Council staff 3
No one .................. 4

24. WITH WHOM WOULD YOU DISCUSS A PROBLEM OF ANY KIND YOU MAY HAVE?

Class-mate .......... 1
Other hospital staff 2
Tutor ............... 3
Nursing officer ...... 4
Relative here ....... 5
Other, please specify 6

Other:

25. HOW AND WHERE DO YOU SPEND YOUR OFF-DUTY TIME?

____________________________________________________

____________________________________________________

____________________________________________________

ALSO YOUR HOLIDAYS:

____________________________________________________

____________________________________________________

____________________________________________________

26. PLEASE DESCRIBE HOW YOU SPENT YOUR TIME FROM YOUR ARRIVAL IN THE UK UNTIL YOU STARTED YOUR TRAINING AT THE HOSPITAL

____________________________________________________

____________________________________________________

____________________________________________________

____________________________________________________

____________________________________________________
27. BECAUSE I INTEND TO INTERVIEW SOME OF YOU, KINDLY GIVE YOUR NAME (CAPITAL LETTERS PLEASE)

MANY THANKS FOR TAKING SO MUCH TROUBLE. WHEN YOU HAVE COMPLETED THE LAST PAGE PLEASE POST THE QUESTIONNAIRE BACK TO ME AS SOON AS POSSIBLE.
This last page is for your views, criticisms and comments. Anything you write will be kept confidential. Remember, your views are very important to this research.

1. PLEASE TELL ME WHAT YOU LIKE BEST ABOUT WORKING IN YOUR PRESENT HOSPITAL

2. ALSO, WHAT YOU DISLIKE MOST ABOUT WORKING IN YOUR PRESENT HOSPITAL

3. WHAT ALTERATIONS IN CONDITIONS OF TRAINING, STAFF RELATIONSHIPS OR SOCIAL FACTORS WOULD YOU SUGGEST TO IMPROVE NURSING TRAINING?

4. IS YOUR EXPERIENCE OF NURSING VERY DIFFERENT FROM WHAT YOU HAD ANTICIPATED WHILE STILL HOME? WHAT DID YOU ANTICIPATE NURSING TO BE?

5. PLEASE TELL ME WHAT PROBLEMS YOU HAVE MET AND HOW THEY WERE SOLVED

I am very grateful for your kind co-operation in completing this questionnaire. Please return it to me in the pre-paid envelope supplied.
1A COUNTRY OF ORIGIN:
1B SEX Male... 1 Female... 2

2 AT THE TIME OF THE RESPONDENT'S DEPARTURE TO, U.K.

<table>
<thead>
<tr>
<th>Family</th>
<th>Education</th>
<th>OCC. then</th>
<th>OCC. now</th>
</tr>
</thead>
<tbody>
<tr>
<td>father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>sister</td>
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<td>sister</td>
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<td>brother</td>
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<td>brother</td>
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<td>brother</td>
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<tr>
<td>self</td>
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</tbody>
</table>

3A HAVE YOU EVER NURSED IN YOUR COUNTRY? yes... 1 no... 2

3B DID YOU APPLY TO BE TRAINED AT HOME? yes... 1 no... 2

3C ARE THERE ANY QUALIFIED NURSES AMONGST YOUR FAMILIES/RELATIVES/FRIENDS yes... 1 no... 2

3D WHAT DO YOU KNOW ABOUT NURSING PROFESSION IN YOUR COUNTRY?

3E WHAT ENTRANCE QUALIFICATION IS NEEDED FOR THE TRAINING IN YOUR COUNTRY? / WHAT YEAR ARE YOU IN?

3F DO YOU HAVE TO PAY FOR THE TRAINING THERE? yes... 1 no... 2

3G IF "no" DO YOU GET PAY? yes... 1 no... 2

3H IF "yes" WHAT IS THE AMOUNT? (own currency) PER MONTH

4A WERE YOU INTERVIEWED AT HOME BEFORE YOU CAME HERE? yes... 1 no... 2

4B IF "yes" WHAT WERE YOU ASKED?
5B ARE THERE EMPLOYMENT OPPORTUNITIES IN YOUR COUNTRY? Yes [1] No [2]
5C IF "yes" can you qualify your answer by... many [1] some [2] little [3]
5D RESPONDENT'S OCCUPATION THEN (if employed)
5E WHAT WAS YOUR SALARY? (own currency) PER MONTH
5F HOW DOES THE NURSING SALARY HERE COMPARE WITH YOUR PREVIOUS SALARY?
5G WHY DID YOU DECIDE TO COME HERE TO FOLLOW A NURSING COURSE?

6A WHO FINANCED YOU TO COME HERE?
(parents).................. [1]
(relative).................. [2]
(self)..................... [3]
(borrowed money)........... [4]
(other, please specify).... [5]

6B IF NOT "self" DO YOU HAVE TO PAY BACK? Yes [1] No [2]
6C IF "yes" HOW MUCH PER MONTH?
6D DO YOU STILL HAVE THIS DEBT TO PAY? Yes [1] No [2]
7A DO YOU NEED TO SUPPORT YOUR PARENTS/SIBLINGS/OTHER FINANCIALLY?
   Yes [1] No [2]
7B IF "yes" WHAT IS THE AVERAGE MONTHLY AMOUNT?
8 COULD YOU TELL ME IN MORE DETAILS HOW DID YOU OBTAIN YOUR COURSE HERE?
9A. Do you feel that your present training gives you an interesting life?

Yes: [ ]  No: [ ]

9B. Why to both answers?

10A. Do you feel that your present training will eventually offer you a secure future?

Yes: [ ]  No: [ ]

10B. Why to both answers?

11. If you could start all over again what sort of profession would you choose?

12A. Of these groups of people which 5 do you consider most helpful to your training and which 2 least helpful (show card.)

<table>
<thead>
<tr>
<th>Most</th>
<th>Least</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>A</td>
<td>P.N.O.(S)</td>
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<td>1</td>
<td>2</td>
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<td>Allocation Officer</td>
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<tr>
<td>H</td>
<td>Clinical tutors</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I</td>
<td>W.S./C.N.</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>J</td>
<td>S.N.</td>
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<tr>
<td>K</td>
<td>S.E.N.</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>L</td>
<td>Senior Nurse Trainees</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>M</td>
<td>Fellow Trainees</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>N</td>
<td>N.A./Auxillaries</td>
</tr>
</tbody>
</table>

12B. Why the 5 most helpful?
12C WHY THE 5 LEAST HELPFUL?

13A DO YOU FEEL THAT YOU HAVE THE SAME CHANCE AS OTHER STUDENTS AND PUPILS TO LEARN IN THE WARDS? yes [ ] no [ ]

13B WHY TO BOTH ANSWERS?

14A BEFORE YOU CAME HERE DID YOU THE DIFFERENCE BETWEEN:
   (i) the 2 years and 3 years course? yes [ ] no [ ]
   (ii) the 3 main types of nursing you can come to? i.e.
      a. general ................. yes [ ] no [ ]
      b. mental handicap ........ b. yes [ ] no [ ]
      c. mental illness .......... c. yes [ ] no [ ]

15 COULD YOU PLEASE TELL ME WHAT IS THE MINIMUM ENTRANCE QUALIFICATION FOR THE:
   a. 2 years course here?
   b. 3 years course here?

16A IF YOU STAY IN NURSING HOW FAR DO YOU THINK YOU CAN REACH?

16B HOW FAR WOULD YOU LIKE TO REACH?

17A ARE YOU SATISFIED WITH YOUR PRESENT NURSING COURSE? yes [ ] no [ ]

17B WHY TO BOTH ANSWERS?
18 WHY DO OVERSEAS STUDENTS AND PUPILS GENERALLY CHOOSE PEOPLE FROM ABROAD AS THEIR FRIENDS?

19 WOULD YOU LIKE TO GO BACK HOME AFTER YOUR TRAINING?
   yes...[ ]  no...[ ]

   COULD YOU TELL ME WHY NOT?

20 YOU MAY DECIDE TO LEAVE NURSING FOR REASONS OTHER THAN (medical, maternity, marriage, family problem) WOULD YOU STILL DO SO WHEN YOU CONSIDER THE VISA PROBLEM YOU MAY ENCOUNTER ONCE YOU ARE OUT OF NURSING?
   yes...[ ]  no...[ ]

21 I HAVE COMPLETED THE INTERVIEW & BEFORE YOU GO DO YOU HAVE ANY POINTS TO ADD?

THANK YOU VERY MUCH FOR YOUR CO-OPERATION & GOOD LUCK IN YOUR TRAINING.
QUESTIONNAIRE FOR OVERSEAS NURSES
WHO HAVE LEFT THE NURSING PROFESSION

To complete the questionnaire simply (✓) opposite correct answer:
e.g. in question 1.E you tick (✓) box 1 if you are female or in
1.B write the number of years or months in the box provided.

1.A. WHAT IS YOUR COUNTRY OF ORIGIN?

1.B. HOW LONG HAVE YOU BEEN HERE?

1.C. WHAT WAS YOUR AGE LAST BIRTHDAY?

1.D. WHAT IS YOUR SEX?

1.E. WHAT IS YOUR MARITAL STATUS?

2. HOW DID YOU ENTER UK? AS:

Other:

3.A. BEFORE YOU CAME TO UK,
WHAT WERE YOU DOING AT
HOME?

IF YOU WERE IN NEITHER FULL- OR PART-TIME EDUCATION, GO TO
SECTION D
3.B. WHAT COURSE OF FULL/PART-TIME EDUCATION? 
GCE 'O' level or equivalent 1
GCE 'A' level or equivalent 2
Other, please specify .... 3

Other:

3.C. ARE YOU STILL PURSUING THIS COURSE HERE? 
Yes 1
No 2

3.D. IF YOU WERE UNEMPLOYED, HOW LONG WERE YOU NOT WORKING? SIMPLY WRITE "SINCE LEAVING SCHOOL" IF THIS WAS THE CASE

3.E. IF EMPLOYED FULL/PART-TIME, FOR HOW LONG DID YOU WORK BEFORE YOU CAME HERE?

3.F. HOW MANY JOBS HAVE YOU HAD SINCE LEAVING SCHOOL AND BEFORE COMING TO UK?

4.A. AT WHAT AGE DID YOU LEAVE FULL-TIME EDUCATION AT SCHOOL?

4.B. WHAT EDUCATIONAL QUALIFICATIONS DID YOU HAVE BEFORE YOU CAME TO UK?
'O' level or equivalent 1
'A' level or equivalent 2
Sat no exams .......... 3
Other, please specify .... 4

Other:

4.C. IF 'O' LEVEL OR EQUIVALENT, HOW MANY SUBJECTS DID YOU PASS?

4.D. IF 'A' LEVEL OR EQUIVALENT, HOW MANY SUBJECTS DID YOU PASS?

4.E. WAS ENGLISH LANGUAGE ONE OF THE SUBJECTS YOU PASSED AT 'O' LEVEL OR EQUIVALENT? 
Yes 1
No 2

5. IF YOU HAVE COMPLETED ANY GENERAL EDUCATION COURSES SINCE YOU ARRIVED IN UK, PLEASE STATE:

SUBJECTS: ___________________________

EXAM(S) SAT: ___________________________

EXAM(S) PASSED & LEVEL: ___________________________
6.A. HOW DID YOU FIRST APPLY TO COME TO DO NURSING IN UK?

Wrote direct to hospital 1
Through agency 2
Government organization 3
Other, please specify 4

Other:

6.B. IF YOU WROTE DIRECT WHERE DID YOU OBTAIN THE ADDRESSES?

Friend at hospital here 1
Relative at hospital here 2
Other, please specify 3

Other:

6.C. APPROXIMATELY HOW MANY HOSPITAL DID YOU WRITE TO?

6.D. PLEASE DESCRIBE AS MUCH AS YOU CAN REMEMBER OF YOUR EXPERIENCE OF APPLYING FOR A HOSPITAL PLACE AND THE PROBLEMS YOU HAVE MET, IF ANY.

7.A. HOW LONG AFTER YOUR ARRIVAL IN THE HOSPITAL DID YOU START DUTY OR TRAINING?

7.B. ON WHAT STATUS DID YOU START?

Student nurse 1
Pupil nurse 2
Nursing assistant 3
Domestic 4

7.C. IF YOU STARTED AS A NURSING ASSISTANT OR DOMESTIC, HOW LONG WAS IT BEFORE YOU STARTED THE PROPER TRAINING?

7.D. DID YOU WORK AT A DIFFERENT HOSPITAL BEFORE THE ONE YOU HAVE JUST LEFT? Yes 1
No 2

[IIF "NO", GO TO QUESTION 8]

7.E. IF "YES", FOR HOW LONG DID YOU WORK THERE?
7.F. IN WHAT CAPACITY WERE YOU THERE FOR?  
Student nurse ... 1  
Pupil nurse ..... 2  
Nursing assistant 3  
Domestic ........ 4  

8.A. HOW LONG HAVE YOU LEFT THE NURSING PROFESSION?  

8.B. WHAT WAS YOUR STATUS AT THE TIME YOU LEFT THE HOSPITAL?  
Student nurse ... 1  
Pupil nurse ..... 2  
Nursing assistant 3  
Domestic ........ 4  
Registered nurse 5  
Enrolled nurse .. 6  

8.C. WHICH PART OF THE STATE REGISTRATION OR ENROLMENT WERE YOU BEING TRAINED FOR?  
General ........ 1  
Mental illness 2  
Mental handicap 3  

8.D. WHICH YEAR OF TRAINING WERE YOU IN WHEN YOU LEFT THE HOSPITAL?  
First year 1  
Second year 2  
Third year 3  

9.A. WHERE DID YOU LIVE BEFORE YOU LEFT NURSING?  
Nurses' Home ..... 1  
Hostels ............. 2  
Private rented room... 3  
Other, please specify 4  

Other:  

9.B. WERE OVERSEAS NURSES GROUPED TOGETHER IN THE NURSES' HOME?  
Yes ...... 1  
No ........ 2  
Don't know 3  

9.C. WOULD YOU SAY THAT MOST OF YOUR FRIENDS, BEFORE YOU LEFT THE HOSPITAL, WERE:  
From own country ........ 1  
Overseas persons in general 2  
A mixture ................ 3  
British ................. 4  

9.D. PLEASE DESCRIBE AS MUCH AS YOU CAN REMEMBER OF WHAT LIFE WAS LIKE WHERE YOU LIVED BEFORE YOU LEFT THE HOSPITAL: WHAT FACILITIES WERE OFFERED AND MISSING; CONVENIENCES AND INCONVENIENCES; LIKES AND DISLIKES.
10.A. WHY DID YOU DECIDE TO COME HERE TO DO NURSING?

Better pay here than being trained at home ........ 1
Better career prospects here than staying at home .... 2
A prestige for young persons to go abroad .......... 3
A job that pays while being trained ............... 4
Difficult to obtain place in own country's hospital . 5
Lack of employment opportunities at home ........ 6
Other reasons, please specify ..................... 7

Other:

10.B. WOULD YOU HAVE GONE TO ANOTHER COUNTRY IF YOU HAD NOT BEEN ACCEPTED HERE?

Yes 1
No 2

[IF "NO", PLEASE GO TO QUESTION 11]

10.C. IF "YES", WHICH COUNTRY WOULD YOU HAVE CHosen?

10.D. WHY DID YOU NOT GO TO THE OTHER COUNTRY OF YOUR CHOICE INSTEAD OF UK?

Training there needs to be paid for ............... 1
Difficult to obtain a place ....................... 2
Pay less than UK's ............................... 3
No friend/relative there .......................... 4
Less career prospects ............................. 5
Other reasons, please specify .................... 6

Other:

11. WHY DID YOU CHOOSE TO TRAIN IN THAT HOSPITAL?

A friend was in that hospital ..................... 1
A relative was in that hospital .................... 2
A friend here heard that hospital is good ....... 3
A relative here heard that hospital is good ..... 4
Only hospital place offered ....................... 5
Other reasons, please specify .................... 6

Other:

12. WHILE STILL AT HOME, HOW MUCH DID YOU WORRY ABOUT:

Very Much Much at all

i) Life in a hospital .................................. 1 2 3
ii) Living with people of different nationality .. 1 2 3
iii) The dirty articles one would have to handle .. 1 2 3
iv) Whether the work would be hard ................ 1 2 3
v) What kind of patients one would meet .......... 1 2 3
vi) Whether people would be friendly ............ 1 2 3
13. WHILE STILL AT HOME, WHAT DID YOU EXPECT NURSING TO BE LIKE IN THE UK?

14.A. WHICH TRAINING COURSE DID YOU FIRST APPLY TO? 
- State registration (3 yrs) 1 
- State enrolment (2 yrs) 2 
- No choice 3 

14.B. WHICH TYPE OF NURSING DID YOU HOPE TO DO WHEN YOU FIRST APPLIED? 
- General 1 
- Mental illness 2 
- Mental handicap 3 
- No choice 4 

14.C. WAS THE COURSE YOU LEFT THE ONE YOU HAD FIRST HOPE FOR? 
- Yes 1 
- No 2 

IF "YES", PLEASE GO TO QUESTION 15 

14.D. IF "NO", WHAT WERE YOUR FEELINGS WHEN YOU FOUND OUT THAT IT WAS NOT THE NURSING COURSE YOU HAD HOPE FOR? 
- Very disappointed 1 
- Disappointed 2 
- Not disappointed 3 
- Did not matter 4 

14.E. DID THE HOSPITAL MAKE IT CLEAR WHICH NURSING TRAINING YOU WOULD BE UNDER-TAKING BEFORE YOU CAME HERE? 
- Yes 1 
- No 2 

15.A. BEFORE COMING HERE DID THE YOU KNOW THE DIFFERENCE BETWEEN THE REGISTRATION AND ENROLMENT TRAINING? 
- Yes 1 
- No 2 

15.B. SIMILARLY DID YOU KNOW THAT RMN AND RNMS ARE TWO DIFFERENT TYPES OF REGISTERED NURSE QUALIFICATION? 
- Yes 1 
- No 2 

15.C. WHICH OF THESE QUALIFICATIONS HAS THE MOST VALUE IN YOUR COUNTRY IF THE TRAINING IS GAINED HERE? 
- SEN 1 
- SRN 2 
- RMN 3 
- RNMS 4 
- Don't know 5 

15.D. WHEN DID YOU LEARN THAT SUCH A COURSE HAS THE MOST VALUE IN YOUR COUNTRY? 
- When still at home 1 
- In UK 2
16.A. WHEN YOU APPLIED TO THE HOSPITALS HERE, DID THEY GIVE YOU ANY INFORMATION ABOUT NURSING?

Yes 1  
No 2

IF "NO", PLEASE GO TO QUESTION 18

16.B. IF "YES", WHAT DID YOU FEEL BEFORE AND AFTER YOU ARRIVED AT HOSPITAL ABOUT THE INFORMATION GIVEN TO YOU?

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<tr>
<td>Doubtful, no facts.</td>
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<td>Promising</td>
<td>3</td>
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<td>True</td>
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<td>Too many facts</td>
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17. FOR THE SORT OF WORK YOU DID, WOULD YOU SAY THAT YOUR PAY WAS:

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18. A. HOW INTERESTING DID YOU FIND YOUR JOB AS A TRAINEE NURSE?

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<th>Very interesting</th>
<th>Interesting</th>
<th>Not interesting</th>
<th>Very uninteresting</th>
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18. B. THINKING BACK, WHAT DO YOU THINK OF THE NURSING TRAINING SYSTEM?

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18. C. WHAT DO YOU THINK OF THE AMOUNT OF PRACTICAL GIVEN TO YOU AT THE SCHOOL OF NURSING?

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18. D. WHAT DO YOU THINK OF THE AMOUNT OF THEORY GIVEN TO YOU AT THE SCHOOL OF NURSING?

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18. E. WAS WHAT YOU WERE TAUGHT IN THE SCHOOL THE SAME AS WHAT YOU DID IN THE WARD?

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<th>The same</th>
<th>Totally different</th>
<th>Slightly different</th>
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18. F. ON THE WHOLE WHAT DO YOU THINK OF THE NURSING COURSE YOU HAVE HAD?

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<th>Difficult</th>
<th>Very difficult</th>
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19. A. SUPPOSE YOU ARE STILL IN THE NURSING PROFESSION, DO YOU FEEL THAT YOU HAVE AN EQUAL CHANCE WITH OTHER PEOPLE FOR PROMOTION?

Yes 1  
No 2
19.B. IF "NO", WHY?

..........................................................................................................................

20. WHY DID YOU LEAVE THE NURSING PROFESSION ALTOGETHER?

..........................................................................................................................

21.A. WHAT IS THE POSITION NOW WITH REGARD TO YOUR PASSPORT?

Got permanent residence
Got British citizenship
Got naturalization
Renew passport annually

21.B. IF YOUR PASSPORT NEEDS RENEWING ANNUALLY, DO YOU HAVE ANY PROBLEMS WITH THE HOME OFFICE? Please let me know the problems you have met. Your views will help others in similar position.

..........................................................................................................................

22.A. IF YOU WERE A STUDENT NURSE, DID YOU TAKE A GNC TEST BEFORE YOU STARTED YOUR COURSE?

Yes
No

22.B. IF "YES" HOW LONG AFTER YOU ARRIVED AT THE HOSPITAL DID YOU TAKE THE GNC TEST?

..........................................................................................................................

22.C. WHAT DO YOU THINK OF THE TEST?

Fair
Unfair
Don't know

22.D. IF "UNFAIR", WHY?

..........................................................................................................................

..........................................................................................................................
23. DO YOU REMEMBER WHO MET YOU AT THE AIRPORT HERE?  
   Friend/relative ............ 1  
   Hospital staff ............. 2  
   British Council staff ..... 3  
   No one ..................... 4

24. WHO DID YOU SEE WHEN YOU HAD A PROBLEM OF ANY KIND WHILE YOU WERE AT THE HOSPITAL?  
   Classmate .......... 1  
   Other hospital friend 2  
   Tutor ............... 3  
   Nursing officer ...... 4  
   Relatives here ...... 5  
   Other, please specify .. 6

Other:

25.A. IF YOU HAVE COMPLETED THE NURSING COURSE, DID YOU LEAVE IMMEDIATELY?  
   Yes 1  
   No 2

25.B. IF "NO", HOW LONG DID YOU STAY?  

26.A. WHAT ARE YOU DOING NOW?  
   Working ..................... 1  
   Studying ................... 2  
   Training for another job 3  
   Other, please specify .. 4

Other:

26.B. IF "WORKING", WHAT KIND OF WORK IS IT?

26.C. IF "STUDYING", WHAT IS THE COURSE?

26.D. HOW DO YOU PURSUE YOUR STUDY?  
   Full-time ............ 1  
   Part-time ........... 2  
   Evening class ...... 3  
   Correspondence .... 4

26.E. WHO IS SUPPORTING YOU FINANCIALLY WHILE YOU ARE STUDYING?  
   Self-supporting ............. 1  
   Parents ....................... 2  
   Wife/husband ............... 3  
   Local Education Authority Grant 4  
   Other, please specify .. 5

Other:

26.F. IF "LOCAL EDUCATION AUTHORITY GRANT", WHAT KIND OF GRANT IS IT?  
   Full grant .. 1  
   Partial grant 2

26.G. WHAT DO YOU HOPE TO DO AFTER COMPLETION OF YOUR COURSE?
27. WHY DO YOU THINK SO MANY OVERSEAS NURSES LEAVE THE NURSING PROFESSION?

28. HOW AND WHERE DID YOU SPEND YOUR OFF-DUTY TIME WHILE IN HOSPITAL?

AND YOUR HOLIDAYS?

29. PLEASE DESCRIBE HOW YOU SPENT YOUR TIME FROM YOUR ARRIVAL IN THE UK UNTIL YOU STARTED YOUR TRAINING AT THE HOSPITAL

30. BECAUSE I INTEND TO INTERVIEW SOME OF, KINDLY GIVE YOUR NAME AND ADDRESS (CAPITAL LETTERS PLEASE)

Many thanks for taking so much trouble. When you have completed the last page, please post the questionnaire back to me as soon as possible.
Mr. Henry Lee,
Research Fellow,
Department of Social Sciences,
Loughborough University,
Loughborough,
Leicestershire,
LE11 3TU.

Dear Sir,

Many thanks for your letter dated 27th January, 1975. I am glad to hear that you are carrying out a research study on problems encountered by Overseas Trainee Nurse in United Kingdom and shall be only too pleased to receive with your compliments, a copy of your papers when they are completed.

With reference to your enquiry, I am to say that:

a. My Government provides Training in Basic Nursing as well as Post Basic Nursing. Post Basic Nursing Courses available are:

(i) Midwifery
(ii) Health Visitors Course
(iii) Paediatric Nursing
(iv) Orthopaedic Nursing
(v) Ward Administration
(vi) Psychiatric Nursing
(vii) Nursing Education
(viii) Nursing Administration

The last two items are available only at the University Hospital.

b. In my country there are two types of training for nurses:

(i) Nursing Course for a period of three years leading to full registration with the Nursing Board.
(ii) Assistant Nurse Course for two years duration.

c. The minimum qualifications required for (i) and (ii) above are MCE/SFM (or equivalent) and ICE/SRP respectively.

d. No additional requirements are in addition to those you mentioned.

I sincerely hope that the above information will be of help to you in your research study and I wish you every success.

Thank you.

Yours faithfully,

Khong Kim Chiew
Education Attache
for Director
Malaysian Students Department
Dear Sir,

Your letter was referred to this Office for reply and I am now answering your query on instruction in nursing in the Philippines.

Nursing Courses Offered in Philippine Schools and Colleges of Nursing.

I. Colleges of Nursing.

Colleges of Nursing offer instruction leading to the following degrees: Bachelor of Science in Nursing (BSN) and/or Master in Nursing (MN).

Minimum Entrance Requirements.

1. Graduation from prescribed secondary education course.
2. Age limit: 17-25 years; at least 5 feet tall.
3. Interview with the Committee on Admissions.
4. Filing of suitable application obtainable at the College of Nursing.

A. The Undergraduate Programme.

The five-year course in nursing is a collegiate course and culminates in a baccalaureate degree in nursing. The first year is taken in the College of Arts and Sciences of the University. Clinical experience is given during the terminal three years in a suitable hospital prescribed by the College.

B. The Graduate Programme.

The masters degree in nursing requires completion of certain course requirements prescribed by the College in the following major fields: teaching and supervision or administration of nursing services in schools and colleges of nursing.

Student who elect teaching and supervision or administration of nursing services may also choose a clinical field such as maternal and child health or mental health or psychiatric nursing.
Those who elect majors in maternal and child health and mental health or psychiatric nursing take courses in these fields including prescribed courses in psychology and sociology.

The masters course normally takes from 1 to 2 years and the student's programme is under supervision of a course director.

II. Schools of Nursing.

Schools of Nursing are normally linked to various teaching hospitals which offer a diploma of Graduate in Nursing (GN).

The course is a four-year undergraduate programme, the first year of which is given as a liberal education course including science and technical subjects. The terminal three years include subjects within the framework of a general type of nursing curriculum as well as clinical work in the teaching hospitals.

Minimum Entrance Requirements.

1. Graduation from the prescribed secondary education course.
2. Applicants must be unmarried females, 18-25 years old, 4 feet 11 inches tall, and must weigh at least 90 lbs.
3. Applicants submit to oral and written examinations.

The National Board of Nursing Examination.

Graduates of nursing courses in the Philippines mentioned above must pass the State Examination given by the National Board of Nursing Examiners as a professional qualification.

Yours sincerely,

Justo de la Paz, DSc., PhD.

Henry Lee, Esq.
Department of Social Sciences
Loughborough University
Loughborough, Leicestershire LE11 3TU
Mr. Henry Lee,
Research Fellow,
Department of Social Sciences,
Loughborough University,
Loughborough,
Leicestershire LE11 3TU.

Dear Mr. Lee,

I refer to your letter of the 27th January, 1975 and with respect to the information requested the Secretary of the Nursing Council of Trinidad and Tobago has advised as follows:

(a) Types of nurse training offered in Trinidad & Tobago:

- General Nurse
- Psychiatric Nurse (Nurse for the Mentally Ill)
- Midwifery
- Nursing Assistant.

(b) Nursing courses may be:

(i) Basic programmes - General Nurse - minimum of 3 years;
    Midwifery (for the non-Nurse) - 2 years;
    Nursing Assistant - 2 years.

(ii) Post-registration programmes:
    For the Registered General Nurse: - Midwifery - 1 year.
    Psychiatric Nursing - 18 months.

    For the Registered Psychiatric Nurse: - Midwifery - 15 months.
    General Nursing - 18 months.

(c) The minimum requirement for entry to any of the courses mentioned in (a) above is evidence of having completed the Primary School programme as may be shown by the possession of a Primary School
(c) Leaving Certificate, and (with the exception of the Nursing Assistant course), passing the Council’s Education Test for Prospective Student Nurses & Midwives. This Test is, with the assistance of an Officer of the Training Division of the Ministry of Education & Culture, directed to assessing the standard achieved by an applicant in

- comprehension and use of the English Language;
- arithmetical reckoning;
- general knowledge and awareness of current events;
- and
- psychological aptitude for nursing.

Council had decided in 1974 that all persons seeking entry to Nurse training should be required to take its Education Test, with effect from January 1975. Because of certain difficulties, however, implementation of this has been postponed and a survey is now underway with a view to ascertaining the wastage occurring among persons entering training on the basis of 'O' Level Subject Passes as compared with those holding merely the Primary School Leaving Certificate and passing the Education Test.

At present, therefore, persons holding four (4) or more 'O' Level Subject Passes, two of which are English Language and Mathematics (or Chemistry or Physics) respectively are not required to sit the Test.

Yours sincerely,

Carlyle C. Adams,
for High Commissioner.

CCA:ch
Hon. J. Cameron TUDOR, C. M. G.
High Commissioner for Barbados
In the United Kingdom

Our Ref: IHF/1/7/1
Your Ref

5th February, 1975.

Dear Sir,

I am directed to refer to your letter of 27th January, 1975 in connection with nursing in Barbados and to inform you that:

(a) The Queen Elizabeth Hospital is a general Training School for nurses with an enrollment of 250.

(b) The following courses are undertaken:
   (i) Basic Nursing - 3 years
   (ii) Post-basic Midwifery - 1 year
   (iii) Basic Midwifery - 2 years
   (iv) Basic Course for Psychiatric nurses - 16 months
   (v) Nursing Assistants Course - 1 year

The hospital is affiliated with the University of the West Indies for the training of Medical Students.

The qualifications for entry to the 3 year nursing course is G.C.E. standards.

As in the U.K., provided the applicants reach a reasonable standard of education, and pass an entrance test, they are accepted for the lower grades of nurse training.

Many of the Staff and Charge Nurses in Barbados have pursued post-graduate courses in this country, several Barbadians also train as State Registered Nurses and State Enrolled Nurses in the United Kingdom, and have been recruited for training dating back to 1955.

It is hoped that the above information satisfies your requirements.

Yours faithfully,

For High Commissioner.

Henry Lee, Esq.
Research Fellow,
Department of Social Sciences,
Loughborough University,
Leicestershire, L.E.11 3TU

DAB/ab
Mr. Henry Lee,
Research Fellow,
Department of Social Sciences,
Loughborough University,
Leicestershire LE1 3 Tu,
United Kingdom.

Dear Mr. Lee,

1. I refer to your letter dated 27th January, 1975, requesting information on nursing education programmes in Guyana.

2. In response to (a) A General nursing education programme is offered which leads to successful completion, and after qualifying at the State Final Examination to registration with the General Nursing Council of Guyana.

Psychiatric/Mental Health Nursing is not offered as an additional course but is integrated in the basic nursing programme.

(b) There are two (2) basic nursing programmes and one basic Midwifery Programme, viz.,

(i) Professional Nursing Programme – 3 years duration
(ii) Nursing Assistant Programme – 2 years duration
(iii) Midwifery Programme – 2 years duration

(c) The minimum academic qualifications are as follows for: (i) Four (4) subjects at the G.C.E. "O" Level, one of which must be English Language. A science subject(s) is an advantage namely, Biology, Chemistry, Physics, Anatomy etc.

(ii) and (iii) Two subjects at G.C.E. "O" Level at one sitting including English Language, and evidence of having four (4) years education at Secondary Level;

OR

The College of Preceptors Certificate.

Academic qualification is only one of the criteria used for selecting nursing students. Prospective students are interviewed and selected by a committee.

We are now in the process of developing an Aptitude Test for students.

(d) Persons are selected for training from the hinterland areas after graduation they are expected to return to contribute to the delivery of health care in the particular area.

If such persons do not have the minimum academic qualifications an Entrance Examination is conducted by the General Nursing Council in

DEPARTMENT OF NURSING,
Ministry of Health,
Brickdam, Georgetown 1
Guyana.

17th February, 1975.
These letters were given to us voluntarily by the respondents who pointed out "I have their letter to prove that I was first offered a student's training". They were then pupil nurses.

Dear Sir,

With reference to your application for Student Nurse training, I now have pleasure in appointing you as Student Nurse at . This appointment is subject to the usual three month probationary period, and also satisfactory references, medical and chest x-ray. In this respect I shall be glad if you will kindly let me have a medical certificate and result of a recent chest x-ray as soon as possible.

Salary (payable monthly on the last Wednesday of each month) and conditions of service are as laid down by Whitley Council.

The next school for Student Nurses commences on 27th May 1974 and we should require you to be here in time for this. I regret that we shall be unable to reserve a room for you in the Nurses' Home after that date, and we must have a definite date when you will be arriving as soon as possible.

Enclosed are some leaflets which might be useful to you, and also directions for reaching . once you arrive in London. Will you please bring with you your Birth Certificate.

I hope you will be very happy working as a member of my nursing team and that you will enjoy your training here.

Yours faithfully,
I am pleased to accept you for Student Nurse Training in my School commencing 5th February 1973 providing that you are able to arrive at the Hospital by 22nd January. (If it is not possible for you to make your arrangements in time, I will place you on my Register for the June School).

Your training allowance will be £792 p.a. less £57.60 for lodging. This allowance works out as £66 per month out of which you will need to spend £16.14 per month on food. Before this first sum is received, however, you will need to spend money on textbooks (£5 approx.), £1 Registration fee with the General Nursing Council and on sensible black shoes for duty, so please bring sufficient money with you. You will also need to buy some warm clothes and you will find that the cost of living is very much higher in England, although your training allowance will be enough to cover these expenses. The remainder of your uniform will be provided free.

Nurses have a room of their own in the Nurses Home but share a communal sitting room with television. Light cooking facilities are available but main meals should be taken in the Hospital Cafeteria.

As soon as you know your travel details, will you please let me know. You should also contact Mrs. Bentley, Overseas Students Dept., The British Council, 11 Portland Place, London W.1 and send her your flight details and arrival time. She will then be able to arrange for a courier to meet you at the Air Terminal in London to guide you on your way to the Hospital.

I look forward to your prompt reply.

Yours sincerely,

With reference to your application for Student Nurse Training, I am pleased to accept you for my School commencing February 5th providing you can arrive at the Hospital by the 22nd January. If this does not allow adequate time for you to make your necessary preparations I can accept you for my School commencing 4th June 1973 and you should arrive by the 22nd May. Should you wish to arrive before this time, however, I can employ you as an Assistant Nurse.

When you know your flight details you should let me know as soon as possible so that I will know when to expect you. You should also contact Mrs. Bentley, British Council, Overseas Students Department, 11 Portland Place, London W.1 who will arrange for an escort to meet you at the Air Terminal in London and guide you on your way to the Hospital.

Uniform will be provided free but you must supply your own stockings and sensible black leather shoes. These can be bought on your Arrival in England. Your training allowance will be £945 per annum less £117 lodging charge. I must emphasise that the cost of living in England is very much higher than in Mauritius. This training allowance is given because it costs this amount to keep yourself in food, clothing, and lodging.

I look forward to hearing from you shortly.

Yours sincerely,
Appendix E
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<td>United Kingdom</td>
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<tr>
<td>Others</td>
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<tr>
<td>Total RNs</td>
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Notes:
- Pupil nurses/registered nurses who are still resident in the country of origin are included in the total RNs.
- Pupil nurses in foreign countries after gaining qualifications in Ireland are also included.

Other Foreign Countries:
- Ethiopia

For list of countries, see Appendix A, pp. 68-69.
Appendix F

ABBREVIATION USED

C.N.O.:: Chief Nursing Officer
D.H.S.S.:: Department of Health and Social Security
E.E.C.:: European Economic Community
G.N.C.:: General Nursing Council For England and Wales.
N.H.S.:: National Health Service
N.A.:: Nursing Assistant
N.O.(S).:: Nursing Officer (Service)
N.O.(T).:: Nursing Officer (Teaching)
P.N.O.(S).:: Principal Nursing Officer (Service)
P.N.O.(T).:: Principal Nursing Officer (Teaching)
P.E.P.:: Political and Economic Planning
R.H.A.:: Regional Health Authority
R.N.O.:: Regional Nursing Officer
R.N.T.:: Registered Nurse Tutor.
S.N.O.(S).:: Senior Nursing Officer (Service)
S.N.O. (T).:: Senior Nursing Officer (Teaching)
S.E.N.:: State Enrolled Nurse
U.K.C.O.SA.:: United Kingdom Council For Overseas Students Affairs
Appendix G
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