Multiculturalism Policies: Identifying the dialectic of the “ideal type” within the practices of Canadian nursing

by

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Abstract

Since Canada’s first multiculturalism policy in 1971, there has been an influx of Internationally Educated Nurses (IENs) of colour to Canada. Studies show IENs occupying low-paid menial positions, while being excluded from policy-making leadership positions. Colonial values currently function through the notion of the “ideal type”, a term defined as a nurse who is white, middle class and occupying policy-making leadership roles. Within Canadian nursing, there appears to be a dialectic relationship between multiculturalism policies and the ideal type that become camouflaged by the term I have identified as the “hybrid space.” The hybrid space consists of public health nurses, clinicians, clinical case coordinators, and unit leaders who are registered nurses that work on the front-line with minimal leadership responsibilities. Although these nurses have comparable qualifications as their Canadian-born counterpart, they are not groomed into policy making leadership roles, but rather remain fixed in the hybrid-space. Through the experiences of IENs, this study shows how the dialectic relationship helps in maintaining Canada’s favourable position within the global market. Post colonial theory, antiracist feminism and Black Canadian feminist thought were used as theoretical frameworks to expose issues of racism and inequalities within the hybrid space. In-depth interviews, a qualitative methodology, explored the experiences of these IENs in the hybrid space. Ten IENs of colour who were from the United Kingdom and the ex-British colonies (India and the Caribbean) were recruited using the snowball method. The research uncovered several major themes such as, Non-Recognition, No Leaders of Colour at the Top, Faith and Spirituality and Valuing Their Heritage. The themes were divided into two further categories: 1) Challenges and 2) Resistance. Although the hybrid space was challenging, the IENs used these barriers as spaces of resistance in order to survive.
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Chapter 1

Introduction

When Canada introduced the first multiculturalism policy in 1971, it received immense respect within the global community, and today it still stands as a model for other countries to follow (Lazcko, 1994; Dewing, 2013). Because multiculturalism policies focus primarily on equity and diversity, their values have been readily adopted into many institutions, specifically the area of nursing (Watson, 1985; Leininger, 1999). Yet, in practice, Internationally Educated Nurses (IENs) of colour fail to benefit from the opportunities and promises that Canada claims to offer as a multicultural society (Bannerji, 2000). Instead, IENs of colour continue to occupy jobs in the bottom tier, while White nurses are positioned at the top (Calliste, 2000; Jacobs, 2009). The few who have navigated their way to leadership positions generally remain as frontline workers who are unable to make any significant changes to Canada’s nursing practices (Jacobs, 2009).

Even though it has now been over 40 years since Canada’s first multiculturalism policy was introduced, IENs still remain outside of leadership positions where nursing policies are made. Their absence from such positions only further discloses that there appears to be an ‘ideal type’ image in nursing leadership that perpetuates colonial cultural practices. The values of the ideal type conflict with the values found within a multiculturalism framework that nursing so readily boasts of practising (Government of Canada, 1988; Canadian Nursing Association, 2010). The existence of a colonial culture has been recognized in the works of Giddings (2005) and Jacobs (2007), which both associate it with “the ideal” or “the ideal type.” Giddings’s (2005) describes the ideal type as a female nurse who is White, middleclass and heterosexual, while Jacobs (2007) adds that the ideal nurse has constructed a culture of her own. As Canada’s healthcare service provides care for a diverse population, other cultural groups appear to be deliberately omitted from participating in these decisions, where the ideal type decides on what nursing policies are needed to reflect Canada’s pluralistic society. Since policies made in the
interest of Canada’s healthcare service will have significant influences on Canada’s multicultural population, this research will question the relationship between the ideal type nurse and multiculturalism policies within the practices of Canadian nursing. It will raise such questions as to whether the ideal type nurse and multiculturalism policies are in conflict with one another, or if they work in partnership with a concealed agenda.

**Background to “the Problem”**

In 2007, I had arrived at the final milestone of my Master’s research. All that remained was to select and interview the participants. It should have been simple; the literature concurred that IENs of colour faced unexpected barriers within the academy, such as navigating their way through the system. It was rightly fitting to interview IENs of colour within the university. My plan was to use interviews as a method of unlocking their experiences and the obstacles they faced since relocating to Canada. I needed to recruit my participants from one reputable university that held bridging courses for IENs. However, it was not as simple as I had anticipated. There were a series of unexpected obstacles that began to surface. The first university I approached claimed not to have any programs for IENs. After presenting them with the evidence that they advertised themselves as having a bridging program, they abruptly directed me to try to conduct my research at another university.

With no other option and little time left, I eagerly sought the other recommended university. As with the first university, I presented my research proposal that centred on the experiences of IENs of colour within the academy. To my surprise, I was met with a short email that stated, “We have enough research conducted on this group.” Shocked and confused by the response, I was now left with a major dilemma.

With no universities to present my work to, and insufficient time in which to complete my research, I had no other option but to change the genre of my research from IENs within universities to IENs within colleges. While talking with one of the administrators from the college, a sigh of relief was warranted as she listened intently to my research and was fascinated with my area of study. Her willingness to support my endeavours removed all fears and inhibitions.

1 A program designed to support qualified immigrants with the relevant education to certify and improve their skills to work in Ontario.
I now had an ally for my cause. Since she had previously outlined how she would support my research, I was reassured that there were no “red tape” or ethics committees to worry about. I could start and finish my research in good time. We eagerly finalized the process over the phone and we were just about to terminate the conversation when I realised that I had forgotten a minor detail in our discussion. Maybe it was due to the comfortable rapport we had developed, but now I remembered and so I interjected that one statement just before we said goodbye:

“Oh yes, by the way, I will need to interview women of colour.”

“Women of Colour?” was the shocked response from my administrator comrade. Now suddenly the atmosphere changed to a chilly climate (Acker, 2004). She instantly told me that I should try somewhere else and that their college had no issues in regard to race. Although I had made no assumptions regarding racial tensions, I was not prepared to walk away. I had worked too hard and refused to risk not completing my Master’s degree in time. Fully aware that time was of the essence I decided to dig my heels in. As she tried to discourage me from conducting my studies at the college she worked for, I tried to alleviate her fears by defining what was meant by the term ‘women of colour’. With her being frustrated and me being persistent, she unwittingly blurted out:

“We don’t have a problem with race, it’s just that the Blacks can’t cope and the Indians can’t speak the language. The only ones who succeed here are those from Eastern Europe. By the way, are you a woman of colour?”

It was to that question that I answered, “Yes,” as tears fell down my cheeks. To be a woman of colour is a problematic term that transcends the politics of institutions, but can be embedded in one’s conscious and unconscious thought (Carty, 1991). Yes, I am a woman of colour, but a woman of colour with a British accent. It was obvious that on the phone, she had visualised me as White and middleclass. I was invisible to her on the phone and so I was the colonizer. It was impossible for her to deduce that I could be a woman of colour because of my English accent; and therefore, my accent became the medium by which she freely verbalized her feelings toward “the other” before realizing that I was “the other.”

To be a woman of colour is commonly associated with the inability to succeed, but to be White is to be already qualified for success (Allen, 2001; Rothenberg, 2002). I was now the “other” who would be denied all support that could warrant my success. However, my persistence compelled her to honour her initial promise of support. She summoned me for a face-
to-face meeting to present my proposal. Complying with her demands, I arrived at her office. While seated in her open-door office, a woman walked past and looked intriguingly at me, no words were exchanged as she continued to walk. It was later I learned that she was the Program Director.

After submitting my proposal to the administrator, it was a few weeks later that I received a phone call from the Program Director, stating that an ethics committee had just been created. Hoping that the Program Director would sympathise with my situation, she informed me that the committee was newly implemented and I would have to wait six weeks for the committee to have their first meeting and a further six weeks for the committee to reconvene if any changes needed to be made to my proposal. It was now inevitable that I could not do my research there without jeopardizing the completion of my Master’s research. Once again, I changed the topic of my research to include the workplace and the academy, and bypass the administrative “red tape” by using the snowball approach (Polit and Beck, 2008).

There remains a close correlation between the way women of colour are treated in the workplace and the academy (Henry 1993; Hassoueh-Phillips and Becket, 2003; Johnstone, 2006). IENs of colour come to Canada armed with a plethora of skills, qualifications and experiences that are deemed equivalent to Canadian standard. However, their skills, qualifications and experiences often go unrecognized within the workplace setting. As they experience systemic barriers, many nurses of colour find themselves either working outside of nursing or slotted into menial nursing positions, which fail to reflect their abilities (Calliste, 1992, 2000; Li, 2001; Lowell and Gerova, 2004). Those who have attempted to steer their way to leadership positions, instead find themselves in a position that provides them with minimal autonomy as frontline workers. To describe these selected positions in nursing, I have called these spaces the ‘hybrid space’.

The hybrid space can be defined as nursing positions that unify frontline nursing with some form of leadership or autonomy over one’s own work. These spaces are reflected by the following type of nursing positions: public health nurses, clinicians, clinical case coordinators and team leaders. They (IENs) remain excluded from nursing management where nursing policies are made, and are alternatively placed into menial or hybrid spaces, spaces that they used to once manage when they were managers and leaders in their home countries (Calliste, 1992; Flynn, 2008).
According to the CNA (2007), registered nurses (RN) in Canada are expected to have an undergraduate degree in nursing; either as a bachelor in nursing (BN) or a bachelor of science in nursing (BScN). Nurses of colour who have undergraduate degrees often occupy menial nursing positions (Calliste, 2000; Jacobs, 2007). However, IENs of colour who have successfully achieved a place into the hybrid spaces are a different calibre of nurses; they all have their undergraduate nursing degrees with honours and many are certified midwives, while some even have their Master’s degree.

The qualifications, skill sets and experiences IENs come with make them suitable candidates to work within management. They are by far academically capable of effectively contributing to Canada’s nursing practices, but through no choice of their own, they find themselves excluded from such leadership positions and considered as incapable of participating in management (Flynn, 1998; Calliste, 1992). Instead, they are only permitted to enter the hybrid space where their services are relevant to support Canada’s economic and social interests within the global community (Bannerji, 1997). Even in the hybrid space, however, they continue to face unforeseen difficulties that are often camouflaged by the very hybrid space itself.

After completing my Master’s degree at the University of Toronto, I re-entered the workplace as one of the most qualified contender within a thriving workforce. Although I had all the necessary qualifications that would make me a suitable candidate for a more senior position, I was not interested in moving up the promotional ladder at that time. However, sometime later a more senior position became available and my interest was soon aroused. It was in line with my area of study and I was by far the most suitable of candidates given my skills, qualifications and experiences. After submitting my application, I became somewhat disappointed when I was not offered the position, but I was further shocked to learn that a nurse who was far less qualified than I was, and who was White, middleclass and had the all-Canadian Great White North image, was offered the position without applying for it. Feeling like the subaltern without a voice, I ignored the issue and consoled myself that the nurse was a nice person and I was fortunate to even have a job. My job was a toe-hold, and like many nurses of colour in the hybrid space, I concluded it was not in my best interest to disturb the status quo (Fellows and Razack, 1998; cited in Nestel, 2006). A few months later, however, after applying for a course, I noticed that another rival who had already been on numerous courses, and who had fewer qualifications and experience than I had, was given the course position I had applied for. It was then that I began to question the whole notion of “natural” selection (Darwin (1871)).
The two experiences, within the academy and the workplace setting depict a current dominant practice that commonly excludes racialized groups from leadership while accommodating those privileged by their given race (Puwar, 2004). Grady states that:

The unfortunate reality, however, is that the senior leadership of our healthcare institution does not reflect the constant companionship of race, ethnicity and culture that weave the fabric of our institutions and the communities we serve (2002, p. 30).

Grady’s comment clearly describes the absence of people of colour in leadership positions within the healthcare system, and that is further reflected within Canadian nursing. Unfair treatment continually occurs within nursing, but very little is being said.

The workplace for many IENs is a place that denies equal access to positions of leadership, but boasts about practising inclusivity in diversity (College of Nurses of Ontario (CNO), 2009). The stories I have shared are the common everyday lived experiences of many IENs of colour, who come to Canada with dreams of a better life (Flynn, 1998; Brand, 1999). Multiculturalism policies are designed to accommodate Canada’s ever growing pluralistic society (Leininger, 1993; CNO, 2009); but for many IENs these dreams do not match the reality that has resulted in many of them leaving nursing or losing their skills because they are forced to take menial, low paid nursing positions (Kolawole, 2009; O’Brien, 2006).

**Statement of the Problem**

This research examines the roles of the ideal type and multiculturalism policies within nursing and questions whether it works in favour of IENs of colour or more as a hindrance to their educational and promotional development. The Canadian Charter of Rights and Freedoms (1982), states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability (p. 3). However, within critical nursing literature and in nursing practice, the notion of the ideal type nurse has taken centre stage, and this has been highlighted by Giddings (2005) and Jacobs
Although Giddings (2005) adequately describes the ideal type nurse as White, middleclass and heterosexual, it is Jacobs’ (2007) work that focuses on the function and operational practices of the ideal within nursing. IENs of colour are unable to compete with the ideal type, because they are not White or considered middle class (Giddings, 2005). Even if the qualifications of IENs prove to be on par, or even more advanced than the Canadian ideal type nurse, their qualifications are often considered as inferior to Canadian qualifications by Canadian employers (Cheng and Yang, 1998; Li, 2001; Jacobs, 2007).

Since multiculturalism policies, which are said to be built on bicultural colonial values (Ng, 1995; Bannerji, 2000), and the ideal type nurse are in conflict with one another, could the two possibly work in partnership with each other to maintain the existing state of inequality found within nursing? Since nursing is a microcosm of society, many colonial practices continue to function within the neoliberal discourse that exists within nursing. Colonial practices are manifested within the binaries that occur locally and globally: among those marginalized and those in the centre, as well as those from developing countries and those from developed countries. This is clearly reflected in nursing, where IENs of colour occupy menial positions and White, Canadian nurses occupy leadership positions. Deardorff (2001) argues that society is stabilized by maintaining developed countries and developing countries in a polarized state. This polarized state, according to Shiva (1997) and Dei (2000), force developing countries to become dependent on those countries deemed as developed countries. Likewise, this research suggests that by excluding IENs from leadership and management, nurses matching the ideal type are able to make decisions that will lock IENs into menial spaces (Bannerji, 1997). However, the ideal type can only effectively operate by working in partnership with multiculturalism policies. Hence, the ideal type and multiculturalism policies co-exist by producing a co-dependent relationship in order to preserve a stable and strong nursing workforce (Bannerji, 1997).

Although there is an obvious co-dependent relationship between the ideal type and multiculturalism policies within nursing, a closer examination of the relationship reveals one that is dialectic in nature. The notion of dialectic is derived from Hegel and also the Marxist dialectics (Fox, 2005), who view a dialectic as the reconciliation of two opposing discourses that merge together in pursuit of truth (Connor, 2003). Therefore, the relationship between the ideal type and multiculturalism policies must be interrogated within the context of a dialectic relationship where both appear to be opposite in nature, but come together with a similar purpose (Bannerji, 2000; Jacobs, 2007).
Rationale

Canada relies heavily on IENs to replace the mass exodus of the 27,000 nurses who have left Canada (Registered Nursing Association of Ontario (RNAO, 2012). IENs are central to the stability of the Canadian nursing workforce. As nurses make up the largest employed sector within the healthcare system, projections already alert us to several concerning issues:

1. There will be an increasing demand for nurses as the baby boomers approach retirement and increase their use of the healthcare system.
2. Projections show another fall in nursing levels by 2016 which will impact nursing care and the stability of the Canadian economy (Buchan, 2002; Oulton, 2006; RNAO, 2012).
3. Canada is losing a number of highly qualified nurses through the North American Free Trade Agreement (NAFTA) to such countries as the United States. Canada must replace their vacant spaces or else the professionalism of nursing will be adversely affected (RNAO, 2006; Canadian Federation of Nurses Unions (CFNU), 2012).
4. There are a large number of registered nurses who are working outside of the nursing profession for various reasons, such as being burnt-out, lack of job satisfaction and early retirement (Rosen, 2001; Nursing Research Unit, 2001).

As Canada strives to maintain a leadership position in the field of Research and Development within the global arena (Harper, 2007), it is in Canada’s best interest not only to recruit nurses, but to discover ways to effectively engage and retain IENs within Canada’s nursing workforce; this is a form of brain drain (Reitz, 2005).

IENs are recruited because of their competitive qualifications, skills and experiences (Li, 2001; Blythe and Baumann, 2006; Higginbottom, 2011; Horne, 2011; CNO, 2011). Yet within the practice of Canadian nursing, they are treated differently from their Canadian educated counterparts. Regardless of their qualifications, their omission from leadership positions has left them deskilled and displaced in menial positions (Das Gupta, 2002; Raghuram & Kofman, 2004; Jacobs, 2008). Currently studies into nurses of colour tend to address the menial positions they occupy within the segregated workforce that exists within Canadian nursing (Brand, 1999; Calliste, 2000). Only a few studies examine the pocket of nurses who have broken ranks and vertically navigated themselves to spaces of leadership (Stewart, 1997).
The term leadership needs to be defined in this study as it carries numerous connotations and understandings. According to the Oxford dictionary, leadership has been defined as “the action of leading a group of people or an organization, or the ability to do this.” Mayowa, from Leadership Definitions By Scholars adds that, “leadership is the ability to evaluate or forecast a long term plan or policy and influence the followers towards the achievement of the said strategy” (2009). Leadership in this study involves a space where changes are implemented and the voice of the dominant is reflected in policies and guidelines for practice (Ono & Sloop, 2002). Within nursing, there exists, what I have termed, the hybrid space within the binary of leadership and menial spaces. I identified the hybrid space based on the works of post colonial theorist Bhabha (1994). The multiple layers within nursing uniquely reflect Canada’s pluralistic society. However, these multiple layers serve to preserve the invisibility of the ideal type that would ordinarily come into conflict with Canada’s image of a nursing system that is pluralistic and inclusive of all.

The hybrid space is neither a policy-making leadership space nor a menial, deskillled position. It is a space by where qualifications, skills and experience play a major part and one can be groomed for the policy-making leadership space. Hence, it can be defined as a pseudo-leadership space that satisfies the requirement of the global community. It displays the picture of true multiculturalism while eclipsing the polarized White space of management and the Brown menial spaces on either side (Bannerji, 1987; Jacobs, 2007). This study will address the issues concerning IENs of colour within the hybrid space where they remain active participants as frontline workers, but remain absent within the area of policy and change. In this study, I have chosen IENs of colour that are from India, the Caribbean and the United Kingdom who presently live in Canada. Although studies show that IENs are predominantly recruited from the Philippines (CNA, 2002; Blythe & Baumann, 2006), I decided to omit nurses from the Philippines for the following reasons:

1. Most studies on IENs of colour have been conducted on Filipino nurses and I decided to study the other groups who are recruited along with Filipino nurses, but often go unstudied.
2. This study focuses on ex-colonies of the British Empire, which bear many similarities to that of the colonizer. Filipinos were not colonized by the British Empire, so their experiences are presumably different.
3. As colonial practices were very prevalent in the structure of nursing practice under the British “colonial” Empire, the countries in this study would have had similar practices filtered into their nursing standards by their colonizers. For this reason, the history of the Philippines could create new dimensions that would not be relevant to the nature of this research.

Canada and the other ex-colonial countries in this study, shared similar historical experiences of colonial rule prior to World War II. After the war they also experienced independence, making it natural to expect that these countries would share a level of understanding and empathy toward each other, as demonstrated through multiculturalism policies. However, this was not the case; Studies about Canadian nursing have shown a racial and class divide, which is more reflective of the colonizer and the colonized (Cope, 1955; Memmi, 1967; Dingwall, Rafferty & Webster, 1988; Wake, 1998). Dingwall, Rafferty and Webster (1988) reveal that the image of “the new nurse turns out to return a surprisingly large number of features of the old” (1988, p. 35). Could it be, therefore, that the ideal type preserves and protects old colonial nursing practices by keeping these practices systemically woven into the structure of Canadian nursing?

As the works of Giddings (2005) and Jacobs (2007) have significantly contributed to exposing the ideal type nurse, the union of their work creates a foundation by which this study can build on. In this study, I wish to address race, as well as political and multicultural issues that are further at play. As nursing embraces multiculturalism within its guidelines of best practice, the nursing curriculum, and its models and theories of nursing, it continues to ignore the lived experiences of those from the margins. Hence, nursing presents a neoliberal stance of being accommodating, but many argue that in reality, it is indeed the opposite (Calliste, 2000; Das Gupta, 2002; Hagey, 2002; Jacobs, 2008). Consequently, as multiculturalism policies continue to play an active role in the recruitment of IENs the works of Bannerji (2000) and Magnusson (2000) expose the neoliberal side of policies, which, instead of operating in favour of marginalized groups, in fact operates within a neoliberal context that makes it difficult to detect its practices of inequality and social injustices. IENs of colour are able to disclose the everyday practices that are unseen within nursing policies and guidelines, but remain present in the day-to-day lived experiences of these nurses.

Much of the literature on IENs is funded and supported by current nursing bodies such as the College of Nurses of Ontario, the Canadian Nursing Association as well as several
reputable faculties of nursing and science departments. Jacobs (2007) argues that the structural bodies of nursing continue to support each other and form an old girls’ club that works in the interest of the dominant space. Because of my own personal and lived experience in this area of study, I have decided to move this study from the conventional dominant spaces in which most nursing research takes place, and instead create a civic space by which the “other” or marginalized groups may be heard. I have chosen to draw from the works of multiple scholars within the academy, as well as give IENs of colour a space to tell their everyday lived experiences (Ono & Sloop, 2002; Smith, 2005). Smith recognizes that the everyday lived experiences of women are a crucial part of research and that “talking our experiences is a way of discovery” (2005, p. 7).

**Research Questions**

As IENs share their experiences throughout this study, we are able to find answers to the many questions that this research poses. This study asks the following questions: Have multiculturalism policies played a role in assisting IENs of colour into leadership positions? What role, if any, has the ideal type nurse played in supporting IENs of colour into leadership within nursing practice? And what is the relationship between the ideal type and multiculturalism policies within nursing? I hope that on a micro scale this study will expose the everyday experiences of IENs within Canadian nursing. As well, on a macro scale, it will also address issues that directly and indirectly affect the recruitment, satisfaction and retention of nurses, and in so doing, this study will assist in producing a stronger and better healthcare system.

Discourses surrounding multiculturalism argue that multiculturalism favours the interests of the dominant groups (Bannerji, 2000). It is clear, that multiculturalism is a problematic space, because it serves the government’s political agenda (Bannerji, 2000). For the purpose of this research, attention will be given to the ‘space’ that multiculturalism provides rather than the current discourses around the role of the space. By focusing on the multiculturalism space as presented by the government, it is hoped that the voices of those from the margins will tell their stories as it relates to the space of multiculturalism and its policies from their own experiences.
Researcher’s Background

Canada has been voted for seven consecutive years as the best place to live by the United Nations. It has sensitively replaced the melting pot phenomenon with the mosaic tapestry that, in a politically correct manner, better reflects Canada’s pluralistic society (Laczko, 1994). Canada is a good place to live. However, as the researcher for this research, I share similar experiences that many newcomers face today. Born and educated in England, I have lived in Canada for over a decade, and I do believe I am relatively well acquainted with the Canadian and English culture.

As an IEN, I came to Canada, like many other IENs, with comparable qualifications, experiences and skills that most Canadian nurses possess. At times, I received more opportunities than my colleagues from such countries as India and the Caribbean, whose qualifications are often considered inferior to their Canadian and English counterparts. I soon realized that coming from England and having a British accent offered me a level of respect that my other colleagues from India and the Caribbean did not receive. However, with non-Canadian credentials, my qualifications were still at times questioned in terms of the idea, “no Canadian qualifications and no Canadian experience.” Feeling as though I did not belong, and as an outsider, I decided to further my studies within a Canadian institution. I soon realized that having Canadian qualifications made little difference, as I watched Canadian nurses with fewer qualifications than I bypass me with better job opportunities.

The treatment that IENs of colour experience has a ripple effect that goes unnoticed and undetected by those in policy-making leadership positions. Having qualifications far beyond my Canadian counterparts, I resided in the hybrid space, which is a fixed space that deprives one of her rights to speak or be involved in policy-making decisions. There is an obvious difference when occupying a hybrid space with other Canadian White nurses. According to Jacobs (2007), Canadian White nurses are groomed, informed and supported to positions of leadership and power, while nurses of colour continue to remain as outsiders. The fact remains that many IENs become deskilled because they are deprived of opportunities to use their managerial and leadership skills. Raghuram and Kofman (2004) add that as women find themselves deskilled, they also find themselves demoralized within the process. In order to avoid being demoralized the participants in this study clearly created different strategies to cope and survive. Strategies of survival are not new to me as one who is marginalized by race and
gender. Therefore, the experiences I share with these women have assisted me in asking the appropriate questions, allowing me to leverage my “insider” status.

**Auto-ethnography**

As this study addresses the experiences of others, I found that my own experience cloned the experiences of the participants in this study. By including some of my own experiences within a cultural context, I realized that I was using auto-ethnography, as defined by Ellis, Adams and Bochner when they say, “auto-ethnography is an approach to research and writing that seeks to describe and systematically analyze personal experiences in order to understand cultural experience” (2011). In order to focus predominantly on the experiences of the women, auto-ethnography is a secondary framework that allows me to blend my experiences into this research without eclipsing the experiences of the participants in this study (Anderson, 2006; Hyman, Meinhard and Shields, 2011). Hyman, Meinhard and Shields point out that when multiculturalism is in place, social inclusion plays a central role. Hence, since this research involves multiculturalism, it is only fitting to include auto-ethnography as a way to further inform the study.

Considering the fact that IENs of colour have been denied a voice within the field of nursing research, I have chosen to report on their experiences within nursing by using in-depth interviews that will allow the participants to have a voice. As there currently is a large body of mainstream nursing scholars whose undercurrent studies address issues of an economic and political nature in nursing, this study will primarily focus on social justice and recommend ways in which multiculturalism policies may operate by supporting and protecting the interests of marginalized groups within nursing.

**Scope and Limitations**

The epistemology of the “ideal type” has been effectively addressed by Giddings (2005) and Jacobs (2007) however, their works have not addressed the ideal type nurse in light of its dialectic relationship with multiculturalism policies. This research study will build on Giddings’s and Jacob’s work. It will provide a broader analysis of how nursing operates under the umbrella of multiculturalism policies, while continuing to perpetuate colonial and
neoliberal themes through the values of the ideal type. Because the ideal type remains invisible within nursing practice, attempting to study the relationship between the ideal type and multiculturalism policies becomes an impossible task without the lived experiences of IENs. IENs of colour are central to the scope of this research, but the intangibility of the ideal type and the non-recognition of its value by mainstream nursing literature limits the scope of this study. Therefore, the ideal type can be better understood through the lens of IENs of colour.

I interviewed 10 participants who were IENs of colour with equivalent qualifications as required by the College of Nurses of Ontario (see Appendix 1). All the participants occupied positions in the hybrid space, but were not in positions that involved making or changing policies. A qualitative research method normally carries a significantly smaller number of participants in comparison to the number of participants in a quantitative research method (Polit and Beck, 2008). Because qualitative data allows for an in-depth analysis of the questions raised in the research, the number chosen is suitable in providing an insight into the population being studied (Kvale, 2007). Smith (2005) further endorses that in-depth interviews produce volumes and layers of information that require interpretation and become a true representation of those groups studied within the population. Smith (2005), along with many other feminist researchers, argues that the small number of participants to start off with provides quality information that is essential empirical data to the research and its outcomes.

All the participants came from the province of Ontario. Ontario was chosen because most new comers to Canada tend to reside in Ontario as it has a large diverse cultural population. Therefore, the participants represent a snapshot of the larger community of IENs living in Canada. As a Canadian citizen and an Ontario resident, I am familiar with the demographics and cultural genre within the province (CNA, 2009; CFNU, 2012). As the researcher and as an IEN of colour, the feminist paradigm allows me to engage with the research. Because interviews are used as the method of inquiry in this study, as the researcher, I am capable of asking appropriate questions that may otherwise be overlooked by another researcher who is not acquainted with the experiences of the participants. Therefore, I am able to interview and, empathetically represent those within the margins, as both a researcher and participant.
Definition of Terms

I have listed a “Definition of Terms” section Appendix 2; however, there are two terms that warrant defining within the introduction. They are: 1. “Praxis and Practice” and, 2. “Women of Colour.”

Praxis and Practice

The term praxis refers to the relationship between theory and practice. I initially referred to the praxis of Canadian nursing, but during the writing of this thesis I realized the political weight of the term praxis. As this thesis was mainly addressing nursing practice, I decided to refer to “the practices of Canadian nursing” instead. Current theoretical frameworks that are used with nursing curriculum, policies and guidelines (except by the few anti-racist feminist nurse-scholars such as Calliste) do not readily address issues of race and class. Because I am introducing different theoretical frameworks that do address issues of race and class to deconstruct old colonial practices, I have chosen to refer to nursing “practices” rather than “praxis” within the body of this thesis. Practice, therefore, relates to the everyday practice that occurs within Canadian nursing.

Women of Colour:

When identifying racialized women, there are numerous terminologies that can be used. The term “racialized women” is commonly used in the works of Jacobs (2007). Jacobs’ reasons for using the term racialized women and not “women of colour” is because, colour includes white and the dominant society racializes the “other” (2007, p. 9).

Another familiar common term used is ‘Black’. Black, when used within the context of British history and politics, describes people who are non-White (hooks, 1981; Mohanram, 1999; Das Gupta, 2009). Black demonstrates injustices and unfair treatment within institutions, laws, policies and everyday conscious and unconscious thought (Collins, 2000). The term Black embraces all women that are racialized as non-White. In addition, Black carries positive images of resistance and solidarity in Britain, such as is seen in the organization of South Asian women called, The Black Sisters of Southall (Sudbury, 2006). Mohanram states that:

Blackness is a discursive practice exercised by the confluence of history, culture, economics, geography and language, which conditions the enunciative function…yet the
notion of Blackness goes beyond its historically specific link to slavery and is also the transfer of an idea of resistance and decolonization (Mohanram 1999: p. xiii - xiv).

Mohanram’s (1999) definition expounds on the socio-political issues that are embedded in the term and how it becomes an effective avenue of resistance and decolonization. However, for some people the term ‘Black’ carries with it, strong negative connotations. Black within colonial thinking depicts a “lack”, of intelligence and ability (Fanon, 1963; Das Gupta, 2009). In the United States, however, the term Black was embraced by the Civil Rights Movement to depict resistance and freedom through such movements as the Black Panther, and terms like Black Power (hooks, 1981; Simmons, 2006).

For many racialized groups, due to the colonizing impact on the mind, the term ‘Black’ continues to have negative meanings and the term “of colour” becomes a more acceptable description. Many feminist scholars, such as Mohanty (2003), refer to women of colour because it appears to be inclusive of all women. Ross (2011) explains that “women of colour” was self-named by Black, Hispanic, Native and other racialized women as a term of solidarity.

I had struggled with what term to use when conducting a research on a group of women who were marginalized by their race, culture and even their professional status. Reflecting on what would speak to the experiences of the participants, while addressing the issues of race and class within this study; I decided to use the term “women of colour” as it seemed less offensive and self-explanatory.

First, the term racialized women was not familiar to people outside of the academy and required me defining it to each participant. Therefore, I decided not to use it, as many felt that it did not speak to their experience.

Second, the term ‘Black’ carried areas of negativity from women who have been educated and cultured into a neo-colonial space of learning. Also, some did not consider themselves as Black, while others, related to the term and found themselves politically charged and empowered. Because of the disparities among the women, it became safe to refer to them as ‘women of colour’; yet, my approach of “being safe” became problematic for me. I had to question whether, I too was appeasing the issues of oppression by being controlled by my own colonial indoctrination. Thinking within the discourse of neo-liberalism, initially, it became increasingly comfortable for me to accept the term woman of colour, as the term has commonly been seized and misused by many within a biological context (Ross, 2011). By gaining a good
understanding of its roots within the movement of solidarity building, I decided to use the term with the intent to reclaim it to its original source, that of the solidarity of women of colour.

I also decided to incorporate Black Feminist Thought as an avenue that addresses racism. Black Feminist Thought is not taught or used within the curriculum of Canadian nursing; however, because of the difficulty I faced with terminologies, it was important not to lose the layers of oppression that women of colour experience, while remaining unrepresented. In introducing Black feminist thought (BFT) I was mindful that my work covered IENs in Canada and for this reason Black Canadian Feminist Thought (BCFT) would be an effective tool to address issues of racism and oppression of these women within Canada (Wane, Deliovsky & Lawson, 2002). For this reason, I will amalgamate BFT and BCFT into one phrase, BCFT. BCFT, along with anti-racist feminism and post-colonial theory are all essential frameworks needed to assist in identifying the dialectic of the ideal type nurse and multiculturalism policies within the practices of Canadian nursing.

Organization of the Study

Chapter 1: This first chapter introduces the overview of the study, addressing the ideal type nurse and multiculturalism policies within the context of Canadian nursing practice. It also provides an overview of the research study, and states the research questions to be addressed in the study.

Chapter 2: This chapter addresses the joint relationship of three theoretical frameworks, namely: Post Colonial Theory (PCT), Anti-Racist Feminism (ARF) and Black Canadian Feminist Thought (BCFT). PCT provides a broad scope by which one can examine how nursing standards were born in colonialism and continue to operate within a colonial-neoliberal framework. The emerging works of anti-racist feminist (ARF) nursing scholars have created a new dimension to the field of nursing literature. Their works demonstrate legitimate research that questions institutional racism within a caring profession such as nursing. The works of ARF nurse-scholars continue to challenge mainstream nurse-scholars who currently dominate nursing research. However, this study will go further by incorporating Black Canadian Feminist Thought (BCFT). As a new dimension to the field of nursing literature, BCFT converges with
PCT and ARF, in creating a more global and specialized analysis of racism and class that systemically function and operate within nursing.

Chapter 3: is the Review of the Literature that forms the major theme of this study. This chapter presents the opposing arguments in current literature surrounding multiculturalism policies, its purpose within the wider society and how it influences the theories, models and practices within Canadian nursing. This chapter further introduces the concept of the ideal type nurse, showing the history and association of the ideal type within the body of nursing and how it continues to impregnate nursing values and principles, while remaining invisible to the naked eye. Chapter Three allows the reader to enter into the arguments around its existence, its relationship with multiculturalism, and its role within nursing practice.

Chapter 4: provides a detailed account of the type of methodology used and the reasons why it was chosen. As IENs of colour are the central actors within this study, IENs remain marginalized with no voice; therefore, qualitative, in-depth interviews provide a space within which they can tell their stories. Furthermore, it describes the process of selection and the difficulties as well as the triumphs faced within the process.

Chapter 5: provides an overview of the questions asked and the data collected.

Chapter 6: begins the first part of the data analysis and presents the themes identified from the research interviews. It examines the first three themes that have been labelled as “challenges” from the seven major themes that have been identified. It looks at how the first three themes connect within the context of the dialectic of the ideal type nurse and multiculturalism policies within the practice of Canadian nursing.

Chapter 7: is the second part of the data analysis, and addresses the last four themes out of the seven major themes that emerged. The last four themes have been identified as spaces of resistance. This chapter also provides an overview of the study, as it relates to the interpretation of the data through the lens of IENs of colour within Canadian nursing.
Chapter 8: is the final chapter, in which the conclusion and recommendations are presented. It demonstrates how the study relates to current literature, showing its importance in building upon existing work and creating new spaces for further study. This chapter also identifies barriers and limitations that may impede further research in this area. In spite of the barriers and limitations, this chapter provides recommendations for further studies and offers practical suggestions to improve Canada’s nursing practice.

Summary

This chapter provides an introduction and overview of into “Multiculturalism Policies: Identifying the Dialectic of The Ideal Type Nurse within the Practices of Canadian Nursing”. This chapter has demonstrated that IENs of colour are not only carriers of cultures, but are capable of shining the light on issues that lay hidden within the ideal type and multiculturalism policies. As multiculturalism policies claim to work for the interest of diverse cultures, its relationship with the ideal type has been questionable; on one hand they appear in opposition, but on the other, they appear to work in unison with one objective. The expertise that IENs bring to the table discloses the existence of the ideal type nurse and how hybrid spaces are created to preserve the binary spaces of leadership and menial positions found within nursing.

In the next chapter, chapter 2, I will present the three theoretical frameworks that are used to decipher the dialectic of the ideal type and multiculturalism policies.
Chapter Two

Theoretical Framework

In 2001, I came from England to Canada and began working as a Public Health Nurse in the heart of downtown Toronto. Considering that Toronto has a highly diverse population, I was somewhat surprised to see just a few nurses of colour that were Public Health Nurses in my department. I remember walking into the team meeting on my first day at work and seeing the shock on their faces. Yes, I was an English woman of colour, and I was not who they were expecting. What had transpired before was a buzz of excitement from the Nurse Manager who had spoken to me on the phone. She had told the staff that I had an English accent and I was from England. So the picture they had formulated in their minds was nothing short of a fantasy. Immediately, I felt a sense that I would have to work hard to fit in there. And my senses were correct.

After several months I became close friends with one of the public health nurses; and feeling somewhat guilty, she decided to tell me what the initial thoughts of the staff were when they first saw me. She said:

“When we first saw you, we all said, when you left the room that we were not going to like you. But you’re really, actually a very nice person.”

On several other occasions, one or two of the nurses would ask me, “Where did you get that English accent from?” Or they would say, “It’s not the real English accent is it? It’s not the Queen’s English, is it?” As I shrugged off such frequent questions, it soon became clear that they struggled with a woman of colour having a British accent.

Historically people of colour were not considered intelligent, yet the British accent was a sign of White supremacy and intelligence (Mohanram, 1999; Tregunno, Campbell, Allen and de Sousa, 2007; Fluertes et al, 2012); therefore, being a woman of colour with a British accent created a dissonance within the minds of many of these nurses.
Nurses from England, the Caribbean and India have similar nursing practices as nurses from Canada; however, there were some obvious differences in their attitudes and customs. Canadian-born nurses spoke openly and adamantly about gender inequalities and feminist issues, which were often uncommon to IENs (England, 2005). In her studies on immigrant nurses, England (2005) found that immigrant nurses found their Canadian counterparts to be more critical and debatable when discussing nursing issues than immigrant nurses who had adapted a culture of subservience. I was, therefore surprised when I was asked by a nurse colleague if I was a feminist. Confused by the nature of the question, I responded, “No”, and then asked her, “What do you mean by a feminist?” Eagerly, she enlightened me about mainstream feminism being the equal treatment of all women, and continued to essentialize her experiences and struggles as the same as mine. For a while I was bothered by her enlightenment; the picture she had painted of feminism was not what I was experiencing within the workplace. Instead, I experienced on numerous occasions, that as a woman of colour, I was fortunate to be in the hybrid space, where people of colour were poorly represented. And to make certain I never forgot, from time to time the authenticity of my English accent was called into question.

I decided to apply to a Canadian university in order to gain “Canadian qualifications” and a better understanding into the phrase feminism; what it meant and how Canadian nursing defined it. Surprisingly anyhow, I soon realized that since most nurses of colour were coming from neo-colonial spaces, the definition of mainstream feminism was definitely problematic. On one hand, to reject feminism within nursing for women of colour could potentially isolate IENs of colour as an outsider within the practices of Canadian nursing. On the other hand, however, to embrace mainstream feminism would be to essentialize all women and further silence the voices of IENs of colour within its practices (Watson, 1995; Sargeant, 2012).

The more I became exposed to the different types of feminist thoughts within the academy, the more I realised how mainstream feminism had assisted in sustaining the ideal type space, by ignoring difference and the different forms of oppression that IENs of colour experience (Collins, 2000; Jacobs, 2007). It became crucial, therefore, to introduce other forms of feminist theories that had primarily remained outside of nursing. By choosing post colonial theory (Memmi, 1967; Fanon, 1967; Loomba, 1998), anti-racist feminist theory (Calliste, 2000; Jacobs, 2007) and Black Canadian feminist thought (Collins, 2000; Wane, Deliovsy & Lawson,
my intent is to criticize nursing discourses of other theories that could enrich and empower nursing theory and practice.

Rationale

Nursing is the largest employment sector within the healthcare system, and with a growing number of people requiring healthcare, there are continual concerns whether the needs of the vulnerable sector of the population are being adequately addressed (Grady, 2002; Johnstone, 2006). According to Johnstone, “healthcare systems the world over are not as responsive as they need to be and are morally obliged to be to the health care needs of minority, racial and ethnic groups” (2006, p. 159).

A comparative study of the United States and Canada conducted by Lebrun and LaVeist (2011) show that Canadian Blacks tend to access the Canadian healthcare system more than African Americans; they have attributed this difference to Canadian Black population being younger, more educated immigrants and having access to a free healthcare system rather than African Americans who have expressed a history of oppression and have to use an expensive healthcare system. Lebrun and LaVeist’s study support the many reasons why Canada’s healthcare system must be reflective of its diversity (2011). With more people of colour in Canada using the services, there must be more people of colour in decision-making positions to advocate for equity of care and service for marginalized groups.

As nursing boasts about multiculturalism policies, transcultural learning, cultural sensitivity and cultural competency within its nursing practice, such claims are criticized by those who use and work within nursing (Boyle & Andrews, 1989; Kellogg, 1996; Brand, 1999; Leininger, 1999; Mohanram, 1999; Calliste, 2000; Mohanty, 2003). From the perspective of antiracist theorists, nursing is an institution like others that needs to adopt multiple frameworks and pedagogies that will be reflective of Canadian society. By adopting multiple frameworks and pedagogies, they will be capable of rupturing hidden practices that reproduce hierarchical relationships that occur within nursing (Shiva, 1997; Dei, 1999; Mapadzahama, Rudge, West & Perron, 2012).
Historically, nursing has been embedded in the patriarchal medical model as the only acceptable form of learning, which, although it supports the scientific dimensions of nursing, has, however, heavily influenced what is researched and what methods should be used in nursing research (Socham, 2011). In fact, Mapadzhama, Rudge, West and Perron, (2012) point out that old methods of quantitative and reductionist theory cannot adequately address subtle issues like class and racial inequalities that are embedded within nursing discourse and practice.

This research addresses three major concepts that pertain to social justice, namely colonialism, racism and inequalities; which are concepts that cannot be adequately explored by conventional nursing theories and models at this time. A moment will be taken to review each concept.

**Concept of Colonialism**

The professionalization of nursing has its roots within the Nightingale Model of Nursing, which recognized nursing as being on par with other professions, such as doctors, lawyers and engineers (Herdman, 2004; Tschudin & Davis, 2008). Florence Nightingale introduced the formal education and training of nurses through the Nightingale Schools of Nursing. Nightingale has been called a scholar ahead of her time, showing that theory and clinical practices can be linked in providing nursing care (Selander and Crane, 2010). But Nightingale’s work suggests colonialism, which Scheurich and Young refer to as “civilizational racism” (2002, p. 22). Colonialism formed the foundations of nursing practice in the colonies and the Empire alike (Wagner & Whaite, 2010; Selanders & Crane, 2010).

With the discursive of colonialism after World War II, colonial practices still continued within the colonies and the empires. Today, with a paradigm shift toward globalization, some have argued that globalization still continues the practices of colonialism, but just under new terminologies like neo-liberalism, neo-colonialism, and even the ideal type (Escabar, 2004; Giddings, 2005; Jacobs, 2007). Colonialism is more than a way of thinking, but includes one’s culture, and hence, one’s identity (Selanders & Craine, 2004; Wagner & Whaite, 2010). The binaries created by colonialism still continue in everyday practice, but become increasingly harder to see within the display of global unity (Bannerji, 2000). Therefore, to deconstruct the
very terrains of colonialism requires a theoretical framework that is capable of addressing its historical, as well as present practices within nursing. Post colonial theory becomes the appropriate framework to unravel the concepts of colonialism within nursing.

**Concepts of Racism**

Canadian nursing aims to reflect Canada’s pluralistic society by implementing discourses of diversity within its nursing policies (Kavahagh, 1993; Bagnardi, Bryant & Colin, 2009). Cultural competency and transcultural learning are some of the discourses that remain central to nursing theory and practice (Leininger, 1995). The College of Nurses of Ontario (CNO), which is the nursing regulatory body for Ontario, makes little mention of the effects of racism within nursing (Jacobs, 2007). The CNO’s primary interest is for the customer and its downplay of systemic racism has created a conflict with studies into racism in nursing. Research shows the unfair treatment and disciplinary procedures that nurses of colour are subjected to by employers, and regulatory bodies alike (Das Gupta, 1997; Jacobs, 2008). However, the Registered Nurses’ Association of Ontario (RNAO) has given more attention than the CNO to the severity and repercussions of racism. According to the RNAO:

Racism is systemic in our society and endemic in our institutions. Racism has the effect of excluding groups of people (based on their race, colour, nationality, ethnic or ethno-religious origin) from decision-making processes and leadership and economic opportunities. Racism is both an attitude as well as the specific actions resulting from that attitude. The result is to marginalize and oppress some people and to sustain advantages for people of certain social groups (2006).

The RNAO clearly identifies racism as being both systemic and institutional, and, therefore, very much present within nursing. This is made further evident through the everyday work experiences of nurses of colour. The absence of IENs of colour from policy-making positions of leadership highlights how issues of racism and inequalities remain hidden in nursing practices, while nurses of colour continue to be ignored by their White counterpart (Flynn, 1998).
When addressing the concept of racism within this study, I have had to unpack deep-seated issues that stand the risk of being generalized or excused. Racism is real in nursing and the few nursing scholars that take the risk in addressing it need to be given a platform by which to be heard. These nursing scholars mainly use ARF, such as Calliste (2000), Hagey, (2004) and Jacobs (2007). Das Gupta, although not a nurse, but a scholar, has done extensive work on racism and nursing that also warrants attention. Although BCFT has not received attention within mainstream nursing literature, BCFT does offer a historical account of racism and works well alongside PCT and ARF.

**Concept of Inequalities**

Since the opening of Florence Nightingale’s first nursing school in 1860, nursing has propelled to a highly desired profession within the global economic market (Herdman, 2004; Tschudin & Davis, 2008). The baccalaureate degree in nursing forms the basis for becoming a registered nurse in Canada. Therefore, nurses are updating their skills and qualifications, and as such producing a competitive environment for leadership (Somers, Finch & Birnbaum, 2010). Sadly enough there still exists a large volume of nurses working outside of the field of nursing (e.g. IENs of colour) who can play a vital role in stabilizing the nursing shortage that currently affects Canada’s healthcare system (Black, Spetz & Harrington, 2008; Canadian Institute of Health Information, 2010).

IENs of colour face more challenges than other nurses in Canada, because of existing obstacles that are already in place; one such obstacle is them having foreign credentials. Although their foreign credentials have been approved by the CNO and the department of Citizenship Immigration Canada (CIC), they continue to have their credentials questioned and viewed as not being the same as Canadian nursing credentials by nursing managers and colleagues alike in the work place (Cheng & Yang, 1998; Wanner, 2001; Li, 2001).

Employment, finance and qualifications all play a significant role in determining how people are placed within the social strata of society, and therefore highly skilled, educated and experienced IENs of colour, not only find themselves slotted into lower paid positions, but they are also placed into a lower social class network than what they knew in their homeland. Brand
(1999) found that nurses of colour are often given casual and part-time positions, and that this has a profound impact on their finances, the chances of furthering their education, and prospects of promotion. In addition, studies on work and employment have either demonstrated that women of colour occupy the lowest paid sector of the population or are purposely omitted from data collection for employment research (Woody, 1992; Bannerji, 1997; Brand, 1999; Li, 2001). Calliste states that:

Black nurses tend to be streamed into the least skilled and desirable areas (such as chronic care) irrespective of their qualifications and experience because of managements’ perception that these women do not have the qualifications to work in other units (2000, p. 143).

From Calliste’s studies, it is clear that the positioning of Black nurses mimics old practices of racial divide. As many IENs of colour are slotted in menial positions, those who find themselves as frontline workers with a title of leadership are rarely permitted into management positions, and are given little opportunity to propel higher and further.

**Choosing a Suitable Framework**

In choosing a suitable theoretical framework it was obvious that more than one would be needed to unravel concepts of colonialism, racism and inequalities. Post Colonial Theory (PCT) has been used by some nursing scholars to unravel colonial discourse within nursing and therefore, proved an already tried and capable type of framework to use for this study (Reimer, Kirkham & Anderson, 2002). Likewise, Anti-Racist Feminism (ARF) has also been used by a selected number of scholars in studying the treatment of nurses of colour within nursing (Calliste & Dei, 2000; Das Gupta, 2011). However, the body of scholars who use ARF often find themselves marginalized within the scholarship of nursing, and their works are rarely cited within the nursing research. BCFT on the other hand remains outside of nursing literature (Collins, 2000; Wane et al, 2002). Therefore, I have chosen to use all three theoretical frameworks, because they are capable of adequately addressing all three concepts.
**Post Colonial Theory**

Post Colonial Theory (PCT) has been used to address issues of colonial dominance. It has the unique ability to extract from the past and make it relevant to the present (Spivak, 1999). Loomba (1998) points out that PCT is a crucial tool for identifying colonial practices within institutions. Loomba (1998) continues by saying that it is inappropriate to study the experiences of women (and nurses) from ex-colonial countries, without using post colonialism. PCT is capable of identifying and providing a broad analysis of issues concerning race, class and gender, as well as illustrating how general disengagement from colonialism takes place.

So why is PCT important to this study? The reason is because of Canada’s history, but also and importantly, the IENs that were interviewed came from the British colonial space. Historically, Canada was once dominated by two colonial empires, the British and the French. However, after the Treaty of Paris in 1763, the British gained exclusive rule, and by 1867 Canada officially became the “Federal Dominion of Canada”, which marked the end of British rule over the Head of Government. Canada continued to allow the British monarch to remain the Head of State (Ross Kerr & Macphail, 1996), thus allowing the influences of colonialism to remain deeply rooted in Canada (Camfield, 2013). Although British rule ended by 1867, after World War II and the dismantling of the colonial empires, it became clear that Canada continued colonial practices (Jackabowski, 1997). It was evident in Canadian politics, culture, education and immigration policies that colonialism was still at work (Sugunasiri, 2001; Gunew, 2004); and it took political pressure from the United Nation and England to compel Canada to change its immigration laws by letting people of colour into Canada (Jacabowski, 1997; Citizenship and Immigration Canada (CIC), 2012).

Canada presented a peace offering to the global community in the form of the first multiculturalism policy, as a way of mending old wounds. But, strangely on a local level, this has not necessarily been the case. Institutions like nursing still continue colonial practices, which require a framework such as PCT to discern and rupture such disguised practices. Some of the strengths of PCT are:

1) It claims gives a voice to the marginalized (Memmi, 1965; Loomba, 1998).
2) It can explain power relations between nations and within nations, thus showing differences between cultures and societies and how power interplays within these differences (Young, 2003).

3) It exposes binary oppositions that are operated through power and culture (Memmi, 1965; Loomba, 1998).

4) It is built around the concept of resistance (Childs and Williams, 1997).

Besides the criticisms made toward PCT, it still remains capable of unravelling hierarchical systems that continue to exist within nursing. That is, the many compelling criticisms concerning PCT do not prevent it being a useful tool to expose colonial practices (Fitzpatrick, 1983; Dingwall, Rafferty & Webster, 1988; Mansell, 2004). PCT is also useful in that it can address macro sites within this study, such as race, historical locations, hybridity of colonial cultures and issues regarding binaries (domination and subordination, etc.). These macro issues need to be addressed within this study, however, there are micro issues that also need to be uncovered, and for this reason I integrate two feminist theoretical frameworks, ARF and BCFT that are imperative to this inquiry.

Anti-racist Feminism (ARF)

One of the problems that arise when using PCT within a gendered profession such as nursing is the influence of mainstream feminism within its practices (McEwen, 2001; Melchior, 2004). For this reason, it becomes relevant to use an anti-racist feminist framework to unravel the multiple discourses that continue to occur within nursing over the past century. Since the implementation of the first multicultural policy over 40 years ago, Canada has moved from being homogeneous, with predominantly White nurses, to heterogeneous, having a pluralistic body of nurses (Weaver & Olson, 2005; Denzin, Lincoln & Giardina, 2006). These changes in nursing call for a new lens by which nursing can be studied. Mainstream feminism has predominantly concentrated its attention on the power dynamics between male doctors and female nurses (Zelek & Phillips, 2003). However, a shift toward ARF within this study will bring a deeper understanding concerning issues of inequality that occur within the nursing institution and
among its nurses. ARF is capable of unearthing racism and inequalities within nursing that mainstream feminism fails to do (RNAO, 2006). Some of these issues that ARF will be able to address in this study are:

1) Bringing the works of ARF nursing scholars to the forefront by opening new and innovative opportunities for their works to be used in further studies.

2) ARF may provide a better understanding into the root cause of Canada losing large numbers of Canadian nurses to the States and the difficulty they face in retention of immigrant nurses (Kolawole, 2009).

3) ARF is capable of addressing issues of race and class that remain poorly studied and recognized in the works of government funded programs and studies pertaining to IENs (Murphy & McGuire, 2005; Blyth & Baumann, 2009).

ARF is central to unearthing the issues that IENs of colour face in their everyday lives; however, there exists another framework that can contribute to this study, that of Black Canadian Feminist Thought (BCFT).

**Black Canadian Feminist Thought**

Why use BCFT? What relevance does it play in such a study that seems adequately covered by PCT and ARF? The relevance of BCFT to this study can be best understood by returning to the opening story of this chapter. When I was asked by a nurse if I was a feminist, my answer was no, since I was coming from a neo-colonial space that did not relate feminism with nursing. In addition, Canadian nursing had identified with feminism, but from a mainstream definition, that we are all the same. BCFT holds a relevant perspective that allows it to diverge from its sisters ARF and PCT. BCFT has been described by Wane as:

> A theoretical tool meant to elucidate and analyze the historical, social, cultural and economic relationships of women of African descent as the basis for development of a liberatory praxis. It is a paradigm that is grounded in the historical as well as the contemporary experiences of Black women as mothers, activists, academics and community leaders. It is both an oral and a written epistemology that theorizes our experiences as mothers, activists, academics and community leaders. It can be applied to
situate Black women’s past and present experiences that are grounded in their multiple oppressions (as cited in Wane et al, 2002, p. 38)

Wane’s definition of BCFT specifies the historical and contemporary context within the relationship of Black women. It identifies the multiple roles they play and honours their achievements as activists. Unlike mainstream feminism that ignores the multiple oppressions that Black women face, BCFT gives attention to how oppression plays out in their experience.

Black Feminist Thought (BFT) has been identified in the works of hooks (1981) and Collins (2000). However, their African-American perspective fails to speak to the lived experiences of the participants in this study, who come from ex-colonial locations. Therefore, Massaquoi and Wane address the “centre of departure” from BFT and they show in their works how BCFT addresses the “multiple” oppressions that Black women face as it relates to living in Canada, a place they sometimes find hard to call their home (2007). BCFT, therefore, becomes relevant to this study, because it is “a distinct method that has the ability to analyze gender, class and nation-building” (Massquoi and Wane, 2007, p17). As this study addresses those from the margins, it is important not to essentialize their experiences that have so often been done by mainstream feminism. Therefore, BCFT will assist in “grounding all theory into practice”, which is the core of this thesis as it looks at the “practices of Canadian nursing (Wane, 2009).

Identifying oneself with Feminism

The term “Feminism” has multiple strains and is defined differently by those outside of Western thought (Mohanty, 1991). To those outside of the West, feminism is a lived experience from within (Narayan, 1997; Amos & Parmar, 2001; Wane et al, 2002). As a woman of colour, I came to Canada with a plethora of ancestral knowledges that catapulted me beyond the Western definition of Feminism, and for this reason, I was unable to be caged into the nurse’s definition of feminism. Therefore, I was not a feminist in her limited understanding, but as far as I was concerned, I lived indigenous values of feminism in my daily encounters and activist work.

Summary

IENs of colour have multiple layers of oppression that are imbedded in their history and their present experiences. They have developed survival skills transferred to them from
generation to generation. Such skills they carry are cohesiveness, community spirit, resiliency, resistance, restoration, memories of their past and their ancestral past, as well as the spirit of activism and spirituality (Amos & Parmar, 2001; Pinn, 2003; Prendergast, 2011). And yet they continually are in need of being decolonized in spaces where colonial thinking and practices dominate. As mainstream feminism, with its discourses, cannot understand the experiences of IENs of colour, and fails to enhance the multiple abilities of IENs, it is for this reason that BCFT plays an important part in deconstructing Western thinking and introducing its own body of relevant knowledge. BCFT needs to enter the nursing space that ordinarily interprets feminism to its own advantage. To omit BCFT would be to omit the voices of women (hooks, 1984; Mohanty, 1988). This study, therefore, demonstrates how PCT, ARF and BCFT converge to unlock deeper issues, which otherwise could not be unlocked by mainstream feminism. In so doing, ARF and BCFT rightly compliment the abilities of PCT on a micro, as well as on a macro level.
Chapter Three

Literature Review

Introduction

Nursing shortages are a growing concern within the discourses and the new global economy (Kingma, 2008; Hirshchfeld, 2008; Tyler-Voler, 2009). With the baby boomers approaching retirement, and people living longer than previously, there is an increasing demand placed on healthcare services to address this shortage, and in so doing maintain a healthy workforce and a strong economy (Little, 1997; Mitchell, 2003; LeVasseur, Wang, Mathews and Boland, 2009). Statistics Canada estimates that by 2036, Canada’s population could increase by 40 million people with a fall in birthrate and an increase in the elderly (Statistics Canada, 2010). As a result of such projections, for the past 40 years, the number of IENs have increased in such countries as Canada and the United States (Blythe, Baumann, Rhéaume and McIntosh, 2009). Blythe et al, (2006) showed that 34.1% of new nurses were IENs in 2006.

One of the influential factors for this increase has been Canada’s multiculturalism policies’ prospects of security and liberty (Reitz, 1988; Dei, 2011). However, studies show that when highly skilled professionals migrate to Canada, they find themselves in low-paid jobs where they experience deprofessionalization and loss of skills (Raghuram, 2009; Groenhout, 2012; Wanner, 2001; Nelson, 2004). In addition, their home countries become brain-drained and dependent on these same thriving countries (Reitz, 1988; Dei, 2000; Wanner, 2000).

In light of multiculturalism policies that have strongly influenced nursing, there still remains a strong colonial presence that is reflected within nursing leadership where White nurses occupy seats of power and nurses of colour are found in menial nursing positions (Calliste, 2000; Jacobs, 2007).

IENs of colour come to Canada with a wealth of knowledge, skills and experiences from their previous positions as leaders and policy-makers in their own country (Hawthorne, 2007; Kolawole, 2009). Yet when they arrive, they often find themselves in low-paid, menial positions.
that are a far cry from the leadership positions they once occupied. The positions IENs occupy keep them as frontline workers with some autonomy over their work. The few who have worked their way to better nursing positions have done so by achieving competitive qualifications.

The hybrid space includes public health nurses, team leaders, clinicians and clinical case coordinators. Although IENs possess comparable experiences, qualifications and skills as their White, Canadian counterpart, IENs are considered unsuitable to enter spaces of leadership where policies are made (Calliste, 2000; Jacobs, 2007). This has led to a range of disappointments and unfulfilled dreams and promises. Although the purpose of this literature review is to examine the concept of the ideal type nurse and probe its inconspicuous relationship with Canada’s multiculturalism policies, this review will also set the ‘soil’ that is produced within the hybrid space by the ideal type and multiculturalism discourses.

The ideal type and multiculturalism policies are dualistic by nature; however, there exists an inconspicuous relationship between the two that allows them to co-exist within the practices of Canadian nursing; and it is the nature of this relationship that needs to be examined. Does multiculturalism support the ideal type in order to preserve the White space of leadership or does it appear to do so, in order to preserve a space for social justice and equality? This study will endeavor to identify and unravel the dialectic relationship, and see if their support for one another is based on their own personal interest. Since the dialectic refers to the unexpected relationship of the ideal type and multiculturalism, this thesis will examine how this dialectic relationship plays out within the hybrid space through the everyday lived experiences of IENs of colour (Connor, 2003).

The literature review will be divided into five sections and these five sections are what make up the soil that IENs have to work and germinate in. The first section will examine Canada within the global economy and how such issues as immigration and a segregated labour market interact within the relationship of the ideal type and Canada’s multiculturalism policies. The second section will focus on specific nursing practices, such as cultural sensitivity and transcultural learning, both of which support the values of Canada’s multiculturalism policies and the determinants of health (Citizenship and Immigration Canada, 2012; Mikkonen and Raphael, 2010). In addition, nursing practices will also give attention to the academic shifts within nursing and how these shifts continue to influence global and cultural changes.
The third section will further look at Canadian nursing as it is today, and the ways that feminism has historically influenced and shaped nursing practice today. The fourth section will take a further look at Canada’s multiculturalism policies and question whether nursing has benefitted from such policies. Finally, the fifth section will discuss the discourse of the ideal type, its origin and its presence within nursing. I will finally conclude by addressing the term, “dialectic”, a term which is used to describe the relationship between the ideal type and multiculturalism policies within nursing practice.

**Canada within the Global Economy**

Canada has gained popularity within the global arena as a benevolent and peaceful country. Along with its multiculturalism policies and support of human rights, Mainstream Canada takes pride in recognizing itself as the “Great North strong and free” (Economic Intelligence Unit, 2003). Even as a relatively new country, Canada is an influential voice among financial institutions that underpin the global economy (MacMillan and Grady, 1999; Financial Post, 2012). One area in which Canada aims to maintain its popularity is in the area of Research and Development. In 2007, Prime Minister Harper stated that:

> We recognize that all Canadians - not just our scientific, technical, and business communities - have a stake in us getting it right. That’s why I believe that Mobilizing Science and Technology to Canada’s Advantage - a bold, new framework to guide Canada’s science and technology policy for the future - will help us meet the many and exciting challenges that lie a-head (Stephen Harper, Prime Minister, 2007, Canada’s New Government Report, p. 1).

From the Prime Minister’s statement we see that in 2007, the Federal government’s investment into Research and Development has led to the advancement and financial support of science and business programs within post secondary education (Cooper, 2000; Cappon, 2008). Canada remains also popular for having one of the largest uptake of post secondary education in the world (Canadian Information Centre for International Credentials (CICIC), 2009; Statistics Canada, 2010); and according to the Canadian Population Health Initiative’s (CPHI) 2004 Report, the government’s support of secondary education has linked the reduction of poverty and
poor health as a way to create a healthy, thriving workforce (Public Health Human Resource Planning (PHHR) 2005).

Canada has also preserved its leadership and innovative image within the global market through its trading power (Hart, 2002). The Department of Foreign Affairs and International Trade Canada (2012) views Canada’s alliance with the United States and Mexico (through the North American Free Trade Agreement (NAFTA)), as crucial in sustaining Canada’s status as a competitor within the global market. The Department of Foreign Affairs and International Trade Canada state that:

The Agreement has brought economic growth and rising standards of living for people in all three countries. In addition, NAFTA has established a strong foundation for future growth and has set a valuable example of the benefits of trade liberalization (Office of the United States Trade Representative, 2002). According to the government, NAFTA is a positive move for all three countries. Hart (2002) supports the NAFTA agreement, because it allows Canada open, secure and free access to a super power such as the United States, while demonstrating its philanthropy toward Mexico. This triad relationship, according to Hart (2002), further strengthens Canada’s status of benevolence within the global arena (Cuddehe, 2009).

The view of Canada being a compassionate and kind country within NAFTA has, however, been heavily criticized by Sebastian and Hurtzig (2004). They argue that Mexico has definitely seen an increase in the numbers of factories and jobs, and in light of all this, poverty remains substantially higher in Mexico than in the rest of North America since its alliance with NAFTA (Sebastian and Hurtzig, 2004). In the 2011 Census, besides U.S. residents in Canada, Mexicans were the second largest group of residence from the Americas (Statistics Canada, 2011).

Overall, Canada’s healthcare system has felt the brunt of having a free trade agreement, the United States recruitment of Canada’s very best professionals. As a result of Canada’s losses, a World Health Organization’s report lists Canada’s healthcare system as a ‘B’, ranking Canada 10th among 17 other countries (Little, 1997; Hoag, 2008; Conference Board of Canada, 2007). Arguably, it is in Canada’s best interest to resolve its nursing shortage problem and create a strong and thriving healthcare system that will further strengthen Canada’s position as a leader within the global economy.
In addition to Canada increasing in research and development funds; having one of the highest post-secondary education uptakes, and being an active member of NAFTA, Satezwich (2004) earlier works stated that Canada’s ‘success’ was due to its multiple laws and policies that claim to provide equal opportunities within its institutions. Satezwich (2004) also stated that Canada’s immigration acts, employment acts and its Charter of Rights and Freedoms seemed to have effectively erased racism and inequality from Canadian culture. Racism, he described, could only occur on an individual level, not on a Provincial or Federal level. Razack (2005) disputed Satezwich’s views by referring to Canada’s history of disturbing practices that have spilled over into present-day practices. Razack (2005) argued that when the British Empire colonized Canada, it left an unsavoury history of cruel treatments handed out by the Europeans toward Canada’s indigenous population (see also Battiste, 2000; Neil, 2000; Bannerji, 2000; Galabuzi, 2005). Fortunately, Satezwich’s later works supports Razack’s argument in which he asks for “Whiteness” to be challenged, because racism remains systemic within Canada (2007). Parera (1999) illustrates how Canada no longer continues to be the bi-cultural society it once was, where oppression was experienced by the French; but rather, Canada is now multicultural and the present discourses, such as the Charter of Rights and Freedoms have only masked the severity of racism that continues to be perpetuated.

Although Canada is highly respected and recognized as an open and accepting society (Laczko, 1994), Galabuzi (2005) argues that Canada has perpetually concealed through governmental discourses its patterns of discrimination and inequities as a means of maintaining its prestigious position within the global economy. For Canada to successfully thrive within the current global economy, it must recruit from elsewhere to preserve a strong thriving workforce (Bannerji, 1997; Hart, 2002). One such group of people is internationally educated nurses (IENs). Kolawole (2010) points out that Canada has had to recruit from other countries to make up for the deficit caused by the exodus of Canadian educated nurses to the United States and the further expected drop in nurses by 2022 (Tomblin et al., 2009). To replace their loss of human capital with the equivalent, Canada is not only recruiting according to one’s qualifications, skills and experiences, but is also turning out record numbers of nurses from post-secondary education.

For Canada to successfully sustain a positive image, while camouflaging practices of supremacy, it has to streamline highly qualified newcomers with foreign credentials into low paid and low status jobs (Cheng and Yang, 1998 and Li, 2001). Canada justifies having highly
educated people in low paid and low status jobs by using the excuse that they fail to have Canadian qualifications or Canadian experience (Cheng & Yang, 1998; Li, 2001; Kreissl, 2011).

Canada’s multiculturalism discourses have built a strong reputation for Canada. By portraying Canada as a land of equal opportunities, IENs come to Canada with skills, qualifications and experience that are comparable to that of Canadians (Li, 2001; Cheng & Yang, 1998). However, their dreams are soon shattered as they find themselves slotted into menial nursing positions which Canadian-educated nurses refuse to occupy (Calliste, 2000). This pattern is familiar to other internationally-educated professionals, such as doctors and physiotherapists and pharmacists (Schalm & Guan, 2009). Raghuram and Kofman (2004), along with O’Brien (2006) and Edwards and Davis (2006), found that immigrant women (including nurses) find themselves alienated from their field of specialty, and as a result, they become deskillled and fixed in terminal positions.

As studies regarding the unfair treatment of nurses unfold (Calliste, 2000; Das Gupta, 2002; Jacobs, 2007), it is commonly believed that internationally-educated professionals experience the same opportunities as others, when trying to navigate their way out of menial positions to positions of leadership (Government of Ontario, 2005; Satezwich, 2004). Satezwich’s argument that professionals have the same opportunity as anyone else in Canada to enter spaces of leadership has been opposed by Tregunno, Peters, Campbell and Gordon (2009) who found that IENs did not have the same opportunities, but rather experienced multiple barriers, such as language difficulties and nursing practices, all of which retain them as outsiders.

The impact of being an outsider as well as a woman of colour often resulted in feelings of inadequacies and insecurities that in turn affected her skills and abilities (Anderson & Kelley, 1998; Gardener, 2005; O’Brien, 2006). Sherman (2007) notes that there was a lack of support for IENs in North America from management; IENs often were left and felt isolated and unable to climb the ladder to leadership. Also, Sherman (2007) suggests that in order for IENs to be assimilated into North American nursing practice there is a need for leadership, supervision and support. Although Jacobs (2007) agrees that support is readily offered, the support is typically offered to White Canadian nurses by their supervisors and managers, but not offered to nurses of colour.

Also, for long time is has been commonly believed that people from developed countries are more advanced than those from developing countries (Flynn, 1998; Gardener, 2005; Scheurich and Young, 2002). Flynn (1998) and Gardener (2005) found in separate studies that
IENs were often labelled as less intelligent and loud. However, Nestel (2002) found that those who come to Canada with comparable qualifications often have a wider exposure of hands-on, practical experiences, which many North American nurses seek to obtain. Nestel demonstrated how Canadian nurses would regularly choose to work abroad as what she calls a form of “tourism” (2002, p. 242). This was done in order to gain greater exposure, which then allowed them to introduce these newly found skills into Canadian nursing practice. Although Canadian nurses who work abroad return to Canada as heroes, IENs who are recruited into Canada receive a different type of welcome from their Canadian colleagues; they are labelled as lacking in Canadian qualifications and Canadian experience (Cheng & Yang, 1998; Brand, 1999; Calliste, 2000; Li, 2001; Kreissl, 2011).

Racism and class inequalities have effectively excluded certain groups of people (hooks, 1984; Calliste, 1996; Raghurum & Kofman, 2004; Acker, 2004). Yet nursing has for so long denied any practices of inequalities and division, by displaying some nurses of colour as occupying the hybrid space. Most studies into IENs continue to address two common areas: the large number of IENs who occupy menial positions, and the few nurses of colour who have broken ranks and entered the echelons of nursing leadership.

The Making of a Hybrid Space

Within nursing there exists another tier that nestles between the menial and leadership tiers within nursing. I have coined this, the ‘hybrid space’. The hybrid space refers to a nursing space that combines limited leadership with frontline work. The term hybrid was first made popular by the postcolonial scholar, Homi Bhabha. However, Burke (2009) produces a good understanding of hybridity by explaining how hybrid relates to mixing. In spaces where mixing occurs, there is a culture of its own that is formed. This new culture combines past and present, new and old, and therefore is capable of identifying conflicts within what Burke terms, “cultural globalization” (2009, p 109). The hybrid space operates on a micro as well as a macro level within nursing.

IENs of colour have to face difficulties when having their qualifications recognized by their nursing employers. Therefore, many have gained Canadian qualifications as a way of carving for themselves the right to an “entitled” space within the dominant space of nursing. As IENs who are already highly educated, they now present themselves with additional Canadian
qualifications and experiences to meet the expectations of Canadian employers (Li, 2001).

Arguably, nursing has had to avoid any backlash by creating this so-called hybrid space to compensate for keeping IENs out of the decision-policy-making space of leadership. Since the hybrid space is comprised of Nurse Clinicians, Public Health Nurses, Team or Unit Leaders and Clinical Case Coordinators, they are given some autonomy on how they deliver the service to the public, but they are restricted from the top leadership space where decisions and policies are made about their role and the services provided to the public.

The hybrid space is occupied by highly qualified IENs who are excluded from the echelons, yet cannot be contained within menial spaces because of their high levels of achievement and superior abilities. Instead they remain frontline workers within the hybrid space where they receive some autonomy, but not enough to influence nursing policies.

The credentials for IENs are evaluated based on the regulatory body of the province they work within (CICIC, 2011). Once they meet the criteria, then they must take a Canadian provincial exam. The discourses around credentials have been the recognition of foreign credentials, can be perceived differently by employers in the workplace, and this often poses problems for foreign educated professionals having difficulties in finding the work in their field of expertise (Li, 2001; Slade 2004).

IENs of colour who occupy the hybrid space have become tokens to the world, to prove that the multiculturalism policies actually work. However, these nurses still remain front-liners, who are not necessarily deskillled, but are subtly barred from opportunities that can progress their skills. For this reason, they find their capabilities and qualifications being continually undermined covertly and at times overtly. For these IENs of colour within the hybrid space, their role is nothing more than a scaffold that holds the existing structure together, yet they are dispensable at any time (Bannerji, 1997).

Currently, there are growing studies tackling the issue of racism and class within nursing, but while writing this thesis, there presently exist no studies that uses the term, “the hybrid space” to address frontline workers within nursing. Therefore, a further look will be taken into how systems, such as immigration and the segregated labour market operate to maintain practices of inequalities by selecting the academically fittest from abroad and strategically placing them in the hybrid space to support Canada’s own agenda.
Immigration

Canada heavily relies on immigration for a successful and reliable workforce within the global economy (Knowles, 2007; Kelley and Trebilcock, 2010). With Ontario being the leading destination for immigrants coming to Canada, Ontario’s thriving economy is constructed as being at threat due to the forecasts that show an ageing population, low birthrates and the future risk of not having enough workers to meet the demand (Sousa, 2012). For this reason, the Province of Ontario justifies recruiting internationally-educated workers that can both address Canada’s pending nursing shortage, as well as maintain Canada’s leading position by recruiting the brightest and best from abroad (Sousa, 2012).

To immediately address the problem of Canada’s projections of a fall in the percentage of working population, the Provincial and Federal governments have stressed the importance of efficiently evaluating foreign credentials (Ontario Ministry of Citizenship and Immigration, 2010). However, when newcomers arrive in Canada, they find their qualifications that had been recognized by the Federal government not necessarily recognized by the Provincial government or the professionals within nursing licensing boards (Ontario Canada, 2009). Reitz (2007) argues that although people may come to Canada based on their skills and qualifications, they are often denied access or opportunities into the occupations that they were recruited for. Even though the Federal and Provincial governments fund numerous bridging programs, Gurchairn and Li (1999) argue that Canada’s immigration policies intentionally support racial segregation and alienation by including some people and excluding others (Kelley and Trebilcock, 2010). Such practices have been described by Loomba (1998), as akin to old colonial practices.

Although Canada has always depended on immigrants for a stable workforce and strong economy (Galabuzi, 2005; CIC, 2012), the type of immigrants have changed over the years. Historically, Canada had depended on immigrants for labouring and farming skills (Hart, 2002; Knowles, 2007; Kelley and Trebilcock, 2010); however, following World War II, the need for skilled workers and professionals grew in order to propel Canada towards the new paradigm shift that was on the horizon (Jackabowski, 1997; Reitz, 2005; CIC, 2012).

The tragic legacies caused by the war soon led to the United Nations and Britain’s critical evaluation of Canada’s immigration policies (Jackabowski, 1997; CIC, 2012). Canada’s blatant racial practices of preserving a “true White North” were critiqued as the new global community (Jackabowski, 1997; Kelly and Trebilcock, 2010). Canadian immigration policies unashamedly documented preferences for people from Northern Europe and curbed those from such countries
as Italy (Jackabowski, 1997; CIC, 2012). Skilfully, old immigration policies were still influencing the new changes that the world was trying to make (Jackabowsky, 1997). Jackabowski (1997) quotes from the Manpower and Immigration policy as late as 1974 show the common thinking of that time when it says:

The policy of the Department at the present time (1910) is to encourage immigration of farmers, farm labourers, and female domestic servants from the United States, the British Isles and certain Northern European countries, namely France, Belgium, Holland, Switzerland, Germany, Denmark, Norway, Sweden and Iceland. On the other hand, it is the policy of the Department to do all in its power to keep out of the country....those belonging to nationalities unlikely to assimilate and who consequently prevent the building up of a united nation of people of similar customs and ideals (Manpower and Immigration, 1974, cited in Jackabowski 1997, p. 16).

Therefore, in light of demands made by England and the United Nations, Canada became actively involved in global affairs and introduced the first multiculturalism policy in 1971 as a sign of its conversion.

Canada was now placed in a favourable light with other leading countries such as Britain and Australia who followed in Canada’s footsteps by creating their own multiculturalism policies (Kelley and Trebilcock, 2010). Canada’s multiculturalism policies have been central in attracting internationally-educated professionals to Canada in support of its workforce. Although Canada appears to embrace newcomers to Canada, it still stipulates who it will or will not take, by evaluating and recruiting the most qualified individuals from developing countries (Li, 2001; Cheng & Yang, 1998).

New immigration policies have changed to expedite the immigration process, and further efforts are being made to recruit more IENs to Canada. Further IENs are expected to meet the seven requirements of Ontario’s nursing regulatory body, the Colleges of Nurses of Ontario (see Appendix 1). Once immigration clearance is achieved, the applicant’s credentials are evaluated alongside Canadian qualifications. Li (2001) and Chang and Yeng (1998) found that racialized immigrants who came from developing countries were expected to have higher qualifications than their Canadian counterparts, which indicated a racist element within the selection process. Even after accepting one’s qualifications, his/her qualifications are further evaluated and verified by a post secondary evaluative body, such as the Comparative Education Services (CES) at the University of Toronto.
Internationally educated nurses—like other internationally educated professionals—face significant barriers when trying to navigate their way through the workplace (Reitz, 1988, 2005; Kolawole, 2009). Although Basran and Li (1998) found that immigrants of colour were excluded from certain working positions on the grounds that they had “no Canadian qualifications and no Canadian experience,” they theorized that the real reasons employers placed them in such menial spaces was, because their own Canadian citizens refused to occupy such menial positions (Globerman, 1992; Brand, 1999; Calliste, 2000, Jacobs, 2002). Based on their study of qualified immigrant women in menial positions, Freund and Quilici (1996) found that as these women became deskilled, they were forced to stay in menial spaces. This supports Li’s (2001) argument that many immigrants remain in low paid positions because of the obstacles they face when they attempt to leave their current positions.

Another way in which Canada has placed internationally educated nurses and professionals into menial spaces has been through government-funded bridging programs. Ng and Shan (2010) argue that Canadian policies support bridging programs because they are designed to undermine foreign qualifications and to reconstruct racialized women within the Canadian workforce by slotting them in spaces not chosen by these women. In discussing the lifelong learning discourses, Ng and Shan (2010) further imply that such programs present themselves as advancing nurses, but in fact are based on sustaining race, class and gender inequalities.

Nursing depicts a typical picture of the processes described by Ng and Shan’s studies on Chinese women. For IENs of colour, many find themselves having to enter into lifelong studies, yet are unable to enter decision-making and policy-making spaces of leadership. Immigration becomes a sifting process by which IENs have to face multiple hurdles to prove themselves worthy of entrance into Canada. Multiculturalism policies play a significant role in the push-pull factor of the immigration process (Sessen, 1999), but once IENs arrive in Canada, the role multiculturalism policies play in supporting them within the workplace is questionable. The investigation of the epistemology of multiculturalism discourse, and how it relates to professional bodies, will allow us to enter into a new discourse as to how governments and employers use what appear to be innocent initiatives for sifting and segregating people.
The Segregated Labour Market

The division of labour within the workforce has been essential in stabilizing Canada’s economy (Webber, 1993; Smith et al., 2002). Adam Smith’s justification of labour division not only helped in creating an effective economy, but also provided work opportunities for all classes of people (Negishi, 1999). Within nursing, the division of labour significantly operates to provide a reliable service that meets the needs of its diverse population (Allen, 2001). Although, on the one hand, the division of labour is essential for a balanced workforce, segregated labour on the other hand has not produced positive outcomes.

Segregated labour is commonly associated with women being unfairly treated by men within the workplace (Acker, 2004; Keimer, 2004). According to Keimer (2004), segregated labour excuses the unfair treatment of women by allowing women to be paid less than men and making it difficult for women to enter into leadership positions. As a result, women are devalued within the workplace. England (2005) and Acker (2004) suggest that within the workplace patriarchy men are clearly more favoured than women. This favouritism is also reflected in a gendered profession such as nursing. Given that 97% of nurses are women and only three percent are men, studies show that men are more likely to end up in leadership positions (Xu, 2008). With such gendered inequalities, England (2005) found that women were more likely to choose gendered professions with better chances of obtaining leadership positions, while being free from male domination. However, England’s (2005) study also showed that as women veered toward gendered professions, marginalized groups were experiencing the same inequalities as women within a patriarchal-dominated workforce. England (2005) supports Calliste (2000) who recognizes that segregated labour division exists within nursing, pointing out that in the case of nursing, it happens to be marginalized women who experience unreasonable treatment by other women.

According to Bettio and Verashchagina (2009), women predominantly occupy gendered positions that reflect domestic roles. Even within such gendered occupations, women experience segregation both on a horizontal and a hierarchical level. Das Gupta (2002) explains in her study that segregating Black nurses onto different floors and assigning them different breaks was a way used to keep Black nurses separated. Bettio and Verashchagina (2009) refer to this type of
segregation as being horizontal. As women of colour are over-represented in menial nursing positions and poorly represented in leadership, Jacobs (2007) has described this effect as the *Cappuccino Principle*, White at the top and brown at the bottom.

Racism in nursing is systemic and is often masked by informal practices (Das Gupta, 2002; RNAO, 2012). When interviewing nurses of colour, Das Gupta (1999) found that nurses of colour were more likely to be reprimanded and minor incidences were documented against them; but not against their White colleagues. The biased treatment experienced by nurses of colour adds pressure and anxiety in the bid to perform well and be noticed. Instead, however, they often find their efforts go unnoticed in their everyday lives at work (Das Gupta, 1999; Hagey et al., 2004). The difficulties that nurses of colour face on a daily basis, has had an impact on only a few achieving entrance into the ‘the hybrid space’ (Sherman, Schwafkopf & Keiger, 2011). Arguably, the few who enter the hybrid space often reconstruct their own identities. Their efforts to preserve their hard-earned positions have left most of these IENs with little or no voice within the dominant space (Ono & Sloop, 2002). There are multiple informal practices that perpetuate unfair treatments of people of colour within nursing; Flynn’s (1998) Caribbean nurses who were labelled loud and less educated by their White, Canadian counterparts, were unsurprisingly deemed as culturally unsuitable for leadership (Razack, 1998; Jacobs, 2007).

Once IENs entered the hybrid space, they not only experienced a change in identity, but were made to feel privileged that they had been permitted to participate in the hybrid space in the first place. This notion was supported by Fellows and Razack (1998) who found that their position in the hybrid space became a toe-hold; they would try hard to hold onto a position in order to receive a degree of recognition and respect. Fellows and Razack`s work is consistent with Fanon’s theories (1967) which describe how people of colour adapt to their new locations by becoming *Black Skin in White Masks*. Fanon referred to ways in which the Black body would be presented in order to attain some level of integration and acceptance. But the need for acceptance comes with a heavy cost; a loss of identity (Fanon, 1967; Houssaeh-Phillips & Becket, 2003).

According to Das Gupta (2002), racism continues to exist within nursing, and is further sustained by Canada failing to equally recognize the qualifications, skills and experiences of nurses of colour. On this premise, employers justify their reasons for treating internationally educated professionals as aliens who must remain separate from the pure, dominant race.
Consequently, the IEN is made to feel that her experiences and qualifications have no value and that Canadian education is far superior (Li, 2001). For these reasons, most IENs of colour are placed in low, menial jobs, while the few in frontline positions are forced to constantly prove their competency and demonstrate their worthiness for being in such a privileged position (Flynn, 1998; Jacobs, 2008).

The phrase, “No Canadian qualifications, no Canadian experience”, allows Canada to present itself as a homogeneous society through the ideal type on one hand, while heralding multiculturalism as its heterogeneous image to the global world. “No Canadian qualifications, no Canadian experience” becomes a loaded term. Basran and Li (1998) and Bannerji (1997) argue that Canada is capable of locking people into certain spaces and in so doing, retain a dominant space. The non-acceptance of other “foreign” qualifications, only emulates Canadian qualifications as superior and others as inferior, and in so doing, Canada is able to excuse having a segregated labour force (Cheng and Yang, 1998).

The IEN in frontline leadership and the IEN in a menial position share many similarities, because they are both trapped in spaces that are ironically foreign to them. The nurse of colour in a menial space is a leader with academic and resourceful skills, but her foreign qualifications go unrecognized. She painfully watches her skills erase, while the nurse of colour in frontline leadership has attained her position, but feels confused, as her skills and qualifications are considered inferior and she is made to feel nothing more than a token (Reitz, 1988; Razack and Fellows, 1998; O’Brien, 2006; Jose, 2011). She is excluded from the dominant space where policies are made, and therefore, she is disempowered to advocate for her colleagues in menial spaces; instead, she is subliminally imprisoned in a space that is entitled “leadership” but gives her the same marginal rights as her colleagues in menial spaces. To speak against inequalities could threaten her present position or further marginalize her within her current position.

For the IEN of colour in leadership, her position becomes problematic rather than liberating; she can see, but is unable to speak; she can identify systemic racism within nursing, but cannot make changes as those who are in positions to help her are the ones who have put such policies in place (Ono and Sloop, 2002). The racial division of labour within nursing is more complex to address, since nursing is grounded in the theory of care (Watson, 1985).

Therefore, it becomes increasingly difficult to see or accept that racism could possibly exist within a caring framework such as nursing.
Nursing Practice

Canadian nursing today serves a pluralistic society (Johnstone, 2006; Dei, 2000). Cultural diversity within nursing welcomes the transcultural and caring model within its curriculum and framework. The epistemology and ontology of care remains central to nursing (Meadows, 2007) just as transcultural nursing is essential within nursing practice. Leininger (1978) recognized cultural differences and the impact it has on both the client and the nurse. Therefore, Leininger’s work still influences nursing practices and the study of transcultural learning today (1978). Since the notion of care is pivotal within nursing, Das Gupta and others fail to see this notion of care transcending among fellow nurses (Das Gupta, 1998; Calliste, 2000; Jacobs, 2008).

Historically, nursing once occupied the space of degeneracy (Cohen, 1991). Fellows and Razack’s (1998) work on space theory refers to the space of respectability versus the space of degeneracy. The colonial space of degeneracy is a space within which only those who were considered society’s outcasts resided. Nurses, along with prostitutes, shared this space within a patriarchal era. However, Florence Nightingale’s vision in the 19th century became a reality when her new nurse model emerged. In line with industrial advancement and an age of enlightenment, nursing had propelled itself to become a profession; and today, nursing occupies a space of respectability (Deloughery, 1995; Fellows & Razack, 1998; Hallam, 2000). Nightingale’s discourse effectively steered nursing to a new level, placing it on par with other male-centred professions, such as medicine, law and engineering, while maintaining mainstream feminist values (Hallam, 2000). However, although Nightingale established nursing as a profession, the colonial customs and practices of her time still remain embedded in nursing theory and practice (Dossey, 1999; Hallam, 2000). Since Nightingale, nursing continues to reflect the socio-political changes in society. During the 1970’s there has been an obvious paradigm shift toward social justice, which was soon reflected within nursing practice. The influx of IENs into Canada as means to support Canada’s healthcare system, had created changes in nursing policies and curricula that today impact Canadian nursing significantly.

Cultural Sensitivity

The influx of nurses in the 1970’s ushered in an era of mass immigration characterized by diverse populations of cultures. Canadian nursing experienced a colossal change as it
accommodated issues of diversity and equality that were occurring in the wider society. Moving from a monolithic appearance, Canadian nursing as well as its healthcare system, soon became more heterogeneous, with an increase of nurses and patients of colour. Nursing addressed these changes by incorporating cultural competency as mandatory practice within the core of nursing. The CNA states that:

Cultural competence is the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients. Cultural competence includes valuing diversity, knowing about cultural mores and traditions of the populations being served and being sensitive to these while caring for the individual (CNA Position Statement, 2010).

It is clear, according to the CNA that nurses need an in depth understanding of the cultures of the clients they serve in order to provide sensitive and appropriate care. Therefore, the application of cultural competence into nursing care, further demonstrates the close link, or co-dependent relationship between health and culture (Kidsman Dean, 2010; Kirmayer, 2012).

Bridging programs have been an effective way by which newcomers to the Canadian workforce can be effectively integrated into Canada’s pluralistic workplace culture. Mainly funded by the provincial government, such programs not only support cultural competence, but also support the assimilation of internationally educated professionals into the Canadian culture. Bridging programs support the assimilation of newcomers into the workplace, while nursing adopts transcultural learning as a way of accommodating other cultures.

Culture, whether through nursing policies as cultural competency or cultural sensitivity, remains central within nursing practice. This is further seen within nursing curriculum, under the notion of transcultural learning. Transcultural learning was very much the brain child of Madeleine Leininger, who, in the 1950’s saw a close relationship between health and culture and so embarked on anthropological studies of different cultures to understand the cultural needs of different groups, especially with regard to recovery. Leininger differentiated between care and cure, and introduced the theory of transcultural learning to the nursing profession.

Today, Leininger’s work continues to influence nursing curricular and practices (Leininger & Reynolds, 1993) in spite of criticism. Such criticisms have pointed out that
transcultural learning and subsequent policies in nursing have not been in favour of marginalized groups, but instead in the ruling class interests (Condiffe, 2001). According to Jacobs (2007), nursing has its own culture and for this reason, racism is capable of thriving within its walls. Nurses belong to a culture unto themselves, having their own set of values, attitudes and practices (Condiffe, 2001). Shiva’s work entitled, *Biopiracy*, addresses new ways in which developed countries pillage from developing countries in order to sustain their power. Arching Shiva’s theorizing within Canadian nursing, the same may be certified in the way “culture” is used as the new term to perpetuate old practices. It can be argued that such terms as cultural competency and cultural sensitivity only conceal the dominant nursing culture that exists and continues to make policies that favours Canada’s own interests (Shiva, 1997; Dei, 1999). Duffy argues that in nursing culture is taught in favour of the dominant culture and ignores the multiple global cultures in our post modern times (2002; Dreher and MacNaughton, 2002). Also, Hagey, in her study on cultural safety encourages a space by which ones culture can be preserved within the confines of its own people protecting cultural practices (2000).

As Canada’s nursing continues to implement transcultural learning and models of care as a basis for nursing education, it continues to gloss over issues of class and racial inequalities that remain absent or silent when teaching issues of culture within the academy. Gustafson (2005) sheds further light into the way transcultural nursing is used to sustain the dominant thinking. She addresses the way “culture” is defined by the dominant space and problems are focused on culture while race and other major issues lay hidden beneath. For such reasons, Shiva (1997) and hook’s (1984) encourages women from the margins to tell their stories and teach their own culture and not others.

Within the study of indigenous knowledges, Dei (2000) emphasizes a need for industrial countries to recognize various ways of learning that primarily come from those within the margins. By implementing indigenous knowledges as new pedagogies is a way to deconstruct colonial practices (Dei, 1999). Dei’s view is supported by Nestel (2002) whose work around natural labour and delivery, found that people from developing countries were often considered less intelligent, yet they maintained many skills that had been lost through advanced technology, such as the hands on skills of diagnosing conditions or the ability to mentally calculate intravenous dosage. These technologies, Nestel argues, has left us depleted of a rich level of knowledge that many from developing countries continue to have.
Although Leininger spent decades on anthropological studies of other cultures, her works can be critiqued through the theoretical lens of Memmi (1965) and Fanon (1967). Leininger’s work proposes that the nurse is the teacher and not the client of colour who is the carrier of her own culture (Amos & Parmar, 2001). Memmi’s discussion of the colonized and the colonizer disputes that the latter has taken it upon him to educate the colonized about his own culture, because he considers the colonized as not capable of educating himself or others. Leininger’s approach is but one method that preserves the binary relationship of the colonizer and the colonized.

Multiculturalism and transcultural learning have been tools by which Canada has tried to educate and orientate nurses in caring for diverse cultures. However, Johnstone (2006) and others show that the services given to people of other cultures and colour are inadequate throughout the world. For example, a study by Brooks-Carthon et al. (2011) showed clear disparities in care by nurses within the acute hospital settings toward Black patients. Their U.S study also revealed that the nurses had low confidence in Black patients and, in addition, the risk of illness and morbidity was significantly higher among the Black population.

Transcultural learning within the nursing curriculum and the workplace setting arguably excuses that patients of colour are treated differently. This difference is obvious also within the relationship of IENs of colour and Canadian nurses. Both the service provider of colour and the service user of colour find themselves marginalized within the practice of nursing that professes equity of care. Although IENs of colour come equipped with qualifications that might afford them a space in leadership and development, they are omitted from educating others about multicultural diversity. Instead, they are re-taught in order to create a homogenous space of learning. Therefore, a discussion about how academic shifts have impacted today’s nursing and the experiences of IENs are relevant.

**Academic Shift**

Nursing has come a long way from a two-year training program in 1874, to a four-year baccalaureate degree in nursing. As I have argued above, nursing is a recognized profession, which allows nurses to work throughout world (World Health Organization, 2000). The Province of Ontario’s decision to make the baccalaureate degree in nursing a mandatory requirement in
2005 has raised the bar for nurses. With drastic nursing shortages, all IENs are required to have the minimum of a baccalaureate in nursing that is equivalent to the Canadian nursing degree (The Canadian Medical Association Journal (CMAJ), 2009). Hawthorne (2001) states that to ensure IENs meet the Canadian requirements, the government has heavily funded programs to aid and assist IENs to be on par.

In their studies of IENs, Murphy and McGuire (2005)’s have also recommended that additional resources - such as bridging programs - are needed to blend IENs into the Canadian standards and culture of nursing, thus providing them with the same opportunities as Canadian nurses. However, Hagey (2002) disagrees with Murphy and McGuire, pointing out that although IENs come from developing countries, like their Canadian nurses of colour, they find themselves segregated by race into the lower, menial nursing positions. Even though Canada was once a colony like the countries that many IENs come from, Loomba (1998) states that ex-colonial countries that are governed by White colonials, have been more successful economically and globally than those commonwealth countries that are run by people of colour. Her argument does not question the level of intelligence in either countries, but rather, demonstrates the reality of colonial thinking even when both types of countries continue similar practices; citizens from countries with Black leadership deliberately receive different treatment within Canada (Memmi, 1965; Loomba, 1998).

With only a few nurses of colour selected for positions of leadership in nursing, Puwar (2004) takes a critical look at what occurs when people of colour enter such dominant spaces. Puwar found that when people entered spaces of leadership they were expected to speak in the vernacular and adopt the culture of the dominant space in order to be initiated into such a position. Failure to do this by individuals has resulted in alienation within the dominant setting, thus causing further marginalization to occur within such professions, including nursing (Puwar, 2004; Ono & Sloop, 2002; Das Gupta, 2011).

For one to enter leadership in nursing, there are three important requirements they have to meet: first, the educational requirements for the position; second, the experience in the required field and third the skills or abilities needed to meet the demands of the leadership position. Therefore, for IENs to be accepted into leadership positions in Canada they would have successfully passed the CIC and CNO requirements and proved their leadership abilities from their previous jobs. However, Jose (2008) points out that they are thus either compelled to return
to the Canadian academy and gain Canadian qualifications, or they have had to prove themselves within the workforce and self-navigate within the Canadian system. As for the Canadian nursing degree, Canadian Medical Association Journal has argued that Canada’s nursing degree program prepares Canadian nurses to be critical thinkers and to work in management (2010). Jacobs (2007), nevertheless, observes that White Canadian nurses receive practical mentoring and support by nursing leaders; thus clearly demonstrating the grooming of certain nurses into management positions, while denying specific groups the opportunity.

The transfer of nursing from the college into the university has had an impact on the direction of nursing. There is more of an academic, rather than an applied persuasion, resulting in many junior, educated nurses entering into the field with little practical exposure and experience (Mooney, 2007). Watson stated thirty years ago that:

In nursing it is easy to fall prey to current trends and fads of education and practice. Nursing is becoming established as an academic discipline [such that] more energy is now expended in the acquisition of scientific knowledge than of understanding. Nursing rarely concentrates on the level of understanding (1985, p. 2).

Is Watson’s observation true today? I would relate her term “understanding” to the valuable role IENs play in Canadian nursing. Although, the educational level of IENs are potentially as inferior to Canadian nurses by Canadian employers, Watson (1985) and Nestel (2002) point conversely to the value of their skills in preserving the fundamentals of nursing, namely care and understanding.

Within the workplace setting, many experienced IENs find themselves in the hybrid space with a manager above them who fails to have comparable qualifications, skills and experiences as they have (Stewart, 2007). The experiences of IENs of colour are best demonstrated by Gardener (2005) who found that nurses of colour often experienced isolation, frustration and injustice. Marvelis (2011) observed that the issue of race was often shunned by White women who themselves were not conscious of operating from a framework of White patriarchy. Marvelis (2011) further observed that White women tended to deny women of colour their identities, by avoiding discussing any issues of race or racism. To survive, therefore, the woman of colour has no choice but to hide her emotions, frustration and fears, portraying what is expected of her by her White counterparts. Fanon (1967) and Hassoueh-Phillips and Becket (2003) refer to this behaviour as wearing a White mask. Many studies that address the
experiences of women of colour within the White space of nursing have highlighted the difficulties that nurses of colour face as “the other” (hooks, 1981).

Much of the nursing literature that address systemic racism and the unfair treatment of women of colour has addressed the binary positions of those in leadership and those in menial positions. The hybrid space concept of nursing is a way to theorize this bifurcation. Ironically, the role of IENs of colour in the hybrid space closely resembles the role that Canada plays within NAFTA: that of one sitting as a daughter to the powerful United States and receiving the benefits of U.S. protection and at the same time acting as a philanthropist for Mexico, assisting a developing country. Likewise, to have a pocket of nurses of colour within a hybrid space, works in Canada’s best interest. IENs, as frontline leaders are visible to the public as evidence of equal opportunity and can serve to erase the bitter memories of Canada’s history of racism. For Canada to boast of initiating a successful multiculturalism policy, significant numbers of people of colour would have to be represented in leadership positions. Because this is not the case, it is prudent, therefore, to address the current issues that influence how nursing looks today.

Nursing Today

Canadian nurses today mirror the pluralism of Canada and the social and the global world in which it functions. During the Florence Nightingale era, nurses were different. The classical nurse of Florence Nightingale’s time had emerged through colonial ideologies and frameworks (Dossey, 1999), whereas today’s nurse is able to travel throughout the globe and work among different heterogeneous societies. Although nursing has been strongly influenced by British colonial standards, Canadian nursing has recognized the multiple cultures within its borders, making it a demanding, economically-driven business (Hawthorne, 2001; Brush, 2008). Nurses are not just pivotal in preserving a thriving healthcare system, but the stability of the global economy very much hangs on having a strong and thriving body of nurses (Rafferty & Solano, 2007; Fox & Abrahamson, 2009; Kolawole, 2010).

Nursing has come a long way. From playing second fiddle to male dominated professions such as medicine and law (Rafferty and Solano, 2007) to becoming a regulated profession in its own right. Nursing as a gendered profession gives women the opportunity to propel into leadership, where once they were denied. However, as a gendered profession, nursing appears to
have transferred the unfair treatment it once received by male dominated professions, to IENs of colour (Calliste, 1993; Dombeck, 2003; Jacobs, 2007). IENs of colour continue to face poor treatment by their fellow White nurses, even if they are educationally and experientially on par with them. The unfair treatment that occurs within a gendered profession that claims affiliation with feminism, calls into question the type of feminism it associates itself with. The next section will explore “Nurses as Feminists.”

Nurses as Feminists

There is a growing debate as to the role of feminism within nursing. According to Wilson (1971) and Melchoir (2002), feminism has played a vital role in propelling and sustaining nursing as a profession on par with male-dominated professions, such as medicine and engineering. According to Webb (2002) and Sullivan (2002), feminism within nursing provides a platform that protects women from patriarchal values that have been entrenched within nursing policies and practices. However, it may be argued that feminism within nursing functions within a homogeneous framework and fails to see the mosaic tapestry that it is today. According to Mohanty (1997), feminism taught within the academy is dominated by mainstream feminism and ignores other differences, such as race, economic and social struggles. Mohanty further explains how feminism as taught within the academy considers issues of race and class as naive, simple and undeserving of time and attention. Instead, attention is given to mainstream feminist thinking that focuses on patriarchal influences within nursing.

Mainstream feminism is seen by many feminists, such as hooks (1983) and Mohanty (1997), as playing an active and important role in the preservation of the White leadership space. IENs of colour, who come from a neo-colonial spaces often cannot relate to the mainstream feminist discourse, which considers all women the same (Clarke, 1997; Thorburn, 2000). Her inclusion and recognition of shared spaces of oppression with other Black women is not easily accepted (Collins, 2000). Collins (2000) argues that for women of colour, Western feminism is invested in White middle class issues. Therefore, the views of women of colour concerning issues of race and gender can be perceived by their White colleagues as backward (Mohanty, 1997).

Recalling my first experience with mainstream feminism, as a newcomer (chapter 2, page 26), I realised how easily the term, feminist was used by White nurses who failed to consider the
neo-colonial spaces that IENs of colour were coming from. For women of colour, their concerns were not with male dominance, but rather with female counterparts that ignored their journeys and struggles. If IENs of colour failed to identify with mainstream feminism, the consequences were that they would be further oppressed by being made an outsider by their nursing colleagues (hooks, 1983; Mohanty, 1997; Collins, 2000).

It is crucial that nursing it addresses issues of race and class inequalities that have for a long while been ignored by mainstream feminists. The overpowering voice of mainstream feminism within nursing has left IENs of colour with a little voice and poor representation in leadership (Henry, 1993; Mohanty, 1997; Hassoueh-Phillips & Beckett, 2003). As Women of colour enter a feminist space, the notion of feminism within nursing is often strange to them. They become further isolated because they are unable to relate to mainstream feminism (Gardener, 2005).

In the past 40 years some scholars, like Winkelmann-Gleed (2006) have expressed the view that IENs receive immense support from their hosts, and are, therefore, able to quickly adapt to their new surroundings. But Calliste’s work on the immigration process of Caribbean nurses to Canada demonstrates a strong racial bias that condones displacement of nurses of colour into menial positions, because they were deemed incapable of physically and emotionally coping (1993). Hagey and McKay (2000) found in their study that the impact of racism within nursing far exceeds political and economic issues.

IENs are valuable to the global economy, but obviously, there is conflict within the current literature as to how these women are treated. Mainstream scholars talk of the positive role IENs play within nursing and their contributions to the workplace from a economic perspective (Bauman et al, 2006); while those writing from the margins describe a different picture of inequality and racism (Hagey et al, 2004). Arguably, feminism within nursing historically protected the interests of nurses, while today, mainstream feminism and its scholars appear to support the interests of the dominant class of nurses at the expense of those nurses who are marginalized.

**Multiculturalism**

Following World War II, the United Nations (UN) became central to the process of re-establishing global peace and unity. Canada’s introduction of the first multiculturalism policy
served to promote the intentions of the United Nation’s vision of peace and unity. In essence, Canada’s multiculturalism policies are defined as:

the presence and persistence of diverse racial and ethnic minorities who define themselves as different and who wish to remain so. Ideologically, multiculturalism consists of a relatively coherent set of ideas and ideals pertaining to the celebration of Canada’s cultural diversity (Canadian Multiculturalism, 2006).

Since multiculturalism policies encourage individuality and differences, multiculturalism policies have been praised by anti-racist scholars such as Dei (2011) who affirms that these policies provide a space where racism can be challenged. However, writers, such as Bannerji (2000) see otherwise. According to Bannerji (2000), although multiculturalism policies appear to address and protect cultural diversity, they in fact reproduce inequalities. Multiculturalism policies, according to Ng (1995), become an ideological frame by which to “reconceptualise and reorganize changing social, political, and economic realities” (p. 35).

The Report on Canadian Multiculturalism prepared by Dewing and Leman (2006), describes Canada’s society as being divided into three major forces:

1). Aboriginal people (all natives as Aboriginal people, based on the Constitution Act of 1982).

2). Colonizing groups, defined as the founding members of Canadian society (The French and English-speaking communities).

3). Racial and ethnic minorities which includes native and foreign-born Canadians who have some non-French and non-British ancestry (p. 2).

This description of Canada’s society constitutes the framework by which issues of racism and class inequalities can be studied. One of the areas in which racism and inequality occur is in the treatment of aboriginal people in Canada. Since the arrival of the colonial settlers to Canada, aboriginal people have been continually relocated and displaced (Razack, 2002; McGregor, 2011). In the process of dislocating and displacing aboriginal people, aboriginal people have been made invisible within many policies and programs (Razack, 2002). This invisibility has allowed much of the history written about Canada to portray the colonial settlers as the
innovators and prime movers in Canada’s progress, while erasing all aboriginal contribution (Razack, 2002; McGregor, 2011).

Razack (2002) argues that colonial settlers hold political and economic power and are able to keep local indigenous people invisible (see also McGregor, 2011). In support of Razack and McGregor’s arguments, Casanova (1996) has identified colonial practices still occurring within mainstream Canadian culture and points out that its purpose is to assimilate everyone into a colonial type culture, which is often disguised by such terms as neo-liberalism.

The treatment of racial minorities in Canada is another area in which racism is another issue of equity. Dei (1999) highlights that as the customs and knowledges of indigenous people become devalued, likewise, it becomes evident that other knowledges such as that of the indigenous Africans are also devalued within the academy; and this is also true within nursing (Flynn, 1998). Both Dei (1999) and Razack (2002) agree that colonial practices continue to undermine the knowledges and contributions of the Aboriginal people and other marginalized groups within Canada.

Although it would appear that the neoliberal paradigm has strongly influenced the direction of nursing from that of a caring profession to that of an economically driven body (Camfield, 2006), the truth is that nursing has always been economically driven, as seen by Harvey’s definition of neoliberalism. Harvey (2007) defines neo-liberalism as:

A theory of political and economic practices which proposes that human well-being can best be advanced by the maximization of entrepreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, free markets and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices (p. 22).

Harvey’s definition of neo-liberalism sheds light as to how multiculturalism policies are used to cloak or camouflage political and economic intent by the relocation and dislocation of certain groups within Canada’s pluralistic society. Berg (2007) uses a critical geographical approach and argues that neo-liberal discourse creates White spaces and sustains White supremacy, while Magnusson (2000) further adds that within the neo-liberal discourse there is a created an ideological fantasy, by which inequality is said to be discounted. In reality, it is still functioning, and this is seen by the way certain groups are treated.
The theories of Magnusson (2000) and Berg (2007) can be used to critique such discourses as cultural sensitivity and transculturalism. The very space in which they function is—as Berg (2007) explains—a White space of supremacy that alienates people of colour from leadership, and keeps them suppressed. That is, multiculturalism is an ideological fantasy, as described by Magnusson (2000). As multicultural policies are said to be designed to please the needs of a politico-economic structure, these policies tend to go beyond global influences, in that they reach local institutional levels, such as nursing. Nursing has accommodated multiculturalism both within the nursing curriculum in the form of transcultural learning and within the workplace setting, as cultural competency.

Therefore, beneath the body of multiculturalism, whether it is locally (i.e., within the workplace or the academy), or whether it is globally (i.e., found within policies), there still remains a dominant ideology by which the dominant space remains secure (Ono & Sloop, 2002). Multiculturalism within nursing is expected to produce a diversified space of equity. Yet multiculturalism policies reflect a colonial space of domination and subordination, and this is often seen in the area of race and class. IENs challenge the status quo by possessing all the required skills needed to occupy spaces of dominance, but instead they are relegated to menial positions or fixed into a hybrid space that prevents them entrance among the higher echelons, IENs expose another facet of multiculturalism policies that may have gone unnoticed. Their very presence in these spaces questions the motives for having multiculturalism policies.

Within the discourse of multiculturalism, the term diversity has been commonly used to convey equality among differences. However Bannerji (2000) has argued that a term such as diversity enables race, class and gender inequalities to go unnoticed. Bannerji (2000) critically evaluates the term diversity as creating a horizontal image of equality, while omitting the vertical picture of hegemonic powers and control that suppresses one group and preserves the status of the other. Razack in fact refers to the whole notion of culturalization as nothing more than mere “culture talk” (1998, p.58). Culture talk acts as a way of further denying the operational practices of racism and likewise taking attention off White privilege (Razack, 1998; also cited in Hong, 2008).

In summary, my argument is that as Canada promotes the values of multiculturalism within its various institutions, by funding diversity and human rights programs, multiculturalism policies support Canada’s fantasy of a utopian pluralistic society. However, Canada’s
benevolence is being called into question and these questions cannot be ignored. By presenting a multicultural society where everyone’s culture is celebrated and respected, Dei (2011) states that Canada is able to ignore the historical errors of racism and oppression by which Canada was founded on and preserved by. Therefore, if we assume that multiculturalism policies provide a means of perpetuating colonial practices, a study into Canadian nursing may be a way of investigating the validity of such a notion.

Canadian nursing has been strongly influenced by the history of Canada’s bicultural colonial system, as has been reflected by the Catholic Order of Francophone nurses and the establishment of the Nightingale School of Nursing by the British (Bates, Dodd & Rousseau, 2005). For many critics of multiculturalism policy, one of the arguments that remain strong is that it clearly reflects the interests of the dominant European culture of the French and the British. Nursing, therefore, continues to pattern the European image of a vertical Mosaic while paying little attention beyond French and English to other diverse cultural groups (Porter, 1965; Bannerji, 2000). Because nursing preserves such dominant cultural practices, it can play a crucial role in helping us understand how multiculturalism policies operate in its institution that has been built on bicultural colonial values. As multiculturalism policies strongly influence nursing practice, the existence of the ideal type within nursing warrants further research into the role that the ideal type plays within nursing.

The Ideal Type

Plato - along with Aristotle and Socrates - is one of the founding leaders in Greek philosophy. One of Plato’s famous theory was the concept of the ideal, and as a dualist, Plato’s concept of the ideal became central to education (Brumaugh, 1987). His dualist discourse of the unreal and the real was grounded in the thought that reason was needed to unveil the ideal forms behind appearance; in other words, what we see in the physical is but a dim reflection of the true ideal thing (Brumaugh, 1987; Takala, 1998). The Platonic philosophy, therefore, sees reality in terms of the ideal.

Weber’s work on the ideal type finds some of its roots within Plato’s philosophy, but unlike Plato’s classical work, Weber addresses both historical as well as modern periods.
Weber’s ideal type is an analytical construct by which a caricature of a collection of social events can be created in order to gain an understanding of hidden realities (Parkin, 1991). In other words, Plato and Weber’s take on the real and the unreal, allows for a dialectic analysis to occur in this study. The opposing discourses require a dialectic analysis to help us arrive at a place of consciousness that is commonly used within anti-racist feminist research (Collins, 2000; Mullings, 2000). For Giddings (2005) and Jacobs (2007) the ideal type, or the ideal, is representative of a type of nurse found within nursing. “The ideal” appears unreal, but according to Giddings and Jacobs, the ideal is very much real.

In a study of Maori nurses from New Zealand as well as African American nurses, Giddings (2005) demonstrates that the White ideal type nurse exists because she excludes nurses of colour. One way that IENs of colour are excluded by the ideal type is through the “culture of the ideal nurse” (Jacobs, 2007, p. 101). The culture of the ideal type nurse is often defined within the terms of leadership and research. Jacobs (2007) points out that the diverse history and locations of many nurses of colour diverge from the “ideal type” of nurse with one another in that many nurses of colour primarily come from working class backgrounds and consequently have difficulty entering nursing leadership and research. Jacobs (2007) further argues that nurses of colour are excluded from the constructs of the ideal type nurse by the very description that the ideal type nurse portrays (Giddings, 2005).

From the works of Giddings (2005) and Jacobs (2007), we can see the influences of Greek philosophy within nursing practice. There exists the real, and the unreal. From one perspective the real can be viewed as the ideal type that is obscured and hidden within nursing, yet makes policies and executes nursing practices within nursing. From another perspective, however, the unreal, on the other hand, can also be seen as multiculturalism policies, that offer opportunities for IENs of colour to enter the hybrid space, where she in fact remains excluded from policy-making decisions. When combining the works of Giddings and Jacobs within the practices of Canadian nursing, it is hard to ignore the involvement of the ideal type and multiculturalism policies.

As I have argued above, multiculturalism policies play a significant role in supporting Canada’s image as a peaceful and pluralistic nation. However, such notions contradict the experiences of IENs of colour who are clearly marginalized by the ideal type. In order for the
ideal type to persist within a neoliberal and post colonial era, it requires the discourse of multiculturalism policies in order to camouflage its movements and, thereby, prevent Human Rights advocates from detecting its existence. I am arguing that the ideal type is supported under new titles and images, one being that of multiculturalism policies.

It is difficult to fathom how the ideal type and multiculturalism policies could co-exist. Attention, therefore, must be given to the type of relationship that allows the ideal type and multiculturalism policies to share the same space within nursing without antagonizing the other. Initially, when conducting a literature search, it appeared that there existed a dualistic relationship that was antagonistic in nature. Yet, for a dualistic relationship to occur, one would have to either cancel, or oppose the other (Fox, 2005). In practice, this was not occurring within nursing. The two were co-existing, which lends attention to the occurrence of a dialectic relationship (Likitkijsomboon, 1992; Fox, 2005). The notion of the dialectic is found within Greek philosophy Lowy (2000) describes how two opposing arguments can in fact come into agreement. Another definition points to how opposing powers are able to work in partnership for a common interest (Likitkijsomboon, 1992). Although the term was first coined within Greek philosophy, it was later used by Hegel and taken up as a theory of historical materialism by Marx (Lowy, 2000).

My work will develop the theory of a working relationship between ideal type nurses and multiculturalism policies within Canada’s nursing practices. Multiculturalism policies and the ideal type continue to be studied separately, but I will argue that it is when they are studied together that new light is shed that expose the hidden practices that would otherwise not have surfaced. One of the agendas that will be identified in my study is the presence of colonial practices within nursing. Current studies show the streaming of nurses of colour into menial positions, but only a few identify a strong colonial presence at work (Giddings, 2005; Jacobs, 2007). In addition, some studies show the role of multiculturalism policies within nursing, but negate the existence of colonial practices (Watson, 1985). I propose that identifying the dialectic of the ideal type and multiculturalism policies exposes how both co-exist and the purpose for which they co-exist. The ideal type is a historical phenomenon that appeared to have been uprooted with the dismantling of colonialism after World War II. However, with IENs of colour working within new spaces, this historical phenomenon is being called into question.
Multiculturalism policies represent the agenda of a global community that works to create unity in diversity (Ng, 1995; Bannerji, 2000; Dei, 2011). When multiculturalism policies are studied in light of IENs and their lived experiences, it is inevitable who benefits from the relationship between the ideal type and multiculturalism policies. The ideal is made visible if IENs of colour are excluded from the hybrid space. Therefore, the hybrid space acts as a front to parade IENs of colour as prodigies of multiculturalism policies.

Although IENs expose the ideal type, they also reveal the construction of a hybrid space within nursing that works in favour of the ideal type. I argue that the hybrid space integrates frontline workers with controlled decision-making responsibilities, and in so doing, the hybrid space operates in favour of the dialectic relationship of the ideal type and multiculturalism policies. Therefore, it is hoped that by further identifying the dialectic of the ideal type and multiculturalism policies within the practices of Canadian nursing, this study will enlighten ways in which nursing can work in favour of creating equitable treatments of all nurses, those in positions of power and those marginalised.

**Summary**

It is now over 40 years since the first multiculturalism policy, and IENs of colour are still poorly represented in leadership positions where policies are being made. These spaces of leadership need representation from marginalized groups in order to advocate for the needs of those who are carers and users of Canada’s pluralistic healthcare system. The literature unquestionably shows that people of colour predominantly occupy low paid menial positions, even though many possess comparable qualifications in leadership as their White counterparts. Yet the few IENs of colour, who have navigated their way to the hybrid space, remain in a space where they possess somewhat of a title of leadership, while remaining as frontline workers. My theory is that IENs of colour in the hybrid space are nothing short of tokens to demonstrate to other countries the successes and equal treatments brought about by Canada’s multiculturalism policies.

The ongoing debate surrounding multiculturalism is further emphasized within nursing, where such terms as “cultural sensitivity” and “cultural competence” appear to only obscure other systemic racism and other inequalities. IENs, lives expose the unfair treatments experienced by some groups by revealing the sustained presence of the ideal type.
The numerous studies that have tackled the various issues relating to women of colour, IENs and particularly IENs of colour have failed to link what I have called nursing’s ideal type and multiculturalism policies. Both ideologies have remained outside the arena of discussion concerning race and class; and on the occasions that they enter the discourse of race or class, they are discussed as separate entities. This research will shed light on my theory or the relationship that the ideal type and multiculturalism policies share. This thesis acknowledges the space that multiculturalism policies provide for marginalized groups to be heard; but it also points out that the space provided seems controlled by the dominant group who define the very term “multiculturalism.” With this said, this thesis will provide another space for the experiences of IENs of colour to be heard. The select few that currently occupy the hybrid space tell a different story than what is professed by having multiculturalism policies. The experiences of IENs of colour, clearly exposes the existence of an ideal type and a dialectic relationship that sustains the ideal type and multiculturalism policies within Canadian nursing practices.

As Canada continues to recruit IENs to address its purported politico-economic crisis, Canada is at risk of practising apartheid principles, while hiding behind the values espoused in multiculturalism policies. It is therefore hoped that this study will help the practice of Canadian nursing to address the relationship between the ideal type and multiculturalism policies. It is also hoped that this study will create a transparency into the policies and laws being made, and in so doing, will forward nursing through the 21st century to be reflective - both in theory and practice of Canada’s pluralistic healthcare system.
Chapter Four

Research Methodology

Introduction

I have argued that there currently exists a dialectic relationship between the ideal type nurse and multiculturalism policies within Canadian nursing practice. With the ideal type being rooted in colonial values and multiculturalism policies supportive of social justice and equal opportunities, these two phenomena appear to stand in opposition. This chapter addresses the method of research used to explore the dialectic relationship of the ideal type nurse and multiculturalism policies within Canadian nursing practice. In this chapter I have provided a step-by-step account of how the research was conducted, what method of analysis was used and the reason for choosing one method of research over another. I have also included in the discussion the difficulties and barriers that I had encountered when conducting this research.

Implementing Feminist Research

This research is about women in a gendered profession. For this reason, the choice of research had to be strongly influenced by research designs that considered women. As nursing is considered a gendered profession, I felt it was suitable to use a feminist research approach rather than a research approach that was more likely to be male-dominated (Gillbert, 1994; Gluck & Patai, 1991). Feminist research is unique, in that it refutes the myth that research on men represents the human experience, and it shifts from the notion of objectivity by inviting the researcher into the interview (Gilbert, 1994). Some feminist researchers believe that research should be done by women, for women and about women (Gluck & Patai, 1991). Since this study would be done by a woman (myself), for women (IENs) and was about women (the ideal type and IENs), it was inevitable that I would choose to use feminist research within my study of the ideal type and multiculturalism policies.

Feminist research provides a space by which inter-subjectivity rather than objectivity is practised and the emancipatory goals aid to influence political changes (Kirsch, 1999).
Therefore, to study women of colour within a gendered space required a research methodology that recognized the inequalities experienced by marginalized groups. ARF and BFT were essential theoretical frameworks in the development of this study. Therefore, feminist research became a suitable methodology for addressing issues that had long been reliant on male interpretation. As feminist research is increasingly popular, because of its ability to engage in historical, political and personal issues that occur in our world (Acker, Barry and Esseveld, 1983; Kirsch, 1999), the experiences of women become valued because feminist research provides a space for critical studies of the various locations at which women arrive (Smith, 2005).

However, there were a few dilemmas I experienced when engaging feminist research that calls for further attention. Critics of feminist research argue that feminist research is mainstream and, therefore, supports mainly White female researchers who may perpetuate race and class inequalities within their data (Acker, Barry & Esseveld, 1983). They further argue that feminist research is not independent of all other forms of inquiry as it claims to be. In other words, feminist research is unable to stand on its own; it heavily depends on the works of other male theorists, such as Marx and others, as a basis for which to work. For this reason, it remains affiliated with the male-stream of research in some way or other (Kirsch, 1999).

Once I had identified the need for using feminist research, I avoided the risk of using mainstream feminism by drawing from the theoretical frameworks of ARF and BFT. For example, in feminist research, interviews are considered problematic, because they are viewed as methods of control, but in-depth interviews are the exception; they give women a voice and ownership throughout the interview (Acker, Berry & Esseveld, 1983; Kirsch, 1999; Gilbert, 2005). With this awareness, I was initially interested in a research that would use methods which were similar to those used within indigenous knowledges, which have, for centuries, used oral traditions and narratives as methods of inquiry. However, as I was studying women who came from countries that were once colonized by the British Empire or whose parents came from ex-colonies, I realised that indigenous knowledges were not necessarily represented in their history, but rather were in some way impacted by colonized knowledges. For this reason, I decided to use in-depth interviews for the main reason of giving women a space by which they could openly share their stories and experiences, and this would be made possible through in-depth interviews (Smith, 2005). In-depth interviews also allowed me to include the voices of women of colour that were often silenced within mainstream feminism.
Research Design

The research design encompasses the most suitable method by which the research questions could be answered. Within nursing, quantitative research designs are by far the most popular style used due to the close affiliation nursing has had with the medical profession (Weaver & Olson, 2006, Walsh, 2011). This has led to many nursing studies viewing quantitative research as “real research” and qualitative research as complementary. Researchers that favour quantitative data often argue that qualitative research fails to be objective, and, therefore, only suitable for the social sciences rather than medicine and health sciences (Nagle & Mitchell, 1991; Strauss, 2003; Weaver & Olson, 2006).

Although nursing continues to operate within the theoretical framework of care and transculturalism (Watson, 1985; Leininger, 2009), there has been a growing demand for research designs that explore social selection, in terms of dialogues, narratives and making-meaning. As my study focused on social justice issues within nursing, I wanted to see how it would be viewed within the field of publishing. So I submitted a paper I had previously written regarding racism and nursing to one of Canada’s leading nursing journals. After a few weeks, I received a response from the editor stating that they did not cover such issues in their journals. At that moment, I realised that I had taken a risk by going into such a sensitive area. Nonetheless, I also realised that there was a growing body of international journals that were open to addressing issues of social justice within nursing.

I decided to use a qualitative method to address the research questions raised in my study. Supported by Denzin, Lincoln and Giardina (2006), who point out the importance of using qualitative research within the current global climate, I became further aware of the multiple paradigms within nursing that required multiple types of research methods. Polit and Beck surmise that nursing calls for different methods of research in order to create a “healthy and desirable trend in the pursuit of new evidence of practice” (2008, p. 17). Furthermore, as quantitative research is deeply rooted in positivism reductionists, it was therefore not capable of accommodating a study into the lived experiences of people, which required that they tell their stories and in turn, these stories would then be used as research data (Maxwell, 1996; Smith, 2005, Sandeloweski, 2008; Polit & Beck, 2008).
To ensure that I had a good understanding of the research design I intended to use, I read several articles and books on the different types of research designs. IENs were central to this study and as actors, I realised that doing a case study or a document analysis on this specific group of nurses would not adequately answer my questions. Therefore, drawing from the multiple types of potential research methods, it became clear that a phenomenological approach was the most suitable.

**Black Feminist Research and Standpoint Theory**

Within the paradigm of feminist research, Black feminist research is both valuable and trustworthy when studying women of colour (Mullings, 2000). Women of colour are placed at the centre of the research and for this reason the research is seen from their standpoint. Mullings states:

> For research to be transformative the subjects in the research must become actors in the transformation of their own environment as well as interpreters of their own space and place...in which everyday people, in their own language and from their own experience collectively work together to change their world. Culture then becomes a weapon of struggle (Mullings, 2000, p. 27).

From Mullings statement, we see that the experiences of women in research are transformative as it interprets for itself their space and place. Therefore, by challenging a nursing space that is not familiar with using Black feminism research from the standpoint of nurses of colour could “trouble the waters” and be easily criticized by White women who have created and owned the White space within nursing. Since using this method provides trustworthy data and allows for a dialectic analysis, it also permits the researcher to engage within the study, I decided to rupture the White space by further introducing Black feminist research along with standpoint theory (Collins, 1990; Mullings, 2000).

Using standpoint theory from a Black feminist perspective, acknowledges the historical locations of women how they conceptualize their identities. Since the study looks at IENs of colour from various diasporas, but with common experiences (they are all nurses, with a degree,
occupy the hybrid space and were influenced, educationally by the British education system in some way), using standpoint theory allows them to speak from their own locations and shed light on how the operational and institutional practices play into their everyday working lives.

**Situating Myself as the Researcher**

As the researcher, I shared many similarities with the participants. Having come from the United Kingdom as an IEN of colour, I also was positioned in low paid, menial jobs when I first arrived. After navigating my way through the nursing system, I finally arrived in the hybrid space, only to find I could not go further and my qualifications were constantly being questioned and undervalued. For these reasons, I felt I was the ideal person to conduct this study as I could closely identify with the participants. As I prepared myself for taking on such a task, I began reading numerous materials, some of which were from a positivist perspective. Exposed to the notion of research bias, I initially felt that I too could become biased as the researcher. It was not until explaining feminist research that I realized that research bias was a positivistic ideology and as a female researcher of colour I was indeed the most suitable person to conduct such a study. Therefore, I implemented reflexive learning as a way of connecting with my own feelings and the feelings of the participants in this study.

Since the participants came from neo-colonial states, I was unsure whether they would question my validity as a researcher. Following the board of ethics guidelines, I showed them my credentials, outlined the purpose of my research and its authenticity. The participants were open, warm and engaging. When I informed them that they would remain anonymous and all information was confidential, they were more than eager to share their stories with me.

**The Interview**

I decided to use interviews instead of focus groups as I wanted to engage with the participants and their everyday lives within the workplace setting. Since I was going to interview women, it was important to hear their own, individual stories, within the confines of safety and privacy. This would allow them to openly express themselves while adhering to the requirements of feminist research that sees the woman’s story as authentic research data (Smith, 2005). In
addition, interviews give participants a space in which they can tell their story. Kvale (2007) highlights that:

> The qualitative interview is a key venue for exploring the ways in which subjects experience and understand their world. It provides a unique access to the lived world of the subjects who in their own words describe their activities, experiences and opinions. The interview is a powerful method of producing knowledge of human situation (p. 9).

In line with what Kvale highlighted, it was more than fitting to use interviews with semi-structured questions that would allow space for the participants to share their experiences and opinions.

**The Research Process**

I was finally ready to start my research after having my proposal accepted by the Ethics Review Board of the University of Toronto. After having my consent letters and questionnaire approved by the Ethics Review Board, I began to focus on how to recruit my participants for my research (See Appendix 3).

**The Participants**

I decided to recruit 10 IENs of colour to participate in my study. One of the criteria required that they were all to have a degree in nursing and either they were all to have come from a country that was once colonized by the British Empire or be born in the UK by parents who migrated from the ex-colonies. Sample size has always been a debatable issue within qualitative and quantitative research. Qualitative research focuses primarily on small sample sizes. Jones (2002) and Crouch & McKenzie (2006) argue that the sample size used in qualitative research is not aimed at representing the population; rather, it is aimed at understanding individuals and identifying common themes among the participants. Riggs (1998) and Harris (2003) refer to “the strength of qualitative research as generating rich and extensive data” (cited in Stewart, 2007, p. 92). For these reasons, I felt justified in choosing 10 participants.

I chose to use the snowball sampling strategy to recruit the participants for this study, because it would provide similar participants from the social network that I had developed
through my Master’s research. Although the snowball sampling strategy has the ability to connect with specific groups that would otherwise be hard to connect with, the participants I sought were IENs of colour. Therefore, snowball sampling was the best alternative for recruiting this specific group. Surprisingly, one of the difficulties I encountered from this approach was the relinquishing of my autonomy in the selection of my participants, to the care and interest of the contacts within that community. But there was a positive outcome to this; I did not know any of these women, yet their stories reverberated with the experiences of other IENs.

By using the contacts within this community, I used the snowball approach as a method of recruiting my participants of IENs and I informed them of the research, and once they agreed to assist me in the study, I emailed them the letter of recruitment, the letter of consent and the semi-structured questionnaire. I asked the contacts to send the letters to people who they considered fulfilled the criteria specified in the letter of recruitment. I made it also clear beforehand that I could not receive any information about any of the new participants that were being recruited. Therefore, the letter of recruitment was to ensure that the new participants were suitable for the study before contacting me as the researcher. The consent letters contained a summary of the study and my contact details for the new participants if they were interested in participating in the study. One of the difficulties I encountered when using the snowball strategy was the overwhelming level of uncertainty it produced for me, the researcher. On several occasions I had to remind a few of the former participants about recruiting participants for the study. When they had recruited, I had the arduous task of waiting until the new participant decided to contact me regarding the study.

Although I had planned to recruit 10 participants, which was in line with the expectations of conducting a qualitative research, there were 13 people who showed an interest in the study and appeared to have met all the criteria. Three were omitted for the following reasons: one did not have a degree in nursing; another had an unexpected bereavement and had to go abroad for the funeral; and the final person had eye surgery and had a slow recovery. This resulted in 10 participants who were suitable for the research. Two of the participants were originally from India, five were from the United Kingdom (their parents had all migrated to England from countries that were once colonized by the British Empire) and three were from the Caribbean, countries that were once colonized by the British. They were all women of colour; three had gained their nursing degree in their home country and had them verified as equivalent to a
Canadian degree. The remaining seven had diplomas in nursing and had achieved a Canadian nursing degree while working as Registered Nurses (RNs).

Once the 10 participants had been recruited, the IENs of colour were all identified as holding positions of leadership. However, I soon realised that there were several tiers that existed within the scope of leadership in nursing. Frontline workers with degrees were considered leaders as they were making decisions regarding nursing care for their clients. Supervisors were another tier and above them were managers and policy makers. Supervisors and managers were not asked to participate in this study as they were not frontline workers and they were often groomed into moving up the professional ladder (Jacobs, 2007). Hence, all the participants fulfilled the criteria of the hybrid space of being frontline workers. Below, are a table and a brief summary of the 10 nurses who took part in the study.

**Sarah** came to Canada from England over 20 years ago. She was an RN and midwife in England and came to Canada for a change of lifestyle and job opportunities. She obtained her nursing degree while in Canada, working as a nurse and studying for her degree. She presently works as an RN in a research-based hospital. She has an intensely demanding position as a staff-nurse specialist. Sarah’s midwifery qualifications were not recognized when she arrived in Canada. She soon found a nursing job, but realized there were no prospects of promotion. For this reason, she returned part time to a Canadian university and completed her baccalaureate in nursing. Although she obtained a better nursing position, Sarah described her experience in England as being far more valuable than what she had gained in Canada.

One of the experiences that Sarah shared was about her application for a position for which she had the qualifications, skills and experience for the job. Having worked on temporary basis in the job, she was shocked to see the position was given to a nurse less qualified than her. She also shared that on another occasion when she applied for a full-time job she was offered a part-time position, while another less-qualified nurse was hired full-time. As a result Sarah decided to take her concerns to the Union. She summarized her nursing experience as a difficult process, with little support from Canada’s multiculturalism policies. She felt the ideal type did exist, but it rather had been more of a hindrance in her process, even though she had her degree from Canada, her RN was from England.
<table>
<thead>
<tr>
<th>Name</th>
<th>Time in Canada</th>
<th>Reasons for Moving</th>
<th>Qualifications received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah</td>
<td>20 years</td>
<td>Job opportunities and change of lifestyle</td>
<td>RN from England Midwifery, England BScN from Canada</td>
</tr>
<tr>
<td>Samantha</td>
<td>22 years</td>
<td>Better opportunities and life</td>
<td>RN from England Midwifery, England BScN from Canada</td>
</tr>
<tr>
<td>Claire</td>
<td>23 years</td>
<td>More opportunities</td>
<td>RN from England Midwifery, Scotland BScN from Canada, MScN, Canada</td>
</tr>
<tr>
<td>Claudia</td>
<td>21 years</td>
<td>Recruited because of nursing shortage</td>
<td>RN from Jamaica BScN from Canada</td>
</tr>
<tr>
<td>Marlene</td>
<td>21 years</td>
<td>Job purposes. Was also considering the U.S.A.</td>
<td>RN From India Midwifery, India BScN from India</td>
</tr>
<tr>
<td>Betty</td>
<td>13 years</td>
<td>Better quality of life and education</td>
<td>RN from India BScN from India</td>
</tr>
<tr>
<td>Pamela</td>
<td>10 years</td>
<td>Different life and different opportunities</td>
<td>RN from England Midwifery, England BScN from England MPH from England</td>
</tr>
<tr>
<td>Sophia</td>
<td>24 years</td>
<td>Stress from extended family and work</td>
<td>RN from Jamaica BScN from Jamaica</td>
</tr>
<tr>
<td>Diane</td>
<td>22 years</td>
<td>Education and education opportunities</td>
<td>RN from Trinidad BScN from Canada</td>
</tr>
<tr>
<td>Gloria</td>
<td>20 years</td>
<td>Job opportunities and change of lifestyle</td>
<td>RN from England Midwifery, England BScN from Canada</td>
</tr>
</tbody>
</table>
Samantha had been in Canada for over 22 years. She came to Canada from England in 1991; she was married at the time and both her husband and she came in hope of more opportunities and a better quality of life. While she waited for her RN qualifications to be verified, she acquired a job at a large teaching hospital. Because the hospital was reimbursing nurses for their studies, Samantha enrolled and completed a degree in Canada. Although she was a midwife in England, she was unable to work as a midwife in Canada.

Samantha went on to do her Master’s and worked as an educator within the hospital setting. She described the difficulties she had faced as a nurse of colour. She felt that she did not receive the respect that she was entitled to, but instead, she was treated like a student by her supervisor. There were no women of colour on the leadership team; and where she worked she realized an obvious difference in the way women of colour were treated. From her experience, she had not seen how multiculturalism policies had helped her, but she had definitely seen the ideal type being favoured, even though the ideal type was not always the best for the job.

Claire came to Canada 23 years ago, to explore more opportunities. Claire stated that she had no problems getting a job at the time. Because she was a midwife who had done her midwifery in Scotland, many people believed she was Scottish. She found that with all her experience she was treated as though she did not know what she was doing. So it took a while for her White, Canadian colleagues to realise that she knew what she was doing and was capable of being in charge. Claire described her observation that despite all the qualifications IENs of colour had, they were not allowed to team lead. She also noticed that the Canadian-trained nurses were not treated in the same manner. They were often given opportunities in leadership. While the Canadian nurses were given the opportunity for management and leadership, Claire saw that the Black nurses were left to do patient care.

Claire completed her studies in Canada and had achieved her master’s degree in nursing. Claire presently works in the community within research and development. She feels that multiculturalism policies had not helped her in any way to get to where she is today; she has also seen where being compared to the ideal type has impeded her growth and development. Claire strongly feels that the only way she was able to progress was to change her job.
Claudia came to Canada 21 years ago from Jamaica. She came on a holiday with her friend, and while on holiday, she attended a nursing fair out of curiosity. At the nursing fair, she was recruited because of the nursing shortage in Canada. She described her experience in Canada as “wonderful” but she also described her experience as more difficult and competitive because she came from a third world country. She also felt that if she had had her Master’s degree she would have had more opportunities. When reflecting on why she had difficulty in getting a job, Claudia blamed her difficulties on the climate of the profession. Claudia recognized that there was a problem in nursing, but did not identify with the concept of an ideal type. For Claudia, the solution to the problem was for everyone to just “work harder.” She identified several experiences where she was not offered a job, because she “was not the right fit.”

Claudia reminisced about good memories when she first came to Canada and was embraced by a Caucasian mentor. As the interview continued, Claudia began to recall incidences where she was treated differently because of her colour when applying for jobs. Claudia refused to put her nursing experiences in the Caribbean on her resume as she felt she would be judged if they realized she came from a third world country. She obtained her degree in nursing from Canada, and she expressed a sense of overwhelming pride in having a Canadian degree. She felt her Canadian degree made her acceptable. Claudia did not comment on the benefits of multiculturalism in her life, and she did not see the existence of an ideal type in nursing, but she did mention a feeling of acceptance once she gained Canadian experience and Canadian qualifications.

Marlene came to Canada over 21 years ago. Born and educated in India, Marlene had no difficulties in getting a job in nursing, because she came from a reputable Indian university with an internationally recognized nursing degree and as a certified midwife. When Marlene came to Canada she was offered a job by phone and told to come to the office. When she arrived and they saw she was Indian, it was obvious by their faces that they were expecting someone else. Suddenly she was told that the job had gone. Marlene found that she was constantly asked if she had sufficient exposure or if she would fit in. For these reasons, Marlene found she had to continuously compete within the workplace. She saw the multiculturalism ideology adding to her experience of being treated as an “outsider.” Concerning the ideal type, she interpreted it as
anyone who was good at her job regardless of race; nevertheless, she felt that being compared with the ideal type was more problematic, because it created competition and made it harder for some groups than others. In her experience, Marlene assessed that having an accent resulted in being treated differently and judged by others.

Betty had been living in Canada for 13 years. She came for a better quality of life and education. She came from India where she had an undergraduate degree in nursing and was a certified midwife. When she came to Canada, however, she had to do a special nursing exam, a refresher course and an English exam, which was a negative experience for her. She came with training from India that gave her a plethora of skills and history of hard work. Betty described the instructors in her home country as strict; when she came to Canada, she found the Canadian instructors to be extremely liberal. Betty emphasized that she had acquired more valuable skills from India than from Canada.

Betty presently works as an educator for a diverse multicultural population. At first, Betty felt indecisive as to whether multiculturalism policies had helped her. She did, however, notice that clients came to her far more often than to the White nurses, as they felt more comfortable with her. She had not come across the ideal type and felt that colour had nothing to do with it. Betty felt that the ideal type was based on one having a good personality and good qualities.

Pamela had been in Canada for 10 years. She came from England with the dreams of a different lifestyle and new opportunities. She had enormous difficulty getting a job, even though she was an RN and midwife with a Master’s degree. It took nearly 6 months before she was finally employed. She found that working in nursing in Canada was harder as there was more scrutiny and policing by managers and staff. Pamela felt that multiculturalism policies were supposed to support equity, but in reality this was not her experience. However, she experienced comparison with the ideal type, but had not recognized it by the term, “the ideal type.” When Pamela went for a job interview, she recalled being told that she would not “fit” the population. For this reason, she felt that multiculturalism had not helped her, and that the image of the ideal type nurse made it harder and more challenging for her.
Pamela talked about finding her own way through the journey and how the ideal type hindered her. She also felt excluded by the other nurses. She found there were not a lot of women of colour in leadership, but many in lower status positions.

**Sophia** had been living in Canada for 24 years. She came for a better lifestyle for her family and herself. Sophia had a nursing degree from Jamaica and was in a good, thriving job; she was a midwife and had a wealth of experience in public health nursing. Yet, she came to Canada because she was frustrated with her job in Jamaica and had some family difficulties. Sophia found that she got a job immediately and had great support when she arrived in Canada. She states she had not experienced any prejudice toward her, but she had heard of cases where friends and colleagues had. She presently works in a multicultural setting as an educator. She found that multiculturalism policies were positive for her and in her department there were no ideal type because of the multicultural setting. Here, she stated that the Caucasians were the minorities. Sophia jokingly referred to the ideal type as a description of herself.

**Diane** had been in Canada over 22 years. She came to Canada as an IEN with a nursing diploma from Trinidad and Tobago. On arrival in Canada, she did agency work, which exposed her to Canadian hospitals and practices. Later, she had a full-time position in nursing and because of the changes in nursing qualifications her employers were financially compensating nurses who were returning to do their undergraduate degrees in nursing. Diane took the opportunity and graduated with a Canadian undergraduate nursing degree. Diane presently works in a position that offers further leadership possibilities, but Diane states that she had refused it because of the politics involved. She explained that she wanted to just go home at the end of the day and not take her work home with her.

**Gloria** had been living in Canada for 20 years. She came to Canada from England with her friend. They were both Registered Nurses, with a diploma in nursing and certified midwives. They decided to visit Canada, but found out while on vacation that Canada was recruiting nurses
from England. They were promised a job and living accommodations. They felt it was an opportunity they should take as neither were in a romantic relationship or had children. Gloria and her friend were offered a job in a labour and delivery unit, but were not allowed to work as midwives. So Gloria, along with her friend, decided to do the degree in nursing as their hospital was encouraging nurses to obtain their nursing degree. Gloria completed her degree in nursing and continued to work in an acute service for neonatal care as a team leader in frontline work.

Confidentiality and Security

To ensure that the participants could not be identified in any way, close attention was applied to the requirements set by of the Research Ethics Board. I clearly stipulated in the letter of consent, the measures that would be taken to ensure confidentiality, anonymity and security. Confidentiality was obtained verbally (when I spoke with them on the phone) and textually (written in the letter of consent). I assured the participants that all information and discussion would be kept confidential unless there was any disclosure of harm or potential harm toward the participant or any other persons. To ensure anonymity, all information that referred to the participant was coded. The names of all locations and places that could in any way identify the participant were changed, and adjustments were made to any other details, such as settings, and events that were relevant to the study.

All information was recorded on an audio tape and these and any notes taken were securely stored in a locked cabinet at my home with keys only available to me. All information on the computer was placed in a folder with a personal code, and on a computer with a password, which was once again, only privy to me and my supervisor. I reminded all the participants that any data sent by email should also follow the code of confidentiality. For example, did others have access to their emails or know their password? They were also advised to never use their work email address. The participants were informed that all recorded data would remain securely stored for five years after the study was completed and then all original information would be destroyed by properly shredding all hardcopy data and erasing all recorded information.
Issues of Safety

The participants were previously informed of the nature of the study in the letter of consent and when I spoke with them over the phone. They were informed that the study could awaken emotions of the past, for this reason they were given the questions in advance for them to review. Prior to the study, I classified my participants as low risk because of their educational levels, their English ability, their comprehension and their communication skills. However, they were aware through the questions, that there was a possibility that issues of discrimination and oppression could arise, and that if they felt uncomfortable at any time, they could terminate the interview. During the interviews, none of the participants became emotional or tearful; however, some were passionate when relaying their stories, but no one wanted to stop at any point.

Research Questions

When I began formulating the questions for the research, I developed nine semi-structured questions (See Appendix 4). I divided them into three categories: the first three questions were foundational in setting the scene. The participants were asked about their reasons for coming to Canada and the length of time they had been in Canada. Questions four to six were central to the theme of the research. These questions focused on IENs, their experiences in Canada, and the role that multiculturalism policies and the ideal type played in their experiences. The final three questions were reflective and meant to be empowering—reflective because they allowed the participants to explore the trajectory of their journey, while asking them to express what changes they wanted to see. In these three questions, I hoped the women had a voice to share their lived experiences and an opportunity to offer solutions to any problems they identified.

The value of open-ended questions is best understood by Hall (2012) who says that open-ended questions are:

The most productive when phrased as open-ended probes. These questions are often used to facilitate clarification; explore attitudes, thoughts, or feelings about experiences; and encourage participant elaboration of events without fear of judgment. Open questions
specifically facilitate participants’ exploration of feelings, thoughts, and meaning of events without setting limits on the type of response (p. 87).

From Hall’s description, the open-ended questions were presented in two ways: Either as probes (e.g., what were the reasons for you coming to Canada?) or directives (e.g., describe your experiences as an internationally educated nurse of colour...). Using probes and directives allowed more than just a narrative of their experiences, but equally provided an exploration of their feelings and attitudes.

**Data Collection**

The participants contacted me by phone and by email; in the latter case, I arranged a time to call them by phone. Once phone contact was made, we entered into an informal conversation and I had a telephone script to ensure that the salient points were discussed (see Appendix 3). I reminded them that no details should be shared on their work email or telephone, to which they agreed, and gave me their personal email addresses. We reviewed the recruitment letter and the letter of consent that included information regarding confidentiality, anonymity and the handling and the secure storing of all information (see Appendix 3). I was aware that if I compromised the standard of research set by the Research Ethics Board, I was at risk of having my study terminated and the participants’ rights being compromised. So for these reasons, I continually revisited the ethics committee’s expectations and conditions of approval in order to keep myself in good and regular standing with the university and with the participants. Once they had verbally agreed to participate, we arranged for a suitable place and time to meet.

Prior to the interviews, the interviewees (participants) had all agreed to the use of audio tapes. The client chose the locations that we should meet, and we ensured that confidentiality and privacy were paramount. We were not to be overheard, or the participant’s identity compromised in any way. The interviews were to be in-depth interviews, which meant we needed a place that would not limit the length of time we took for the interview.

Unlike general surveys and quantitative data, in-depth interviews allow room for how the participant responds, and how she feels and engages in the interview. As the researcher, it was
important to be attuned to the non-verbal dynamics that were occurring in order to create a more thorough picture of the information that the participants were sharing. The richness of the study was not to be limited to only what was shared verbally, but how they reacted, sighed and even laughed when sharing information.

Whenever we met for the interview, I reminded the participant verbally, and also made reference to the letter of consent regarding issues of confidentiality, anonymity and safety. Times, places and situations were altered in order to protect the identity of the participant without distorting in anyway the information shared. However, according to the requirements of the Research Ethics Board, the participants were made aware that if there were any concerns or danger with regards to an individual that it was my duty to report it to the relevant persons. The participants were also informed that they had the right to terminate the interview at any time, and to bypass any questions that triggered discomfort. They were not obliged to give a reason, and their decision would be highly respected without being pressured or cajoled in any way. During the interviews, however, none of the participants bypassed any of the questions.

During my phone conversations with the participants, I informed them of the length of time the in-depth interviews could take. In-depth interviews could take anywhere from 45 to 90 minutes. I reminded them of the importance of confidentiality, and that this was equally important when I visited them at their homes. It was important that no one could hear our conversations. However, for such reasons occasionally an office cafeteria in the evening was a suitable place that provided no disruptions.

Trust and integrity were important to this study. I reminded the participants that if they were dissatisfied and wanted to speak to someone else other than myself, they had the contact details of my supervisor and the Ethics Board of Research, which were available on the letters they had received. Once again, I reassured them that their rights and anonymity would not be compromised. We conducted the interviews either in the evenings or on Sundays, according to the participants’ choice or interest. Prior to the interviews with the participants, I tested all the equipment and brought with me a “back-up” audiotape just in case any technical difficulties occurred. Before each interview, I did a practice run with the participant to test the audio device and voice comprehension. Once everything was organized and working well, I then proceeded
with the official interview. Each question on the semi-structured questionnaire addressed the issues contained within the research statement that needed to be unraveled.

During the interview, it became evident that accent was an issue. Participants from the Caribbean and India considered the British accent to be a sign of intelligence; therefore, they were receptive to me as the researcher. This was at times evident in them praising my British accent before the interview began. The participants from England had not made any remarks regarding any differences in our accents; I assumed they felt affiliated to me by us sharing similar accents. There were some specific terms and phrases that we commonly knew. For this reason, there was an easy flow within the interview and a willingness by all the participants to speak more openly and deeply about their experiences. The in-depth interviews were intensive and time-consuming, yet they provided much more detailed information than any other form of data collection (Boyce & Neale, 2006; Kvale, 2007).

During the interviews, I would take occasional notes that were relevant and that highlighted non-verbal cues that had meaning to what they were saying; these non-verbal cues included the laughing, rolling of the eyes and gestures made with their hands. At times, such non-verbal responses indicated important information for the research. The semi-structured questions allowed the participant to speak more openly and extensively, while affording me the opportunity to probe further. Probing questions give room for further reflection, as well as deeper and richer responses from the participants. Some of the participants began with a professional approach to the questions asked, in other words, being ‘politically correct.’ Oftentimes, it was not until a third of the way into the interview that they would have an “eureka” moment. They would then begin to verbalize their experiences and recall incidences they had forgotten about, or were unable to make sense of, until the interview.

At the end of the interview, I presented them with the promised token of a $10 Subway food voucher, and arranged to contact them once the transcribing was completed. They were informed that once they received their transcriptions, they had a week to read and then follow up with me if they wanted any changes or omissions made, before I would start writing up my findings. They were also reminded that they could contact me by phone or email. When all the interviews were transcribed, I contacted all the participants by email to inform them that their interview was transcribed and I then sent them their individual transcripts with their
pseudonyms. Within the week, only one participant emailed me with amendments to her transcript, while the others had no concerns. The relevant changes were made as advised by the one participant. However, the content was very much the same, only certain tones and expressions were changed. Therefore, the changes did not alter the analysis in anyway.

Interpreting the Data

Interpreting the data was one of the most challenging aspects of this research. As it involves several processes, if not carefully conducted, this process can lead to misrepresentation of the study and false outcomes (Kvale, 2007). Therefore, after completing each interview, I would put it in a secure case, return home and review the information before storing it away. By reviewing the information before storing it away, I was able to reflect on the visit and gain a clearer understanding of the interview. According to Kvale:

Transcribing involves translating from an oral language, with its own set of rules, to a written language with another set of rules. Transcripts are not copies of some original reality, they are interpretative constructions that are useful tools for given purposes (2007, p. 98).

Therefore, Kvale’s comment pointed out to me the intricacies and accuracies of interpreting each statement correctly. Transcribing the interviews required continual rewinding and matching my written notes to the transcribed information. On my written notes, was additional information of the participant’s response and attitude that was not readily perceived when transcribing from audio to text.

Once I had completed transcribing, I had to tackle how to best interpret the data. At first I had contemplated using the computer program NVivo, but I had difficulty getting into a training program after several tries. I decided therefore, to use the traditional way of “eye-balling” and coding or categorizing similar themes by highlighting the transcripts with different highlighters, according to their themes. I made another attempt to enroll in another NVivo training session after I had transcribed, but the librarian discouraged me from doing so, because I had already gained the data I needed. Unintentionally, while working carefully with the manual methods, or
what Bernard (2000) calls the “ocular scan” method I found that I became more engaged with the study on a personal level. Even though the process took longer to complete, I began noticing intricate details and patterns that I probably would otherwise not have noticed. Dey (1993) points out that the non-computer methods allow the researcher to draw from her hunches and intuition, thus making the research more meaningful.

I used different coloured highlighters as I re-read each transcript. Soon I began to identify certain themes emerging. Each theme had a colour-code and a title-theme. As I went through the transcripts, seven of the participants agreed with the assumptions I had about the results of my study, but there were three who did not agree with my assumptions. These three participants had not identified racism or inequality as a factor in their own lives, but one of the three recognized racism as a factor in the experiences of others rather than in her own experience. I had assumed before the research that all participants would have been aware or experienced racism in their work experience. As the interviewer, there was a dissonance between what I had assumed and what the actual results showed. Instead of ignoring these conflicting issues, down-playing them, or even writing them up, I decided to confront my discomforts. By confronting these discomforts and unexpected responses, I realised that these were locations that were providing further data and enriching my study. I found myself challenged by my own assumptions and by my own expected outcomes.

**Identifying Themes**

Once I had colour-coded similar issues throughout the interviews, there were seven major themes and several subthemes that surfaced. These themes were interpreted within the context of the research and flagged important discourses that were occurring within Canada’s nursing practices. The themes diverged into two overall groups, which were, the challenges the participants faced in their everyday work, and the spaces of resistance they had produced as a means of survival. Both themes carried with them their own subthemes, and I decided to create two separate chapters for the themes.
Reflexive Research

Reflexive research is commonly used the feminist and anti-racist feminist research (Mullings, 2000; Smith, 2005). Reflexive learning was a useful way of reorganizing and addressing my own thoughts and feelings before and after each interview. By confronting my own thoughts and feelings through reflexive research, I was able to prevent my own standpoints standing in the way while observing others (Gulman, 2010). Consequently, I was soon able to interpret more of the data. It was important for me to recognize that my experiences were my experiences, and although I could empathize with my participants, I had to focus on the bigger picture. I soon realized that it was first a privilege that they invited me into their lives and it was my responsibility to understand or piece together issues of domination and subordination that were occurring within the practices of Canadian nursing, and it was their experiences that could reveal these issues.

Decolonizing Agenda

As a nurse and a researcher, I was cognizant of my role within the institution. The dichotomy of being a researcher and working within the field was initially complex and confusing as one who had been educated and taught from a positivistic perspective. In conducting this research, I had to undo all I had been taught about research and research bias, and recognize that as a nurse I was part of this story and my standpoint was valid. Therefore, I had to decolonize my own mind. One of the advantages I had in freeing myself of the positivistic dictates that nursing research finds itself so often tangled in, was the research was not funded by any institution. Therefore, I had no obligation to “report back” to anyone. My autonomy within the study provided a safe space for my participants to speak and express themselves openly. However, my research was accountable to the Research Ethics Board, which meant I had parameters and limitations that worked in the interest and safety of the participants and me. For this reason, I was continually aware that “Researchers who take a critical perspective of the ruling relations are not immune to institutional capture and that the analytic goal is to make visible the ways the institutional order creates the conditions of individual experience” (McCoy, 2006, cited in Smith, 2006 p. 109).
Summary

In this study, I coupled the qualitative paradigm with feminist research. This union opened up a greater understanding into the experiences of women within research. As nursing research has been greatly influenced by positivist thinking, using feminist research removed all the notions of research bias and the ideology of the presence of “a lack of objectivity.” I was able to freely engage in the research, while allowing the women to freely tell their stories. Because I was studying women of colour, there were useful frameworks were implemented into the research and data collection, such as ARF and BFT. The union of these theoretical frameworks within the methodology of a qualitative paradigm brought a new dimension to research and, therefore, enriched the quality of the study. In-depth interviews offered a space in which women could talk openly about their lived experiences while relating to feminist methods of inquiry. This study made room for further studies in the area and allows researchers to venture into new fields, while testing different methods within the ever-changing global world that we work in.
Chapter 5

Overview of the Research Findings

This chapter provides an overview of the answers to the nine semi-structured questions that the participants were asked. The questions were divided into three sections that addressed the following issues: 1. Personal Issues (Questions 1-3), The Core of the Study (Questions 4-6) and The Participant’s Perception (Questions 7-9).

**Personal issues (Questions 1 to 3)**

1.  *How long have you been in Canada?*
   
   All the participants had been in Canada between 10 and 24 years (see Fig.1 on page 71).

2.  *What were your reasons for coming to Canada?*
   
   Nine out of ten came to Canada for one or more of the following: Work opportunities, a better quality of life or for a chance to further their education. Only one of the participants came because of stress factors from her extended family and work environment. (see Fig.1 on page 71).

3.  *When you came to Canada, what was your experience in trying to find a job in nursing?*
   
   All but one of the participants expressed that they found work immediately when they came to Canada. Pamela had the longest wait; she reports a six-month wait. All of the participants found that when they arrived in Canada, they were unable to get employment in jobs that they were skilled in. Seven out of ten participants who were experienced midwives in their own countries were not allowed to practice as midwives.
The Core of the Study (Questions 4 to 6)

The next three questions - questions four to six - were consciously situated to address the core of the research statement: “Identifying the dialectic of the ideal type and multiculturalism policies within the practices of Canadian nursing” through the experiences of IENs of colour.

4. *Describe your experiences as an internationally educated nurse of colour practicing within Canadian nursing from the time you started until now.*

Three out of the ten participants in the study - Diane, Sophia and Claudia who were originally from the Caribbean - expressed that as IENs of colour they had not experienced any forms of racism or inequality. The other seven women, however, shared different experiences. Some of the terms the seven women used to summarize their experiences were; “being scrutinized”, “lots of competition”, “no space for promotion”, “you’re not good enough”, “feeling not good enough” and being “treated like a child.” Although the seven participants noted racism in their experience, the findings also showed that not all the participants were willing to taint every situation as racially motivated.

Although Sophia was one of the three nurses who stated she had not experienced any forms of inequality toward her, she did describe being made aware of institutionalized racist practices when she shared that:

The head nurse on that particular unit was fascinated by Jamaican nursing. She told me to come and start as part-time and then I would have been considered for full-time. The head nurse at the Doctor’s (where I used to work) told me that there would be prejudice at this hospital and I went and I have never once experienced any prejudice towards me or treated me unfairly. The head nurse at the Doctor’s told me that I was the first Black nurse, who didn’t experience any prejudice at this hospital.

Sophia’s shared experience unlocked several issues; first, the head nurse at the new unit had a fascination for “Jamaican nursing” and Sophia fulfilled the nurses’ curiosity. Secondly, when the head nurse told her she was the first Black nurse who didn’t encounter prejudice at the hospital, this statement alluded to a ‘common sense’ knowledge that institutional racism was occurring in the hospital.

Overall, question four identified that the issue of race was evident in the experiences of nurses, whether it be directly through work colleagues and management, or indirectly, within the
nursing infrastructure. Even though racism was not always obvious, on the few occasions when racism was not visible, the participants expressed feeling valued and respected.

The nurses from Britain, India and the Caribbean continually stressed how advanced educational programs were in their countries; however, nine nurses experienced the same difficulties in having their skills and experiences recognized within the workplace setting. One participant stated that she had no problem with her skills being recognized, while seven out of the nine alluded to the difficulties they experienced as being influenced by their racial identity.

Marlene, a nurse and midwife from India was exempt from practising as a midwife. Nonetheless, she found that her nursing skills and qualifications were highly recognized when she stated that:

Luckily the training I received from where I was trained, it was almost advanced. My training and my experience helped me through my assessment and I also had my TOEFL\textsuperscript{2} ready and I started my assessment from the country which I was applying from. So, they only asked me to write the exam, so I was able to land my job as a grad, and start my job as a grad and do my exam and I came through the exam.

Marlene found that when she went for interviews, she encountered many difficulties as a woman of colour. She shared the following incident that occurred when she was applying for a job and before the interviewers had met her:

They (the interviewers) said that this was not the person that they expected. The interviewers said that I had a slim chance to get through with the position. I asked for them to still give me a try. They sent for me to come to give the interview a try, but when they saw that I wasn’t the person that they were expected, they changed their mind. Marlene gestured in the interview by rubbing her hand, indicating that the reason was

\textsuperscript{2}TOEFL: “Test of English as a Foreign Language”, used to test the English language skills of non-Native English speaking individuals. It is a test of comprehension of the English language through reading, writing, listening and speaking skills. \url{http://www.ets.org/toefl/ibt/about}
her skin colour. Sophia was the only participant that had a positive experience within the workplace and she could not relate issues pertaining to marginalization as present within her nursing experience in Canada.

5. Canada was the first country to have a multiculturalism policy. When you hear the word multiculturalism, what does it mean to you?

The participants had interpreted multiculturalism in similar ways. Diane interpreted it as: all different cultures working together”; and Gloria described it as follows: Multiculturalism? When I hear it, in my head it’s like a country that embraces different cultures and accepting people (pause)... of …you know…of food and appreciate people from where they are from. As a Black woman…I think there is still racism here. Some is blatant.

Although the women generally held similar definitions, for Claudia, Diane and Sophia, multiculturalism policies spoke about a respect and reverence for other cultures and practices. Claudia defined multiculturalism as:

... a group of people with different cultural backgrounds, in terms of colour, lifestyle, practises. Canada is multicultural and it’s just a matter of working together and living together.

There was an obvious consensus of what multiculturalism policies were meant to represent, yet it was not until the last three questions—which related to their experiences—that a clear disparity could be seen between the perceived values in multiculturalism policy and how these policies were being implemented as evidenced in the participants’ everyday practice. This will be further discussed under the last set of questions labelled, The Participants’ Perception.

6. Have you ever heard of the term, the ideal type? What does it mean to you?

One writer described it to mean that in nursing there is an ideal type of nurse, she is White, middleclass and heterosexual. The argument she presents is that unless
someone fits those criteria she will feel excluded within nursing. What are your thoughts and experience on this view?

Although the participants gave similar responses when addressing the question of multiculturalism, their responses to the sixth question about the ideal type were clearly different. I had given them the definition of the ideal type that was according Giddings, however, they were given room to define the ideal type according to their own understanding. One participant admitted that she had never heard of the term before; six referred to the ideal type as a person who was a “perfectionist” or more “preferred”; and three identified the ideal type as “White” or “Caucasian.”

The ideal type nurse (Giddings, 2005) and the ideal nurse (Jacobs, 2007) are similar, but in addition to Giddings definition of the ideal type nurse being White, middle class and By informing the women of Giddings definition of the term, the ideal type, Diane shared that she had never come across the ideal type. However, when it was defined, she quickly interjected that, “It, doesn’t matter where you come from, once you are efficient, and be able to do the job. That would be my ideal type.” Betty also defined the ideal type as similar to Diane when she said:

Someone who is a perfectionist; that person should be punctual, approachable, trust worthy, skillful. I wouldn’t say that because with Canada being a multi-national country it shouldn’t be that a White woman should be the ideal type. Any person who has the qualities of a good nurse should be the ideal one.

Although Diane and Betty had their own perception of the ideal type, they rejected the definition offered, which addressed issues of race and class. However, Samantha, who worked in the hospital as a clinical educator, identified the ideal type before a definition was given. She described her as a nurse who was “Caucasian, blue-eyed blonde, middle class.” After being told the definition, Samantha went on to share the following scenario:

There was a lot of undermining going on and I didn’t know because I was new. And they continued to treat the other (White) educator with much more respect. I was really upset one day so I reported it to the two directors, and I told them that I was really upset with how I am being treated. But before we could have the meeting, one director was fired. I asked another educator, who was another woman of colour, to support me, as the other
educators who were White, were in support of the White educator. So when they had the meeting they argued it was very unfair to the White educator, because had she known that I was bringing another educator to support me, she would have brought someone with her. One of the directors actually told me that she favored the White educator more than me. And I was not happy about that because even though she did have a preference, she shouldn’t have shown it and treated us equally. The meeting was then cut short because they were told that the meeting was about something else and I was not given a chance to voice my other concerns. It made things more intense for me, and the new director actually would have found out from the previous director before what may have happened because she treats me the same way the previous one treated me.

Along with Samantha, the other two who related the ideal type to issues of race, shared their stories as a way of explaining why they defined the ideal type as racially oriented. Although I had defined the ideal type to the participants, according to Giddings definition, these three participants’ definitions were the same as Gidding’s definition, even though they had no former knowledge of her works (2005). Jacob’s argument that the ideal nurse reflects a culture within nursing was accepted by the six participants who defined the ideal type as a perfectionist.

Sophia, the participant who had not heard of the term, “ideal type” still attempted to define it. When asked what she thought the ideal type was, Sophia responded:

I don’t think I have really heard the term before. But it would mean that there is somebody who is the one ideal for certain things. So, it could mean that the ideal type could be anything, being negative, meaning that it could be a Black person, or if it is a position of power, then it might mean a male Caucasian. Some people would think that the ideal type could be Caucasian.

Sophia’s attempted definition of the ideal type was close to Weber’s definition. She exposed two significant features: It was negative and it was a position of power. In reviewing the ten definitions of the ideal type, one generalization was clear and that was that the women all felt less than the ideal type, treated differently from the ideal type and desired to be the ideal type.
The Participant’s Perception (Questions 7 to 9)

The final three questions were central to what I have termed, *Identifying the dialectic of the ideal type and multiculturalism within the practices of Canadian nursing*. Once establishing that the ideal type existed, it was the answers to the last three questions that further disclosed and ruptured the manner in which the ideal type and multiculturalism policies operated within the practices of Canadian nursing. In the third component (questions 7 to 9), the women became more engaged with the research questions and more expressive and open in providing further details. I noticed three occurrences that were not as evident in the first and second components, but were in the third component:

A) There was significantly less prompting from the researcher, because the participants were more willing and forthcoming in sharing additional details about their experiences.  
B) Some of the participants’ views that were expressed in the beginning had changed by the time we arrived at the last three questions. As they began to talk openly, they began to reflect more and would often say, ‘come to think of it’ or ‘I can remember when…’  
C) There was more of a realization of their journey. Nine of the participants described their journey as a struggle or a challenge. By struggle, some felt they had arrived at their present position with a struggle, while one of the nine felt she was still struggling to arrive; another out of the nine found it a challenge and decided not to try to “arrive” as she could not cope with the politics. The tenth participant expressed the view that she never had a struggle, because she said “ever since I came it has been very positive, and I have not had any major problems.”

The seventh question addressed multiculturalism and the ideal type, and the roles they played in supporting or hindering IENs of colour into frontline leadership positions. Although question seven and eight appeared to be very similar, they were in fact very different. This is how these questions were formulated:
7. As you are in a position of leadership, or a position that offers opportunities for leadership, explain how the following have impacted your position today:

- Multiculturalism (positively/negatively)
- The ideal type (positively/negatively)

8. As a woman of colour, how have the following supported or not supported your journey to the position of leadership that you now occupy?

- Multiculturalism (positively/negatively)
- The ideal type (positively/negatively)

As the researcher, it was my responsibility to clarify the differences within each of these questions to ensure that the participants clearly understood them. Consequently, probing was commonly used to shine further light on the questions without navigating them into a specific standpoint.

In asking question seven, I wanted to find out about the participants’ current position in nursing, and allow them to reflect on where they had arrived and what they had achieved. This approach allowed the participants to locate the events, issues and support mechanisms that were currently sustaining them in these positions of leadership. Within question seven, I also considered the role that multiculturalism and the ideal type continued to play in their present position. However, in question eight, there was a subtle difference that would field significant data on understanding the role of multiculturalism and the ideal type, in their nursing practice and experience.

Mechanisms of support were the essential issues addressed in question eight, whereas impacts were the central theme for question seven. Impacts focused on the outcome, whereas mechanisms of support explored the processes by which multiculturalism and ideal types operate in the work experiences of the participants. In these last three questions, the participants went deeper into their feelings and perception of their experiences. There was further exposure into who they were, where they had arrived at and how they were coping within the practices of Canadian nursing. Out of the ten women, all but one felt that multiculturalism played a role in helping them arrive at the place they were today.
One of the participants who viewed multiculturalism as positive, but with a significant hidden meaning was Samantha. Samantha stated that:

The positive part is that I am in this position because back then I wouldn’t have been able to. The other side is that my friend said that she felt she got the position because the hospital needed to be multicultural. So [I] was like a clone that was to fit a part, rather than [them] see[ing] me as an individual. So it was just to fit the role and do as I’m told.

So far Samantha’s, multiculturalism may have opened doors, but for her friend, it made her a token.

Marlene described multiculturalism as having an adverse outcome on her journey when she said that:

I think sometimes, because you belong to a certain cultural group, you experience it in one or another form. There are few chances for you to come up, not only in nursing but in any field. In all other job areas, such as offices, hospitals companies, banks, universities, you hear about some job inequalities. Many foreign trained professionals remain jobless or they don’t find the right job in their own field. It’s not that they don’t have enough qualifications or skills to do the job.

Marlene identified a multiple tier system by which internationally educated professionals either remained in fixed positions, or had to struggle to move vertically into better positions.

The second part of question seven explored the ideal type and whether it had an impact on the participants’ present positions. Pamela felt that the ideal type had an influence on her position as an IEN. She stated that:

I think ideas of the ideal type have [had an] influenced in some way. It makes getting positions of higher power more challenging. I am also encouraged because the ideal type doesn’t always resonate. But even when you get the position, especially when you are working with diverse cultured people, once you get the position, do you fit? Sometimes, sitting in with colleagues, and their expectations on things you would be interested in, would be kind of difficult to find resonance.
Pamela recognized that the ability to get leadership positions was more challenging for IENs than for Canadian nurses. Claudia, who, throughout the interview, had not identified issues of discrimination and difference, felt the ideal type had a little impact on her experiences. She said that:

It may have impacted me a little, because when I look at it now, I feel a little more comforted to know I did a degree here. So now, I get to put a Canadian degree on my resume. So there is a level of comfort. You feel as if you will be more accepted and get better positions, because you have Canadian experience.

Although Claudia perceived the impact of the ideal type as small, her feelings toward having Canadian qualifications revealed the high value she saw in Canadian qualifications.

By exploring the ideal type in questions seven and eight, it became increasingly obvious to me that among some of the nurses, there was a need to strive towards the ideal type or to even visualise oneself as the ideal type. Sophia, who felt strongly that she had never experienced racism (and neither had she been supported by multiculturalism policies), questioned that, “maybe I was the ideal type...it has never had that problem with me. It has helped me a lot...”

Marlene viewed the ideal type as attainable to anyone when she said:

No matter, if you are able to do the job, it doesn’t matter what colour, nationality you come from. You are able to function in the ideal trained way, then that is the real ideal.

It is clear, therefore, from Marlene’s response and others that the participants had not only demonstrated reflexive thought but were also aware of the trajectory of events in their lives. They were also able to separate any influences that multiculturalism policies and the ideal type may have had or not had on their present positions.

As the participants reflected on their successes in the area of leadership, qualifications, skills and experiences, three major factors emerged as important. Question eight revealed that eight out of the ten participants felt that the evidence of multiculturalism discourses had not assisted them in their journey; whereas, seven out of the ten participants felt that being compared to the ideal type nurse had not assisted their journey.
Although Marlene never saw being compared to the ideal type nurse as positive of her journey, she does mention that there were occasions when some White Canadian nurses would help her on her journey; but she also felt that because of her skin colour, she was never accepted as equal. As nurses of colour, the participants expressed the barriers that they faced by not matching up to the image of Giddings’ ideal type, and once again, they described the processes as, “a struggle,” “competitive,” and “challenging.” Claire talked about being compared to the ideal type as being positive for her when she said:

“It has kind of supported me in the sense that, the White Anglo-Saxon (White male/White female), isn’t as educated as myself. So I would end up being the person, from an academic perspective, I was ahead of the White person. That is why my education has been the real pivotal point for me in my workplace.

Samantha on the other hand, described being compared to the ideal type as helping her, “because it is showing me what I need to get to. Has it been helping me now? I don’t know.” Samantha’s response was consistent with the overall findings. The ideal type has acted as a guide for the IEN to know what is expected. Women of colour have had to work harder, because they are not recognized as the ideal type. It appears that even when they improved their status after working harder, they were not necessarily helped further by being compared to the ideal type. Hence, Pamela’s answer elaborates on the role that comparison to the ideal type can in fact play:

“There is more scrutiny and this undermine [s] your confidence as well. I would say that obviously there were times in which it [the ideal type] hindered my journey [as with] the public health nurse position interview. There was another position where I felt like I didn’t fit. I was the odd one out, where nurses spoke the same, looked the same, social class and background. They would socialize and work together while I would feel excluded. You would feel excluded and not integrated and not as part of the team. So I think those things affect one personally and how you work, it makes it more difficult [to know] how to find the resources you need to work more effectively.

Although the IENs of colour had achieved academically and had come to Canada with a plethora of experiences, skills and qualifications, they were most affected by being negatively compared to ideal type ideology in a personal way; they often found themselves, not so much battling with skills, but rather with the undermining of their confidence.
The final question - question 9 - was designed to empower the participants by soliciting their intellectual and experiential input into what changes could be made. This question was solution-focused and it addressed the current status of nursing. The questioned stated:

9. *Are there any changes that should be made in Canadian nursing practice to produce a more equitable treatment of nurses? Give reasons for your answer.*

Eight out of ten of the participants suggested that changes should be made within Canadian nursing practice. One of the participants could not think of any changes that were needed, and another was unsure, but suggested changes in the area of administration.

Changes to the curriculum to help students understand different cultures and issues of racism were mentioned four times; whereas issues related to diversity and multiculturalism in practice were mentioned five times. Another recommendation that was posed five times was that there should be more representation of people of colour in leadership positions. Claudia, who could not think of any changes that were needed, expressed that she felt the system was equitable. Sophia was not sure if there was a problem. She felt that if there was a problem, it all came down to the administration. She finally surmised that change within the area of administration would be the solution.

The majority, however, felt that changes were needed and listed them: There was Diane who expressed a need for more IENs who would be able to support diverse cultures; Betty who felt that student nurses should learn to care more for patients, rather than pursue new opportunities [in leadership]; and Claire who felt the issue of systemic racism needed to be addressed by first changing management and then educating colleagues regarding equity, and distributing equal workloads. Claire further discussed the need for changes in policies and for ways of assessing the “true feelings” of nurses toward people of colour.
Summary

The concept of the ideal type has remained an elusive term that is not distinguished within the practice of Canadian nursing. In this study, it was clear that it was invisible. Many IENs were not acquainted with the term, but most could clearly describe the experiences they had that depicted the existence of the ideal type. Hence the ideal type is invisible/visible; it is invisible within policies and within the nursing curriculum, but it is visible in the everyday practices that IENs share within the workplace setting. By identifying the dialectic of the ideal type and multiculturalism policies, it is made obvious that the ideal type is naturally exclusive, yet it is able to function within the same space as multiculturalism policies, which is politically inclusive. Therefore, this study has shown that the ideal type and multiculturalism policies may in fact be functioning in partnership. Whereas multiculturalism policies remain visible to the masses, the ideal type continues to be invisible to the masses. The one that continues to be invisible to the masses is the one that in fact visibly steers the direction of nursing practice.

Using an open-ended questionnaire in an in-depth interview disclosed the existence, of what Giddings has termed the ideal type as well as the operational practices of multiculturalism within the practices of Canadian nursing. The lived experiences of IENs also revealed the visible/invisible nature of multiculturalism and the invisible/visible nature of the ideal type. Multiculturalism is visible, operating within the discourse of Canadian nursing. It is found within its policies, its curriculum and its organization. However, when put into practice, it is not always operationally-visible. There are no clear inclinations showing its assistance in navigating IENs through the nuances of nursing bureaucracy. Within the lived experiences of IENs, I could find no emphatic statements about the benefits of multiculturalism policies in the outcome of their nursing experiences. Rather, they described it as nothing more than a terminology or discourse; therefore, it remains visible to the global community, but invisible in its functions within the local community: a phenomenon known publically, but not functioning privately in the everyday lives of IENs of colour.
Chapter 6

Data Analysis: Challenges

The main purpose of this chapter is to demonstrate the type of relationship that exists between the ideal type and multiculturalism policies within the practices of Canadian nursing. It was clear in the findings that the ideal type and multiculturalism policies both existed, but surprisingly there was not a dualistic relationship that had been previously anticipated. Instead the relationship was dialectic in nature, where the ideal type and multiculturalism policies created a dependency on each other. This was obvious in the seven major themes and subthemes that had emerged throughout the interviews. The themes are divided into two components. The first component identifies the challenges that the participants faced within the dialectic relationship. The challenges consist of the first three themes, which are: 1) feelings of belonging; 2) non-recognition, and 3) that there are no leaders of colour at the top. The second component addresses four themes that demonstrate spaces of resistance by which the participants had created as a way of surviving hegemonic settings within nursing. The four spaces of resistance include the remaining which are: 4) being liked by others; 5) mirroring the ideal, 6) faith and spirituality, 7) valuing their heritage. The themes that address spaces of resistance will be discussed in chapter seven, while the challenges IENs faced will be discussed in this chapter.

Challenges

Regardless of the various Diasporas that the participants came from, they all either came from countries that were once colonized by the British Empire or from the United Kingdom itself. Those from the United Kingdom were the children of parents who were recruited from the ex-colonies to work in England following the aftermath of World War II. They all shared similar aspects in their culture, which was brought about by colonialism (Zinkin, 1993; Ryan, 2008). Although the participants and their Canadian hosts shared similar experiences, it soon became obvious that there were vast differences between them; and these differences often materialized as challenges. The challenges they faced strongly arguably replicated the treatments that their ancestors had experienced under colonial rule-- challenges that they thought were erased after
World War II (Loomba, 1998; Murphy & Zhu, 2012). The following three themes identified specific challenges that IENs of colour experienced.

**Theme 1: Feelings of Belonging**

*Someone has to not belong in order for others to belong (Ahmed, 2000).*

Canada has been described as the more pluralistic society, linguistically and culturally, when compared to other pluralistic societies such as Switzerland, Belgium and the United States (Laczko, 1994). In fact, Canada’s multiculturalism policies have been instrumental in attracting newcomers, while preserving Canada’s socio-economic status within the global market (Reitz, 1988; Hum & Simpson, 2002; Duncan, 2010). With fantasies of being warmly welcomed because of the British culture, language and education they share, it was natural for the participants to assume that they would be easily integrated on their arrival. Instead, they experienced the opposite; most were not welcomed as they had expected they would be.

Marlene, one of the participants from India, had worked in several other countries where she had been exposed to other cultures. She felt that Canada was to some degree appreciative of immigrants when she said:

*I understand that Canada respects all the countries that people are coming from and also they recognize that since they are willing to embrace the immigrant, they should be willing to utilize the skills that they had from their country. And they should be able to receive them and train them in such a way that they can work here. It’s a real struggle to work in this country.*

Marlene felt that Canada had embraced immigrants, but in practice, they failed to accept or utilize their skills. This posed a serious problem; because Canada failed to embrace the skills of immigrants, Marlene described that the newcomers found it “a real struggle to work in Canada.” The term struggle depicts the difficulties and challenges that newcomers’ faced and this was obvious in the lived experiences of the participants.
One way in which IENs are made to feel that they do belong, is when their skills and qualifications are recognized. Denying any recognition of their skills and qualifications creates a feeling that they do not belong (Bannerji, 1997; Cheng and Yang, 1998). Although multiculturalism policies have played a significant role in helping IENs feel that they belong (Dei, 2011), some of the participants felt that multiculturalism discourses painted an unrealistic picture of acceptance of immigrants and obscured the evidence that they did not really belong. They felt that this occurred by deliberately devaluing their skills, qualifications and experiences within the workplace. Hence, their skills, qualifications and experiences that were once held prestigiously in their home country had become of less value in their new home country.

Throughout the interviews, Marlene’s observation was fully supported by the other participants who used the following terms to describe their experiences: “didn’t fit,” “work harder” and they spoke of having “to prove one’s ability” as well as “to strive for respect.” These terms frequently indicated ways in which IENs felt they did not belong. Regardless, however, some of the participants felt that there were times that their cultural differences were embraced. For instance, Marlene had noticed that there was an element of embracement that occured, Sophia described it as an embracing of cultural diversity when she said:

The whole area was multicultural and I had to work with these various languages and cultures. In our area we speak 14 different languages. So multiculturalism has been very positive, because you learn how to be tolerant, accepting and not judgmental. Rarely, before I didn’t know much about Indian culture and Pakistanis, and the media can give a bad image of them, but working with them, I saw it differently. It has really taught me to be very different. So it was positive for me.

In spite of Marlene and Sophia’s similarities, Sophia did not share the struggles that Marlene and the other participants had expressed when working in Canada. According to Sophia:
It [Multiculturalism discourses] has been positive, because in the area in which I work, the catchment area is very multicultural with a lot of Caucasiens, Polish and Italians. But not so many Blacks. From then until now, I was the only Negro back there and I have never experienced prejudice. I was the person, if there was a problem they would come to, doctors included.

Sophia viewed multiculturalism policies as positive, and experienced a feeling of belonging, whereas Marlene felt that the feeling of belonging was transient or short lived. For Sophia, her skills were invaluable because of the highly diverse multicultural population that she worked with.

Although some of the participants believed that multiculturalism policies played a major role in them coming to Canada (Dewing, 2009; Banting & Kymlicka, 2010; Hyman, Meinhard & Shields, 2011), not all shared the same optimism as Sophia. For instance, Claire did not see the benefit of multiculturalism policies, but rather attributed her successes to her own hard work and effort in attaining the academic requirements needed. Claire stated that:

Multiculturalism, as it is today, hasn’t really had an impact on me currently, because I don’t feel that there are many opportunities for me to move up. Maybe because of the type of organization, that is open to many cultures, I don’t have a negative slant on multiculturalism right now. The position of leadership that I have now hasn’t really been supported by multiculturalism. The position I have now, is supported by my credentials and academic background and not by multiculturalism policies.

Both Claire and Marlene showed the difficulties faced in spite of living in a country with multiculturalism policies. The lack of opportunities that Claire expressed, support the notion that IENs of colour do not necessarily feel that they belong.

To better grasp the notion of belonging and how it is interpreted by the general public and those in leadership, it is essential to view it from two different lenses: 1) a sense of belonging and 2) a feeling of belonging. Ng's discussion on multiculturalism policies notes that the government frames belonging, as ‘a sense’ of belonging (1995), whereas, through the participants’ lens, belonging was associated with ‘a feeling’. These subtle differences are better theorized by Bannerji (2000) and Ng (1995), who argue that multiculturalism policies are
politically constructed for the purposes of those in leadership. Therefore, “a sense of belonging” works in favour of preserving Canada’s economic position and multicultural image, rather than in the interests of those marginalized.

The participants referred to the term, ‘feelings of belonging’, according to how they were treated and respected by their Canadian colleagues, employers and the patients they cared for. When Pamela came to Canada, she expected to experience a feeling of belonging, but instead she was made to feel that she did not belong. One incident she describes occurred when she went for an interview. She said:

I didn’t know that the area was mainly White, and at first I didn’t think it would have been a problem. I was an experienced public health nurse and had everything required for the job; I was capable of doing this. But when I went for the interview, there was one who had some type of affiliation with England, so she was very interested and very forthcoming in her questions. So I felt that she was interested and the other one was not interested and disconnected. The woman who did not have the connection with me, told me that I would not fit the population that they were looking for.

Pamela was surprised to find that her credentials, skills and experiences were “not sufficient.” Being told that she “would not fit the population” was another way of saying she did not belong. Such personal feelings might go unnoticed within nursing research as attention is often placed on service delivery and the feelings of those who use the services. Bridging programs and multicultural celebrations only feed into the government’s requirements of providing a “sense of belonging” from an organizational perspective, while ignoring the real, everyday issues that people are made to feel that they do not belong by the way they are continually treated.

The whole issue of the need to feel a sense of belonging has been challenged by Gershiere (2009) who argues that a neo-liberal agenda is at play. Gershiere (2009) suggests that the neo-liberal agenda triggers an obsession with the notion of belonging and in so doing, creates and sustains segregation. Gershiere’s observation is supported by Bannerji (2000), who notes that endeavors to address issues of diversity only create a horizontal plane where vertical inequalities can be preserved and continued.
I have argued that IENs of colour reside in a neo-colonial space with neo-liberal values. Although capable of identifying and addressing unfair treatment within the workplace, the participants found that they often had to become advocates for their own cause. This is seen in the lived experiences of Sarah and Gloria. Both participants were treated unfairly within the workplace and academy. Sarah stated:

When I came and decided to apply for the new position, I was the only applicant for the position and I was over-qualified for the position. I had all the credentials and experience and then I learnt that the job was offered to another nurse, who actually didn’t apply for the position. When I enquired, they offered me a temporary full-time position... and they gave the other nurse a permanent, full-time position. So, I took it to the union, and reviewed why I was given full-time temporary position, and the other nurse was given full-time permanent position.

Similar to Sarah’s experience, Gloria returned to the academy, where her expectations were that there would be more consciousness of equity. However, she found that:

It was pretty negative and I remember that it sounds like it was going to be a practical exam and they were going to talk you through the scenarios and you were going to go through the situation, and so it was my turn to go into the room …. and so when I was coming out of the room a Black girl came out when I was about to go in. And she said to me, “Don’t go into that room, that woman’s a racist!” and she was crying when she came out… I did sense that I was set up to fail. And um…she (the educator) was really negative. So when I came out of the room, I knew why I had failed. She failed me on something trivial, and then she just walked out the room. I put a letter of complaint about her, how rude she was and how she was speaking down to me…even as a woman…yeah, she was just very unprofessional. Nothing ever came of it, but no one ever came back to me. No, nothing. I was writing this out of principle and I shared with them my experience and no one came back. It was really negative.

Both women (Gloria and Sarah) lodged complaints in their respective situation. Sarah decided to take her complaint to her union, while Gloria addressed her issues to the head nurse in her academic program. The outcome was that Sarah’s complaint was heard, action was taken, and she was reinstated into a permanent, full-time position. In Gloria’s situation, her issues never
received a response. In both incidences Sarah and Gloria were made to feel they did not belong, but in addition, the nursing infrastructure confirmed that neo-colonial practices continued to ensure they did not belong.

Within the research, it became increasingly clear that there exists within nursing an ideal type, and this substantiated the works of Giddings (2005) and Jacobs (2007). There were mixed feelings in regard to the role of the ideal type in the lives of IENs of colour. The mixed feelings toward multiculturalism were somewhat of a surprise to me. Some of the participants’ in the hybrid space commentary was consistent with Bannerji’s (2000) argument that multiculturalism policies are constructed for the sole purpose of those in leadership. But there were also those participants in the hybrid space who clearly argued that multiculturalism policies served an essential purpose in protecting the rights of IENs of colour.

Dei’s research was consistent with the views of those participants who saw the importance of having multiculturalism policies (2011). Dei (2011) suggests that such policies provide a space where issues of inequality and discriminatory practices can be challenged. A space is created within the workplace to protect marginalized groups, such as workplace unions and departments that address human diversity. Dei’s argument is further understood through Sarah’s experience when she went to the union. Dei’s views on the importance of multiculturalism policies, are not inconsistent with my theory that there exists as a co-dependent relationship between the ideal type and multiculturalism policies (2011). This relationship can be interpreted as a dialectic relationship.

The dialectic relationship has posed a problem within the contexts of ‘feeling’ belonged and ‘a sense’ of belonging. Although multiculturalism policies may provide a space to challenge inequalities, the dialectic relationship, may in fact create a space that perpetuates colonial domination (Bannerji, 2000; Koopmans, 2013). Although IENs and Canadian educated nurses share a similar style of nurse-education as introduced through the British education system, there is a disparity as to how their qualifications are recognized and how they are treated (Calliste, 2000; Jacobs, 2007; Das Gupta, 2011). Historically, the practice of negative and condescending treatments had been commonly used by the colonizer toward the colonized (Memmi, 1965), and this treatment still continues today (Mohanram, 1999). For instance, when Gloria returned to the
academy to have her midwifery qualifications recognized, she was treated in such a way that she was devalued. She describes the following:

I had made notes on what was I going to say…and she (the educator) just shouted out at me when there were two of the people, one was the patient and the other was the midwife I was telling them what I was going to do… I then had to go into another room because it was two exams, one practical and then I had to go into another room, and her attitude was negative when I came into the door. She said aggressively: “What are you doing with that paper?” {Repeats statement} She didn’t greet me or say ‘hi I’m whatever, whatever…’ she just said, “What are you doing with that paper?” It totally threw me off…so I put my notes down and then I, you know, went through, the exam. It was a practical. She would ask me questions and ask me to demonstrate on the patient…she was very negative and very condescending.

Within the context of the treatment that Gloria experienced, she describes what she felt multiculturalism represented; she says:

Multiculturalism? When I hear it, in my head it’s like a country that embraces different cultures and expecting people of …um… you know…of food and appreciate people from where they are from. As a Black woman…I think there is still racism here. Some is blatant.

In Gloria’s experience, the implementation of multiculturalism policies fails to challenge the hegemony of the ideal type. The ideal type is thus a technology within colonial practices, which subtly ignores and devalues the experiences, skills and qualifications of others who fail to fit into its ideal image (Giddings, 2005). However, it cannot be ignored that within a dialectic relationship, multiculturalism policies do preserve a space where some levels of equality can be addressed, such as through unions and departments of human diversity in the workplace and the academy (Dei, 2011).

Since the ideal type is culturally constructed (Jacobs, 2007), why does it exist? Perhaps its “use” is to retain a lower tier of nurses (who happen to be women of colour) in a segregated labour market within nursing (Calliste, 2000). In Gloria’s encounter with the ideal type, Gloria was slotted into the lower tier, ignoring the value of her qualifications, skills and experiences and undermining her ability (Collins, 2000).
Pamela’s experience with the ideal type sheds further light into its relationship with multiculturalism policies. Her exposure also exposes the role that the ideal type plays in using race to segregate labour in nursing. Pamela says:

I think ideas of the ideal type have influence in some way. It makes getting positions of higher power more challenging. I am also encouraged because the ideal type doesn’t always resonate. But even when you get the position, especially when you are working with diverse cultured people, once you get the position, do you fit?

Pamela’s observation suggests a dialectic relationship between the ideal type and multiculturalism policies. Both are capable of co-existing and functioning, dialectically, under the common purposes of providing services for its diverse population and maintaining an admirable position within the global market.

By centralizing the ideal of European culture of the ideal type within leadership, an impermeable wall is created by the ideal type, or what Jacobs (2007) refers to as “the old girls’ club.” “The old girls’ club” is capable of keeping women of colour outside, while preserving a euro-cultural identity. According to Dei (2000), multiculturalism policies play an essential role in exposing these Eurocentric spaces through anti-discrimination and antiracism policies. These policies are reflected in the revision of Canada’s 1985 multiculturalism policy. Dei (2011) further states that multiculturalism policies antagonize the autonomy of the settler nation, and therefore, decentralize the European identity as the dominant and only form of identity. However, for many of the participants, multiculturalism policies do not function in centralizing differences. IENs experiences reported here are similar to those reported by Porter (1965) and later by Koopman (2013) who showed that there are still exists major differences between those immigrants from Europe and non-European immigrants, even in the presence of multiculturalism policies.

The essence of the first theme, ‘feelings of belonging’ is that the ideal type does exist and that being compared with it has been instrumental in making the participants feel as though they do not belong. Although the women could not always define what was meant by the term, “the ideal type”, they could clearly describe encountering the ideal type within their experiences. As their encounters with the ideal type were real, most of the participants, therefore, perceived multiculturalism policies as failing to create a feeling of belonging.
Multiculturalism policies have remained a visible component that have been used by the Federal Government to locally and globally support Canada’s economic power and stability. However, multiculturalism policies have also been used to obscure the activities of the ideal type which continues to function systemically, yet invisibly in the Canadian clinic. For this reason, the experiences of IENs’ feelings of not belonging were not detected outside the nursing arena. It was, instead, experienced in their everyday working lives. Hence, in reality, they were insiders by virtue of the status of their profession, but outsiders by the way they were treated within their profession.

1:1. Insider/outsider

The binary concept of the insider/outside refers to those with power being insiders (at the centre) and those without power being outsiders (on the peripheral). Nursing carries the insider/outside concept within the tier system that it invokes. The two-tier system by which Black nurses are slotted into low menial jobs and White Canadian nurses in leadership and management positions have been identified as the insider/outside; the insider possesses a colonial identity, which claims to be superior and therefore making anything or anyone else an outsider (hooks, 1983; Ng, 1995). Since the insider is centralized, it is portrayed as possessing the national identity, which is the Great White North (Urobi, 2008). The national identity, or the Great White North, reflects the homogenous society of the pre-war European culture (Urobi, 2008, Baldwin, Cameron, Kobayashi, 2011). Hence, for IENs of colour to be considered an insider is difficult. The insider/outside becomes complex within nursing for IENs. They are forced to wear both titles and in so doing operate in favour of the global world as an insider, but remain segregated on a local level as outsider. This binary of the insider/outside is preserved through the so-called national identity.

Identity plays a significant role as to where one is located in society, and especially for immigrant, women of colour. Like Gloria, many of the participants had difficulty feeling part of the national identity and this posed a problem as to how they were perceived. Gloria states that:

As a Black woman growing up, your parents tell you that you are Black, you know you are different…so when I was going into nursing you knew you had to work harder because you
were Black and so when I was growing up in England I knew it would be different. And there were girls that were these ideal type…that when I did my nursing exam, I remember…there was a Black teacher who would give extra tuition to a group of us Black girls. Because he knew we had this thing going against us…because we’re Black. So I saw that as very positive. It was sad that he had to do this but it helped me as a Black woman to even try. He was a Black teacher and he pointed us out to say we have to work really hard to get through. Because where we were was quite racist, so we had to work even harder. I was sad he had to do it; it helped me also. Because even as a Black woman I had to work harder and I needed that.

According to Gloria, identity was taught at an early age by her parents, but in addition, there was an expectation that society would have of her. According to Memmi (1965), those who possess the national identity would be the ones to impose an identity on her. Gloria continued to face further difficulty and lack of support from those imposing such changes. Gloria’s only support eventually came from someone who shared the same experiences as her, culturally and racially, but who had attained a leadership position by which he could try and support people of colour. In Tierney’s work (1993) called *Cultural Citizenship and Education Democracy*, he argued that marginalized groups required support from those in leadership, because they face insurmountable barriers that their White counterparts did not experience. This helps explain the lived experience of these participants in this study.

Today there continues to be an ongoing debate as to whether Canada has an identity of its own or not (Bannerji, 2000; Balwin, Camern and Kobayashi, 2011). According to Ng (1995), Canada does not possess a culture of its own; but Ng’s comment is debatable, based on Canadian history. Before, the 1960’s national identity was not questioned, however, with the Civil Rights Movement in the US and pressure from Britain and the United Nation, the possibility that Canada could have a national identity came into question (Jackabowski, 1997; Urobi, 2008). Ng (1995) argues that Canada has no culture of its own, but rather an Anglo-French divide. Whether Canada does or does not have its own distinct or unique culture, its efforts to create a multicultural society has worked in Canada’s own favour within the global network. Either way it is not hard to argue that Canada tries to hold onto a Eurocentric culture that preserves European values as superior to other cultures (hooks, 1984). Sarah sums it up when she says, “I always have at the back of my mind to try harder…I am not really what they are looking for.”
That is, people of colour are outsiders because they are different by race, by immigration status and because they come from resource extraction colonies (see page 262). Although IENs of colour are highly skilled, qualified and experienced, Bannerji (1997) says that they often find themselves locked in menial positions; and those occupying menial positions are known as outsiders. It is, therefore, fair to say that the ideal type is an insider as she symbolizes the national identity and has the privileges that only the insider possesses (Memmi, 1965). Sarah explained the disparity between being an insider and an outsider in nursing when she gave her definition of the ideal type as, “light skinned, Caucasian middle-class, female, slim-built, possibly blonde hair and blue eyes.” Sarah’s definition of the ideal type supports Giddings (2005) findings and explores the difficulties IENs of colour face. Samantha’s frustration of who the ideal type is, led to her to ask:

“Why can’t I be the ideal type?” Samantha’s question was typical of others who hoped that one day they would be treated equally.

For those participants who saw a relationship between race and the ideal type, they believed that there were numerous barriers for a woman of colour to become the ideal type. Marlene describes some of the barriers when she says;

I think the nurses that come from other countries, and servicing the clients who are usually White, they look down at them and ask the kind of experience they have. Most people don’t know your experience and they are very judgmental.

Marlene shows that beside experiencing difficulties within the workplace, IENs also face difficulties from the clients that they serve. For Marlene, race was an issue. But for some of the participants who defined the ideal type in relation to culture rather than race, their take was somewhat different. They saw possibilities. Claire for instance said:

Despite the definition given that may have been the ideal nurse back then over the last twenty years, but now, that is not the ideal nurse. Now we have nurses from all different types of backgrounds. In the system, that is what it is (the ideal type), but not in reality. In reality, you will see a wide diversity of nurses from many backgrounds, not just the typical White, Anglo-Saxon female.
Claire identified the ideal type from a cultural perspective, which she saw as removing barriers. Claudia agreed with Claire; but in addition Claudia believed that to become an insider one would have to relinquish ones cultural identity and embrace the national identity. Claudia stated that:

> When I look at it now, I feel a little more comforted to know I did a degree here. So now, I get to put a Canadian degree on my resume. So there is a level of comfort. You feel as if you will be more accepted and get better positions, because you have Canadian experience. Sometimes I think I deliberately avoided the impact by leaving my Jamaican experience off my resume. To avoid questioning, I just left the Jamaican off my resume.

Claudia considered Canadian qualifications to be much more important to her than her Jamaican qualifications; even though Citizenship and Immigration Canada (CIC) and the College of Nurses of Ontario (CNO) viewed both qualifications as on par. Claudia’s Jamaican qualifications were her rite of passage into Canada. But to be accepted required on abandoning of her Jamaican qualifications and embracing of the Canadian qualifications that she believed gave her a new cultural identity.

The insider is capable of situating who and when one is an outsider. When the CIC and the CNO were recruiting nurses to work in Canada in the 1980’s, Claudia was considered an insider, but when she entered the Canadian workplace she was considered an outsider. Hence, the insider/outsider is not fixed, but can be adjusted to meet the needs of those in power. Jackabowski (1997) notes that Italians and Hungarians were once considered Blacks (outsiders), but as people of colour began migrating to Canada, Italians and Hungarians were considered Whites (insiders). Recall that Claudia had commented:

> The ‘ideal type’ to me in terms of nursing? I don’t see it as someone by colour, but someone who is competent, someone who is confident, professional, passionate about care, passionate about learning more, having good leadership, being a good mentor, being what the client expects. To have the adaptability and to provide care despite race, creed.

Claudia denies the role that race and class play in keeping people of colour out of leadership spaces, and placed as outsiders.

Mohanty’s work supports the insider/outsider within the discourse of race (1997). Mohanty’s work within the academy criticized mainstream feminism for perpetuating colonial
values. For this reason, she advocates for an anti-racist feminist perspective to be used within the pedagogies of learning. According to Melchior (2004), nursing has had a longstanding affiliation with mainstream feminism and it is these same values that Mohanty speaks about that remain rooted within nursing. Mainstream feminism fails to advocate for the needs of women of colour, and fails to address issues of race theory (Calliste, 2000). This may be because nursing is considered a gendered profession and as such, racism becomes blurred by White women in power who fail to see their own women or “sisters” as also being marginalized by race.

The feeling of being an outsider is further expressed by Pamela who shared her experience when she went for an interview. She shared that:

There was another position where I felt like I didn’t fit. I was the odd one out, where nurses spoke the same, looked the same, social class and background. They would socialize and work together while I would feel excluded. You would feel excluded and not integrated and not as part of the team. So I think those things affect one personally and how you work, it makes it more difficult how to find the resources you need to work more effectively, and they look at your work with more scrutiny and this undermines your confidence as well.

Pamela was also made to feel like an outsider, because she was different. Her experience resonate with a report by the CNO on a study of 400 IENs working in Canada who reported being they were treated like “outsiders” by co-workers, patients and their families. The study further showed that co-workers were quick to base their judgements on the IEN’s physical appearance, fluency and whether they received their qualifications in Ontario. The CNO’s study illustrate that the insider/outsider exists within Canadian nursing.

Within nursing, the emphasis has been on women as the oppressed rather than being the oppressors. Therefore, the issue of racism occurring in nursing where White women could be the oppressors sits uncomfortably within nursing research and studies. Deliovsky theorizes:

The failure to see White women as raced has created a situation where the burden of race primarily falls on the bodies of racialized women. [W]hite women are raced in the first place, and this acknowledgment allows for the critical elaboration of the conditions that bring “raceness” into focus (2002, p. 238).

From Deliovsky’s statement it is easy to conceive how issues of race are not easily addressed in nursing, and how a focus on multiculturalism can easily replace discussions on race (Bannerji, 2000; Turrittin, Hagey, Guruge, Collins & Mitchell, 2002). Bannerji (2000) further adds that
issues of diversity create a horizontal space that denies a vertical domination, commonly found within a gendered profession like nursing. Although Turrittin et al. (2002) partially agree with Bannerji (2000), they argue that if multiculturalism was to be absent, then discussions regarding racism would be obliterated (see also Dei, 2011). To better understand the role multiculturalism has played in the experiences of IENs of colour, Marlene provides a good example, when she states that:

I came looking for a better position. It was a struggle to take several courses so that I can be qualified to get where I am and it was a great challenge. The policy is there, but I don’t know if it will really help me, or how well you can neglect or face the challenges, or defeat. It’s always a struggle; you have to work harder to prove yourself.

Marlene clearly identified the struggle and the challenges she faced, and her experience appears to support Bannerji’s argument that multiculturalism discourses obscure the struggle that women of colour experience as a racialized problem (2000). Returning to Bannerji’s argument regarding diversity, she further argues that diversity within the multiculturalism discourse redirects the experiences of women of colour from not only being outsiders, but being different.

According to Urobi (2008) and Mohanty (1997), when anti-racist theory enters such spaces as nursing, it is capable of disrupting colonial spaces, decentralizing colonial values and introducing spaces for cultural identity—which is inclusive of all—to occur. If cultural identity is centralized, it is capable of being a voice for other cultures, and in turn promotes Canada as a benchmark for other pluralist countries to follow (Lazcko, 1994). As a result, would removing multiculturalism policies leave IENs of colour in a subservient space with no legitimate spaces from which to speak from (Ono & Sloop, 2002)?

It would be fair to say that the insider/outsider ideology functions within the practice of Canadian nursing by creating colonial spaces that fail to reflect Canada’s pluralistic healthcare system. IENs of colour are made to be outsiders by omitting them from leadership positions and slotting them into either menial or hybrid spaces. Therefore, those in hybrid spaces remain locked into these spaces as outsiders, even though they possess comparable qualifications, skills and experiences that by right warrant them a place in policy-making leadership by default.
1.2. Sameness and Difference

Another subtheme was that of ‘sameness and difference.’ IENs saw themselves as the same as their Canadian counterparts, but their Canadian counterparts viewed them as different. IENs interpreted sameness as it related to them both being nurses and leaders in nursing. However, for the Canadian nurse, differences were based on IENs having foreign qualifications, coming from different geographical locations and also being culturally and racially different.

Gloria, an IEN from England, found that the notion of difference was often related to race and was addressed sarcastically and insensitively. She described the following incident regarding some White nurses who had returned from their holiday abroad:

They come with their tan and even now they say, “oh now look at my tan, I’m nearly as dark as you.” Then I answer them and say, “Well, mine’s a natural” (participant starts laughing, then becomes serious), but you know it’s so sad…it just seems really negative…you know they come back, hold up their hands to me that they’ve got a tan. You know I’m a Black woman, you know, and it’s really insensitive. I have to come to it and say “mine you know, mine’s natural, you had to go on holiday for it.”

Gloria’s experience demonstrates how different she was considered by her White colleagues, even to the point of their emphasizing their skin pigmentation. In staying with the discussion of becoming like Gloria, this was arguably another way of showing how different they were from Gloria. Such indirect statements or attitudes were common, everyday experiences for the participants. The participants had learned to ignore or acclimatize themselves to such comments and attitudes. Diane describes being constantly policed. She said:

I remember when I first started in an acute care hospital on a medical surgical unit, and I was the only coloured nurse there, on that unit... You know what, they were always looking to see what you could do and what you could have accomplished, yes you’ll find the other staffs were looking to see what your practice is like.

Diane reported that she was constantly monitored because she was considered different. Even though the intent of multiculturalism policies is to sustain the uniqueness of different cultural identities, these differences in nursing played out differently. In nursing, differences in culture were seen as differences resulting in comparisons in which non-White skin color was subordinate. Therefore, skin was seen as a mechanism to sustain spaces of power and domination that perpetuated colonialism within nursing practice. Canadian nursing practice was influenced
by British nursing practices and has since then implemented transcultural learning within it (Flynn, 1998; Hagey, 2000). The notion of being different and of less value is oppressive for IENs of colour since this mark of roots of colonial oppression remains historically imbedded in nursing (Bannerji, 2000; Jacobs, 2007). It is these differences that need to be unpacked.

The aim of Canada’s multiculturalism policy, under the United Nation’s Human Right’s Mandate, is to protect cultural differences as a way of preserving ones individual cultural identity (Marvasti & McKinney, 2011). Such countries as the United States have used their government policies to work on assimilating people into the US culture and, thus perpetuate a melting pot. But Canada’s multiculturalism policies have moved away from the melting pot ideology and attempted to construct a pluralistic society, by which individual cultures can be appreciated rather than assimilated. Canada’s revised 1985 multiculturalism policy states that:

It is hereby declared to be the policy of the government of Canada to (a) recognize and promote the understanding that multiculturalism reflects the cultural and racial diversity of Canadian society and acknowledges the freedom of all members of Canadian society to preserve, enhance and share their cultural heritage (Dept. of Justice Canada, 1985).

Canada’s denial of attempting to assimilate people into a Canadian culture has been contested by Hagey’s (2000) study on Cultural Safety. She looked at Maori nurses, from New Zealand who worked in North America. These nurses wanted their cultural practices respected. However, Hagey’s study showed that North American nursing had failed to recognize, protect and implement cultural practices; it also failed to acknowledge the benefits of indigenous knowledges within its nursing curriculum and practice (2000).

Although Hagey’s study rightly addresses the experiences of Maori nurses, the experiences of nurses in this study are somewhat different. The nurses in this study have been mentally colonized by the colonial culture imposed on them over hundreds of years, and therefore do not possess an indigenous understanding of their own ancestral or indigenous knowledges. Fifty per cent of the participants were first generation of children born in the United Kingdom of parents originally from the colonies. Hence, the participants born in the United Kingdom are “twice removed” in that their parents were affected by their home countries being colonized, and after migrating to the UK, their children have undergone a form of colonizing of the mind. Gloria demonstrates how she had to constantly relearn nursing, which depicts how far removed she had become from her ancestral knowledges. She said:
My experience has been…mixed…as in um…um (pause)…When I came to Canada I had a lot of experience, being a midwife and nurse also in England for quite a few years. So when I came to Canada, I entered a different area. I did it partly because I did some special care nursing in England, but not all of it, so it was like starting all over again. So although my qualifications got me the job, got me into the country, I had to do more courses for the job I wanted to do, that is working in special care nursery. And that was fine because I entered into another new area and I was open, open to learning.

Therefore, the issue of sameness and differences is clearly seen in how IENs have to continuously adjust to new environments and new cultures that take them further from their own. By placing little value on the qualifications, skills and experiences of people from other cultures outside of Canada, Canada has established its own culture as the national culture. In so doing, Canada is able to continue practices of its own that go unchecked. This is summed up in what Diane, who had a Canadian degree in nursing, experienced in the workplace when she says:

I can remember when I was applying to some facilities they said that they only want certain degree nurses and of certain, probably training and background. I’m not sure if they were hoping to get a certain class of nurses, but everyone should have an equal opportunity.

By specifying the degree, training and background, the employers had a way of excluding some and including others. Hence, the national culture, very much mirrors colonial values (Ng, 1995; Bannerji, 2000; Cassanova, 2006; McGregor, 2011).

The national culture works in favour of producing an image of everyone being treated the same or having “equal opportunity.” The notion of “sameness” provides a positive image of Canada within the global market and this notion of sameness further saturates into nursing. Sameness is constructed by assimilating other cultures into the dominant culture by denying foreign credentials, skills and experiences, and instead imposing Canadian qualifications and bridging programs to assimilate IENs into a Canadian framework (McGuire & Murphy; 2005; Blyth & Baumann, 2009). The evaluated superiority of Canadian qualifications is evident through Marlene’s experience. As she says:

Luckily the training I received from where I was trained, it was almost advanced. My training and my experience helped me through my assessment and I also had my TOEFL ready and I started my assessment from the country which I was applying from (Canada)
should be willing to utilize the skills that they (IENs) had from their country... Everyone should be given equal opportunities, despite which country they are trained in. From Marlene’s experience, it is clear that there was an underlying practice of unequal opportunity occurring through the non-recognition and assessment processes put in place.

1.3. Language and Accent

When I completed my Master’s research in 2007 on women of colour in the academy and the workplace, accents were identified as a problem and became one of the major areas to be investigated in my PhD study. It was somewhat surprising again to see that issues surrounding language and accent had re-emerged in this study, but this time it was within the workplace setting. For this reason it is important to address the role languages and accents play within the context of my theorizing about the ideal type and multiculturalism policies. Given that fifty per cent of the participants came from the United Kingdom and spoke with an English accent, the study still showed how languages and accents had become problematic from a race perspective.

Marlene shared how having an accent played a major role as to how much she would be accepted or made to feel like an outsider. Marlene was educated in one of India’s leading universities. She came to Canada with an overabundance of qualifications, skills and experiences and while in Canada she volunteered her time and services in teaching and preparing other IENs for the Canadian system. Marlene was able to speak, read and write in several languages due to her extensive travel. However, Marlene had an Indian accent. In describing her educational abilities, Marlene says:

I had all the requirements the CNO [College of Nurses of Ontario] was looking for in a foreign trained nurse. I was given the eligibility to appear for the RN qualifying exam within 6 months and passed the exam at 1st chance... because of my work experiences in different advanced countries. I realized that I had a lot more experience above other people who came from my country (India) alone. And I had to help train them and help them understand the system.
Marlene’s academic achievements made her a valuable nurse within Canada’s pluralistic healthcare system. But her accent posed a problem. Reflecting on her experiences she described how:

... I still struggled, although I did get help from these ‘exceptional’ people. They still don’t consider us equal because of skin colour or accent. The accent and language that I use is very different and sometimes I am not able to relate with many patients, even in my mannerisms. I have a different background. I can see certain people treat me differently in the way they act et cetera; when talking, dealing with them, et cetera.

Accents have had a significant effect on the experiences of IENs of colour in Canada. But from Marlene’s statement it appears that it was not so much the accent that was a problem, but how people evaluated the accents negatively was the issue. The CNO’s report by Tregunno, Campbell, Allen and de Sousa (2007), also found the same problem in their study. They say:

Overall, the issue of language and fluency was an emotional topic for many of the nurses interviewed, and several nurses admitted being embarrassed to say that they still have difficulties with language (Tregunno, Campbell, Allen & de Sousa, 2007, p5).

In the CNO’s report, the general focus was on the experiences of IENs and how nursing terminologies and instructions were implemented. Within this thesis, the general focus regarding accent was about how IENs were perceived. As the CNO’s report showed, “language and fluency was an emotional topic” (p5). It failed to further explore the series of events and emotions that compounded the women’s experiences. Not feeling that they belonged, treated as an outsider, and now being viewed as different were emotional triggers that affected the women physically, socially as well as emotionally.

For Marlene, the lack of language fluency resulted in a sense of her feeling that she did not belong, and as a result, she was treated differently by co-workers and patients alike. Fuertes et al. (2012) has categorised accents into two groups: 1) the standard accent, which the majority of the population have; and, 2) the non-standard accent, which is considered foreign or spoken by the minority. According to Fuertes et al. (2012), people are stereotyped by their accents and certain groups are considered more intelligent than others. In their study, the authors found that Blacks who spoke with what they term a “Black English” were considered less competent; they
were stereotyped and were treated unfairly in the workplace setting. When discussing the root cause that language plays within the colonial framework, Bannerji states that Whites become the indicators of civilization; skin signifies inferiority, Bannerji continues that “Englishness-Whiteness including the English language is hegemonic” (2000, p. 108). Therefore, language and accents are spaces of domination, making one group feel superior to the other. The presence of colonial practices that still function within Canadian nursing calls for an understanding of how languages and accents produce a hegemonic discursive formation by which certain groups could remain oppressed.

The politics of languages and accents have been closely associated with nationalism and nation states (Tegunno, Peters, Campbell & Gordon, 2009). Language effectively preserves one’s cultural identity (Loomba, 1998). The colonizer imposed their language on the colonized as a means of power and control (Fanon, 1952). For this reason, countries colonized by the British Empire were compelled to speak English and those colonized by the French had to speak French. But the ingenuity of the colonized cleverly hybridized the colonizers’ language with theirs, thus producing what Burke calls, “linguistic hybridization” (2009, p 26) Linguistic hybridization allowed the colonized to still hold on to much of their cultural identities even though the colonizer had legitimized their European language as the dominant language (Loomba, 1998). With regards to the participants in this study, they all came from the British colonies, which imposed their language as the mother tongue.

Multiculturalism policies appear to embrace the different language, dialects and accents as well as recognize the contributions that immigrant workers play in Canada’s pluralistic society. However, IENs who come from resource extraction colonies found that their accents posed a problem (Flynn, 1998). As previously noted, Flynn (1998) describes how nurses from the Caribbean were described by White nurses as loud and unintelligent. The participants of colour in my study who were born in the United Kingdom, and fluently spoke with the so-called legitimized English accent shared similar obstacles. According to Gloria, even though she was born and educated in England, and English was her first and only language, she had to undergo the same scrutiny as her colleagues for whom English was a second language. Gloria stated that:

I had to do the English written test even having come from England, which was pretty ridiculous and um…because I was born in England. And I had gone through English
schools, but I still had to do things. They cast you like your foreigners who couldn’t speak English…so I had to do a written English test then when I got through that part then I had to do an oral test, again.

Gloria found that she was often not believed or was questioned in the workplace because she had a British accent. She stated that:

Sometimes the conversations are,

“Where are you from?”

“I’m British.”

“So you’re not from the Islands?”

“No, my parents are from the Islands.”

“Oh, I’ve been to Jamaica”….

It’s like a springboard for someone to have a conversation with you, not about your nursing or you as a person…

Gloria’s experience is one of many. As women of colour, the IENs in my study all shared similar experiences, of being treated as though they were inferior, which could be surmised as being race-related. Possessing the British accent for IENs of colour became a toe-hold for further opportunities, but in practice it was problematic to the White colleagues acted as the “owners” of “their” language. Fanon comments on this when he states-although he comments on the mentality of the colonized White my focus is the colonizer:

It should be understood that historically the Black man wants to speak French, since it is the key to open doors which only fifty years ago still remained closed to him. The Antillean who falls within our description goes out of his way to seek the subtleties and rarities of the language-a way of proving himself that he is culturally adequate (1952, p. 21).
According to Fanon (1967), the more their accent resembles the accent of the colonizer, the more the person of colour esteems himself as being “culturally adequate” (p. 21)

As noted above, my Master’s research, which looked at nurses within the academy and workplace showed that nurses in the academy who had an accent other than the British accent were treated as being less intelligent than their fellow Canadian students. Yet the student nurses of colour who were from England and who spoke with a British accent were readily accepted by both the lecturer and Canadian students. They often felt a sense of belonging within the academy, even though the treatment within the workplace was clearly different.

Consistent with my earlier research, the participants in this research found that their British accent did not benefit their workplace position in anyway. I can only conclude from the two studies that the participants in my Master’s study were in the academy, a place of learning and intellectualism. As students, they were not a threat to their lecturers or to their fellow students, but rather an esoteric intrigue, which is a historical feature created by the colonial intelligentsia (Said, 1978; Loomba, 1998). Nevertheless, in the workplace setting, the challenges are different. There is competition as IENs of colour are on par academically and experientially with their Canadian counterparts. For them to receive the same level of respect and acceptance in the workplace as they do within the academy, could threaten the safe, White space of the managers in the “ivory towers” of the workplace.

Multiculturalism policy emphasizes the importance of a sense of belonging for all immigrants, but this was not commonly experienced by the participants. Among the participants, there was one who painted a different picture as previously noted. Sophia’s discourse on how she felt about working in Canada indicated a feeling of belonging, but she also highlighted the point that her friends of colour did not share the same experience as she did. Sophia’s experience was an isolated experience that was not reflected by those she encountered on a daily basis. With this in mind, I will further discuss the next emerging theme, that of non-recognition.
Theme 2: Non-Recognition

Despite how dedicated and committed, or educated and proficient IENs might be in the workplace, they reported that they were often made to feel that they were not good enough, and hence, that they did not receive recognition. Ford (2011), in her study of women of colour in the academy, refers to three types of recognition: 1) recognize - to render fully visible; 2) misrecognize - to render selectively visible; 3) not recognized - to be rendered invisible. The participants overall felt they were “not recognize” and, therefore, they were rendered invisible. An example was Claire’s experience. Claire, a well-experienced nurse, team leader, and qualified midwife described how she was treated while working as a nurse in Canada:

I was never good enough for the doctors that would come by. The doctors would overlook me as the team leader, always. The doctor, who was White, would come in and speak to the White nurse, treating her as the team leader, when she was not. So, by my peers as well as by the professional MD’s, they overlooked my position as team leader.

Claire was overlooked by both colleagues and medical staff. Sophia recalled an incident with a client in the hospital who belittled her ability and experience. She related the following event:

There was one incident that happened. I bonded with the head nurse and things were good there. I used to do the inpatients for the top floor and I was seeing a patient who happened to be an elementary teacher. And the minute I entered the room, he looked me up and down and he said “YOU! You could never teach me anything!”

Claire and Sophia’s experiences were similar to the experiences that the other nurses shared. Examining their experiences unravelled a series of events that revealed they were not being recognized within the work setting while their Canadian counterparts were. Because non-recognition can occur in different ways, a moment will be taken to address five of the ways that were identified by the IENs within the study.
2.1. Silencing.

Silencing is a method used to ignore an individual and therefore, make one feel devalued or not important. Gloria shared her experience in the hospital as follows:

There was a case where I looked after a mother’s daughter with a student. And when I brought this mother into the room, the woman... turned to the student. And she was addressing the student and said “thank you so much for taking care of my daughter and for nursing her, because she just told me of how the great care she received.” But the mother was not looking at me; she was looking at this tall ideal type student nurse (chuckles). Even though this girl was a student and was learning, I was the one who was doing all the care. So on the second day on the floor, I was confident enough to say that you (the woman who delivered the baby) know what she (the mother) was doing, but she (the woman who delivered the baby) was protecting this girl. The mother knew this girl was a student. I didn’t even speak to the mother and I just came out of the room. I’m just confident to know that I know what I did, and the mother knew I took care of her daughter and her mother was addressing the student with “thank yous” and praises. And I wasn’t looking for that, because she was probably her ideal type and I wasn’t. I am confident to say, “It’s alright, it’s okay” (chuckles)

Gloria’s experience of being ignored by a client’s mother clearly shows how the code of silence is used in the process of non-recognition. By the student remaining silent and the client also not defending the nurse by her silence, they intentionally or unintentionally, colluded in aiding the client’s mother to strip the nurse of all recognition and value.

Silencing is also practiced by qualified nurses within the workplace setting. Nursing has always been considered as a profession that advocates for patients; however, a study by De Marco et al. (2007) found that among nurses there was a self-silencing, by which they would not advocate for themselves and others. This self silencing can also be related to the deliberate non-recognition of certain people.

In her work on girls of colour, Briskin (2001) found that girls of colour were deliberately ignored in the classroom, which had a significant impact in poor performance and self-value.
IENs of colour experience the same treatment as the girls of colour in Briskin’s study (2001). IENs also feel devalued and not recognized for their skills, qualifications and experiences. IENs find themselves further excluded from decision-making spaces of leadership and they are deemed unsuitable and incapable of being part of the elite group. Shpungin, Allen, Loomis and Dello Strotto (2012) discussed the effects of silencing. They draw reference to situations where people of colour have had to sit among White people in spaces of power and have their voices ignored. Shpungin et al. (2012) argue that not only are the voices and opinions of people of colour ignored, but they are further silenced and ignored when their White counterparts are heralded for repeating the same idea that those of colour had shared.

2.2. Performance monitored

Work performance was commonly mentioned by IENs, but not always in a positive light. Many of the nurses felt that their work was frequently scrutinized and that they were made to feel inadequate. As mentioned before, Pamela shared how a staff member would sit in her class to observe how she was teaching:

For example, there was a teaching position, and someone would just turn up in the class to just monitor what I was doing, without being told that that was going to happen, so in a way I felt that was inappropriate. It happened on two occasions.

Pamela’s experience is not uncommon. For nurses of colour, the constant experience of being monitored was not just occurring on an individual level, but on an organizational level. Das Gupta’s work on racism in nursing found that nurses of colour were often scrutinized and if a complaint was made, it would inevitably go on the records of the nurses of colour, while their White counterparts were never reprimanded the same way (2002). In addition, Das Gupta (2002) draws reference to how nurses of colour were deliberately separated by placing them on different floors or on different work-breaks as a way of keeping them isolated from one another.

2.3. Overlooked

Another way that IENs of colour felt that their skills, experiences and qualifications, were not being recognized was when it came to promotion. Claire and Gloria felt that they were
overlooked for promotion and often ignored by doctors and visitors and attributed to this being Black. According to Claire, she was never considered a team leader or capable of leadership by others, even though she had worked effectively in these positions. She says:

[I]t took a long while for them to accept that I did know what I was doing. And it took a long while for them to realize that I could be in charge. In that institution, you would always get looked over, you’re never good enough for the higher positions.

Betty also felt her abilities and qualifications were overlooked, even though she had equivalent skills as the Canadian nurses. Betty said, “After the special exam, I had to go for refresher’s course. It was negative for me. I had to do an English requirement exam as well.”

For nurses like Diane, it was felt wise not to complain, since complaining would create additional stress with a costly price to pay (Hagey et al., 2002). Diane expressed it in the following way:

To me the way how I look at it, it’s like you are more babysitting others and trying to watch what we say [avoid] like getting into the politics; getting caught up in the politics...you know what it is; you know I just want to come, do my work and go home, instead of getting into the red tape and the White tape and all those different things that are going on; that are maybe going on often.

Like Diane, there are those IENs of colour who experience the trauma of non-recognition and choose Diane’s way of remaining marginalized and silent when it comes to issues of unfair treatment.

2.4. Not Good Enough

Feeling that “you’re not good enough” is closely associated with how the colonizer devalues the colonized (Memmi, 1965). Claire describes her experiences in nursing as “you would always get looked over; you’re never good enough for the higher positions.” Claire’s experience of being treated as though she was not good enough or being overlooked is explained by Fanon (1967) who describes the effect of colonialism as people living in a different place with
a different culture and practice. He calls it a “hybridized split existence.” This refers to a situation where one has to assimilate into being “White” or try to fit into the White culture as much as one can, in order to be recognized. Fanon (1967) goes on to argue that one is never able to become quite White enough. Thus, the struggle of IENs to be recognized is not so much that they are not good enough, but rather that they are not White enough.

Fanon’s argument is reflected in Claudia’s experience. As a nurse coming from Jamaica, she would hide her Jamaican nursing experience on her resume and boast of having a Canadian degree (1952). For Claudia, it was a situation of, “I get to put a Canadian degree on my resume. So there is a level of comfort. You feel as if you will be more accepted and get better positions, because you have Canadian experience.” Claudia’s sense of self-worth and feeling good enough came from denying her own identity and embracing a Canadian identity by obtaining Canadian qualifications.

As I have repeatedly pointed out, many of the IENs of colour had equal or more qualifications than their Canadian counterparts, but they continued to go unrecognized, making the issue not about qualifications, but more about racial discrimination. These processes of non-recognition, and made to feel you are not good enough, can be daunting for women who have come from positions of leadership in their own countries. Often these nurses are left to feel devalued and stripped of their own identity (O’Brien, 2006).

2.5. Self-Blame

Another familiar sub-theme that kept emerging in the discourse of non-recognition was that of self-blame. During the interviews, the participants broached upon issues of unfair treatment because they supposedly lacked what an ideal nurse was expected to possess. Sarah shared that:

I don’t identify myself as being dark or light-skinned; I always have at the back of my mind that I have to try harder. I’m not really what they are looking for; and also I really think it does have an effect.
When Sarah, felt that she could never be what those in leadership wanted, she decided it was her responsibility to work harder; hence the effect was that of blaming herself indirectly. The way Sarah blamed herself was to identify skin shades, a method used during the Atlantic Slave Trade. The fairer in complexion one was, the likelihood of slaves working within the master’s house and gaining some level of recognition; therefore, her value depended on “what they want” and fitting herself into their ideal.

Jolley and Brykcunznska (1993) have claimed that within nursing is built the Victorian value of servitude; and I would add that it is the systemic servitude that continues the levels of oppression in the everyday lives of women of colour. For Freire (1970), colonization dehumanizes a person, and thus makes her feel that she is the problem, hence, self-blame.

The ideal type is the expositor of who is acceptable and who is not, and for some of the IENs of colour, they had been convinced by the ideal type. This was apparent (as mentioned before) with Claudia, who felt that it was a privilege to have left Jamaica (what she termed a third world country), work in Canada and gain a Canadian degree. Although Claudia indicated that the Canadian educated nurse might have had far less skills than herself, she deliberately refused to acknowledge her Jamaican experience, as she felt it would not work in her favour. This was evident when she said:

I did an interview where the experience they were looking for was the experience I got from Jamaica. I put the experience on the resume, but not the location. Looking back now, there was an impact on people of my colour, but I think it was my mindset. I don’t think they would want someone of my colour in the managerial position. So, I didn’t think that the managerial team would have been comfortable about me being in that position.

Claudia had become intrinsically socialized into the notion that she was the problem; such terms as, “I think it was my mindset” and “I don’t think they would want someone of my colour”, were used by Claudia, was not merely an indicator of how Claudia viewed herself, but also, how social constructs had supported the ideal image (Ford, 2011). Taylor (1992) states that:

Our identity is partly shaped by recognition or its absence by the misrecognition of others and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirrors back to them a confirming or demeaning or contemptible
picture of themselves. Non-recognition or misrecognition can inflict harm and can be a form of oppression, imprisoning someone in a false distorted and reduced mode of being (as cited in Ford, 2011 p. 25).

Taylor (1992) outlines how the view of those in power may strongly affect people of colour. Claudia’s impression of herself was influenced by the oppressive powers she encountered on a daily basis. Bonilla Silva refers to race being a social construct as well as a lived reality (Ford, 2011, p. 452).

Self-blame works in favour of those in dominant spaces. It shifts the problem away from the oppressor being the problem and makes the oppressed the problem (Freire, 1970). The transfer of guilt made the oppressed feel responsible and therefore, absolved the oppressor of all responsibility or need in order to make systemic changes. Efron and Miller (2010), in their study of women within the workforce found that women were not doing well in leadership positions as compared to their male counterparts. Furthermore, even in locations where there were a few men, these men generally occupied more leadership positions than women. Professional women would often blame themselves for not achieving and this was seen in levels of lower confidence, especially if they decided to return to work after having children (Efron & Miller, 2010). Efron and Miller’s (2010) study reflects the experiences of IENs of colour, who also develop low confidence and self-blame. In this study, self-blame became pivotal in how they viewed themselves, which was constantly being measured in light of the ideal type.

Without a doubt, self-blame has had a traumatic effect on both the health and performance of IENs of colour. It not only affects their confidence as nurses who enter Canada with a wealth of skills, experiences and qualifications, but it also ‘justifies’ why they are not worthy of a place among the echelons of nursing. From In the light of previous studies and theorizing, it is increasingly clear that self-blame is but one of many tools used to perpetuate old colonial practices within a new global paradigm. Self-blame is pivotal in shifting the lens from the perpetrator or seats of domination, and casting blame on the victim, who then becomes a perpetrator herself.
Theme 3: No Leaders at the Top

“No leaders at the top” was a common theme among the participants. Samantha expressed that:

There are not many colored persons at the top. I’m not saying to put someone of colour to the top; she must prove herself with qualifications. I think the whole interview and HR (Human Resources) process must be revamped. There are a lot of processes where people are being coached for the position. Sometimes positions are advertised, but they already have people assigned for those positions.

Here Samantha exposed a system by which women of colour were absent at the top, and also noted that they were hindered from getting to the top, regardless of their qualifications and suitability. She identified a select group being groomed for leadership, while the nurses of colour were left unsupported.

Like Samantha, Marlene identified the same issues that related to the lack of nurses of colour in leadership positions when she stated:

You see that in the front line jobs and with people in the higher positions, by the people holding those positions. Then you would feel comfortable and think that there is equity, but people will not suspect that there is a hierarchy in this profession. When you see that certain jobs are held by a certain colour group of people, the public feels that there is a difference. There is an obstacle that is preventing other colored groups from attaining those positions, and only very few can hold that position, because of something different. So there is more opportunity given and not much more obvious reasons for giving the jobs to people of different cultures. Even the most highly skilled professionals from other countries, such as doctors, nurses and engineers, they cannot obtain these positions because of these reasons and these people see that.

Both Samantha’s and Marlene’s statements are supported by Puwar (2004), whose work shows the construction of dominant spaces. Puwar’s study on parliament and civic spaces shows how the dominant space is constructed to exclude and alienate certain groups by keeping the
dominant space White and male. Marlene had identified how race became an obstacle for preventing IENs entering the ivory tower within nursing.

According to Puwar (2004), these obstacles are further entrenched through secrecy and ritual and ceremony. Puwar (2004) points out that the dominant space uses a subtle and slippery manner to keep people of colour out of its space. Ono and Sloop (2002) support Puwar’s argument by demonstrating that the dominant space also possesses its own culture and vernacular which further excludes marginalized groups.

The ideal type occupies the dominant space and in so doing sustains a colonial culture. Pamela argued that it was a problem to have a dominant space without representation of people of colour. She stated that:

It seems to me that persons of colour have the lower status typed positions, and there are very few people in “those” positions. That is in itself is bad for clients to see these things, because if they are giving only the colored people the bed side work then it does not come off as professional. If there were more colored people in higher positions then there might be a higher response. Recognition should be given to colored nurses despite whatever colour they are. They shouldn’t be treated in ways that suggest that they cannot reach those levels. I think that the same kind of principles that are used in teaching, I think students need to see a diverse faculty. Not just diverse in colour but the students are able to talk about issues in relation to some of the real issues that students may have. Such as issues of racism should be allowed to be discussed, which will affect the health of the students and the clients. They need to actually understand what clients go through. They need to understand why people do the things they do.

Pamela’s view addressed the effect that the absence of people of colour in leadership had on clients, students and healthcare. Calliste (2000) and Bannerji (1997) agree that women of colour are intentionally kept out of these spaces and slotted into lower positions.

Another dimension is added to the discussion of exclusion when Jacobs discloses a dual method that excludes women of colour from leadership. Jacob states that, “within this caring profession, there is an unwillingness to acknowledge and distinguish White privilege and to realize that all women are not equally oppressed” (2007, p. 9). Jacobs shows that there are events
that operate to keep the leadership space a White space. In addition, As Samantha stated above: “Sometimes positions are advertised, but they already have people assigned for those positions”; and Gloria who commented that, “people ... who are screening... the nurses shouldn’t all be Caucasian people, because ... I have seen all Caucasian people and not people of color.” In other words, barriers were strategically placed to prevent women of colour entering the dominant space.

Within the academy, there has been much criticism of the lack of Black representation in leadership (Henry, 1993; Tierney, 1992; England, 2005; Acker, 2009; 2011). Within nursing, however, the vast majority of studies addressing the poor representation of Black managers in nursing have been done in America. The scholarly works of Canadian anti racist feminists who have written on the issues of Black leadership in nursing can more readily be found within the body of social sciences, equity studies or among selected international nursing journals. Canadian nursing has not created a terrain by which critical race theory can be voiced. Taken together with these observations, the theme in my interviews of “no leaders at the top” can be seen to show that those in leadership positions have failed to address this problem when making policies.

When IENs of colour enter Canada’s nursing workforce, they are obviously met with the ‘cappuccino principle’ (Jacobs, 2007). Even though IENs of colour enter the Canadian nursing arena with a wealth of experience, confident skills, and competitive qualifications, their unfair lack of representation in leadership continues within its practices. For nursing to fairly represent multicultural diversity, while preserving its colonial heritage, it strategically creates a hybrid space that creates an illusion of its practice in the eyes of the global community.

**The Hybrid Space**

I have argued that IENs of colour have been slotted into a hybrid space because they are needed for their additional skills of sharing the same cultures and languages of many who use the healthcare service. As mentioned earlier, Sophia stated that:
In the area in which I work, the catchment area is very multicultural, [there are] a lot of Caucasians, polish, Italians. I was the only Negro back there and I have never experienced prejudice. I was the person, if there was a problem they would come to, doctors included. The whole area was multicultural and I had to work with these various languages and cultures. In our area we speak 14 different languages...because of the ethnically diverse culture in our work place. And we ask ourselves, how best can we serve? We cannot serve them, unless we speak their language. So the Caucasians are the minorities there.

Sophia points out that within the hybrid space where she worked, Caucasians were in the minority. Jacobs (2007) reminds us how White nurses were readily mentored into leadership positions in White spaces, while nurses of colour were not. Calliste (2000) also says that Black nurses were made to occupy positions that the White, Canadian nurses refused to take. From Sophia’s statement, IENs of colour would appear to be crucial to support the growth of Canada’s workforce and economy.

According to Burke (2009), the “hybrid space” produces its own a hybrid culture and class that allows its inhabitancies to teach their own. Marlene’s comment supported Burke’s argument when she said:

There is nobody to offer them support unless you are able to identify yourself and willing to help others. There are lots of people who struggle to get through the exam here and then to get a job is hard unless you have someone to recommend you, and then it’s quite hard....
And I had to help train them and help them understand the system.

Because IENs of colour who occupy the hybrid space are highly educated they too have to use the grooming process to support other IENs to enter the hybrid space and avoid being slotted into menial positions. If the hybrid space works to support Canada within the global economy, then we are led to ask, what is the purpose of multiculturalism policies if IENs encounter difficulties when trying to enter leadership spaces?

As noted at previous times, the role that multiculturalism policies have played in supporting IENs in the hybridized space, has had mixed reviews from the participants of this study. IENs of colour that came from resource extraction colonies responded differently to issues of inequalities than those who came from the United Kingdom. Those who were educated in the
UK had more exposure to inequalities and their rights as they came from heterogeneous societies. However, those from homogeneous cultures, or resource extraction colonies, could not quickly identify acts of racism. Therefore, as those from a homogeneous society enter a heterogeneous society such as Canada, multiculturalism policies might sometimes work in favour of protecting such vulnerable populations. With this said, for IENs from the UK, their exposure to equality and rights demonstrated a higher level of expectancy when it came to fair treatment than their Indian and Caribbean colleagues.

If multiculturalism policies do provide a safety net for marginalized groups to have a voice, and if these policies were to be removed, a greater problem could be created. Some IENs of colour felt that multiculturalism policies had serviced their needs within the nursing profession. This sheds light on the role of multiculturalism policies and the ideal type within nursing. There are occasions when multiculturalism policies appear to be invisible, while issues emerging from the ideal type are visible.

Summary

The challenges that IENs of colour face within the space of Canadian nursing is complicated by the interplay of two diverse ideologies which reside within its space; namely, the ideal type and multiculturalism policies. In explaining various themes throughout the interviews, there emerged a disparity between them. For most of the IENs of colour, multiculturalism policies were essential in opening doors for these nurses to enter Canada. But their actual careers were not supported by multiculturalism policies. Although most of the participants identified the constructs of an ideal type nurse, they were not aware of her visible presence, but nevertheless they could still give a clear description of her function within their everyday lived experience, and this became increasingly obvious when examining the barriers IENs of colour faced when trying to advance to positions of leadership.

I thus conclude that although multiculturalism policies appear incapable of addressing issues of inequality, they are, however, capable of preserving a space by which discourses on inequalities and discrimination may be made visible and also challenged. Dei (2011) clearly points out that multiculturalism policies are unable to resolve and rupture systemic issues of
racism and inequalities. Multiculturalism policies can, therefore, be criticized for not addressing such issues adequately (Bannerji, 2000). Bannerji’s work reminds us of the intent of multiculturalism policies: it was constructed by the state as part of its Capitalist-nation-building project (2000). With this in mind, we can concur that multiculturalism also works to preserve the hybrid space in nursing and if it were to be demolished this would risk IENs being slotted into menial spaces with no voice or representation (Calliste, 2000).

Although neo-colonial and neo-liberal practices have constructed a hybridized space to appease both the local and the global economy, IENs of colour who occupy the hybridized space are capable of making it work to their advantage. While multiculturalism policies appear to be invisible to some of the participants in this study, these policies in fact continue to function and therefore allow nurses of colour and critical nursing scholars to carve out spaces of resistance in order for IENs of colour to survive. Because of multiculturalism policies, such issues as racism, discrimination, and other forms of inequalities are kept visible and therefore, can be areas of contention in which the dominant space is forced to recognize. Chapter seven will demonstrate how the next set of themes point to spaces of resistance, by which IENs of colour are able to survive within the current practices of Canadian nursing.
Chapter 7

Spaces of Resistance

Introduction

Women’s studies continue to reveal ways in which women are unfairly treated within institutional settings (Smith, 2005). Much of their experience has often gone unnoticed or devalued; yet the resilience of these women is seen by how they survive in the face of trauma (Smith, 2005; Jacobs, 2008). The following themes that emerged from this study went beyond the theme of challenges and I have termed these survival strategies spaces of resistance. At a glance, it is easy to label all seven themes identified in my research as challenges; however, a closer look reveals that the last four themes should rightly be entitled, “spaces of resistance.” It is in these spaces that the participants reclaim ownership and map their own routes of survival within a space that could otherwise be oppressive.

Many studies done on women from resource extraction colonies have often misrepresented them as weak, second class and in need of being rescued from male domination (Said, 1978; Mohanty, 2003). For this reason, when issues pertaining to resistance arose, these women were neither given credit nor viewed as capable of creating spaces of resistance. Mohanty (2003) argues that mainstream feminism has wrongly defined these women by using a Westernized, humanistic interpretation. This interpretation continues within Canadian nursing (Flynn, 1998, England, 2005). This chapter will focus on the last four themes, which paint a different picture of nurses that come from resource extraction colonies and those who came from the UK. Through these themes, we will see these women as women who have intelligently created their own spaces of survival, and therefore, they are extraordinary women who have learned to live within the nominal spaces of Canadian nursing practices.
Spaces of Resistance

The term spaces of resistance is best understood by Madibbo (2006), who defines resistance as, “a struggle against different forms of oppression such as colonialism, patriarchy, racism and homophobia” (2006, p. 4). In the same breath, Madibbo (2006) goes on to say that “resistance is taken from oppressed people’s common experiences of domination, calling upon their social histories to challenge oppressive practices” (2006, p. 4). Since the participants are highly educated IENs of colour who occupy the hybrid space, it could be perceived that they are not oppressed, but rather privileged, when compared to their colleagues who occupy menial, low paid positions (Brand, 1999; Calliste, 2000). However, according to Collins (2000), privileged women of colour are still subjected to oppression; and she calls this the “matrix of domination” (p. 246). Collins (2000) continues that the matrix of domination is the overlapping of domination and oppression. She recognizes that everyone has some level of privilege, and for this reason, oppression is also associated with the outcome of privilege. Since the matrix of domination is about privilege, it must be studied in conjunction with oppression as it relates to intersectionality theory.

The participants in this study all shared a level of privilege, because as IENs they all had a degree and occupied a hybrid space as frontline workers with restricted decision-making responsibilities. Yet, they were also subjected to oppression, alienated from the leadership spaces where policy-making decisions occurred and, in addition, they were deprived of the respectability that was readily given to White, middle class nurses (Flynn, 1998; Gurchairn & Li, 1999; O’Brien, 2006). In view of these multiple obstacles, these women were able to create spaces of resistance that preserved much of their identity and respectability. The remaining four themes identified as spaces of resistance are: 1) To be liked by others; 2) Mirroring the ideal type; 3) Spirituality and faith, and 4) Valuing their heritage.

At face value, these themes could be problematic and challenging by their title, but each one uncovers spaces of resistance within Canadian nursing practice that are pertinent to the findings of this study. As a result, this chapter will unravel how the following themes are spaces of resistance are woven, and how the participants are able to somewhat change their circumstances by creating these spaces into secure spaces of survival. In light of Canada’s multiculturalism policies and the ideal type ideology, the findings in this chapter further show how these women are able to bring about change by reconstructing and reclaiming these very spaces for themselves.
**Theme 1: To be liked by others**

A common and recurring theme in the study was that the participants wanted to be liked by others, in which the term others referred to White-Canadian nurses. Although this theme closely resembled the themes that were originally labelled as challenges, it became increasingly clear that it was different in nature. For three of the participants, it was a way of becoming integrated, fulfilling a need to be accepted; but for the others, the same theme took on a whole new meaning.

Sophia and Claudia were two of the participants who wanted to be liked in order to be integrated into Canadian nursing. Sophia described herself in the following way:

*I am very open and very wanting and questioning, and I am a very positive person. I think people are very much drawn to me and I think people feel very comfortable around me.*

*The head nurse said that she looked at me and that she could have trusted me.*

Several occasions throughout the interview, Sophia expressed how she was liked by doctors and nurse managers alike; and that “I was the only Negro back there and I have never experienced prejudice. I was the person, if there was a problem; they would come to me, doctors included.” Sophia measured how much she was liked by how she was treated by those in leadership.

When those in the dominant space told Sophia she could be trusted, and when they went to her with a problem, Sophia considered these as indicators that she was liked.

Claudia, however, wanted to be liked based on her experience and qualifications. Claudia would go to extreme lengths to erase her Jamaican qualifications, while still claiming the skills she gained from Jamaica. She stated that:

*Sometimes I think I deliberately avoided the impact by leaving my Jamaican experience off my resume. To avoid questioning, I just left the Jamaican off my resume. I did an interview where the experience they were looking for was the experience I got from Jamaica. I put the experience on the resume, but not the location.*

Claudia’s intentions to avoid any association with her Jamaican training followed her experiences with issues of racial identity. On one occasion, Claudia shared how she forewarned recruiters that she was an African Canadian. She described the event as follows:
I have proven leadership positions where I was totally accepted, and I presented myself well etc. However, despite those skills, so even in spite of that, there was a certain profile that they were looking for. Someone saw my resume and emailed me back and told me about the managerial position. At the time I asked, “What do you think based on your experience? How do you think a different culture would be accepted?” I put in brackets, that I was African Canadian. They replied and said that Canada was becoming more multicultural now and the interviewer was interested in moving forward with the position. They were willing to move forward with the interview. The recruiter was looking hard for someone to fill the position, but there was something that made me feel uncomfortable about it and I don’t think they would want someone of my colour in the managerial position. So, I didn’t think that the managerial team would have been comfortable about me being in that position.

Claudia’s desire to be liked was manifested in the need to be accepted and presented in a way that would be suitable to the recruiters.

Claudia and Sophia’s attitude has been the centre of Fanon’s study in his book, *White Masks, Black Skin* (1967). Fanon (1967) describes how Black men [and women] present themselves differently to White people. They have feelings of inferiority and “they are constantly trying to overcome it” (p.9). IENs struggle to be liked Fanon (1967) goes on to argue that the “Black [wo]man’s attitude” is a direct result of colonization. Through this theoretical lens approach, the Black nurse loses her own identity and indirectly submits to the White culture as being superior. Like Fanon, Hassoueh-Phillips and Beckett (2003) found similar behaviours occurring within the academy among PhD nursing students of colour. Hassoueh-Phillips and Beckett (2003) refer to the behaviour of Black students toward their White counterpart as having a desire and need to “fit in” or otherwise be liked. They describe the Black nurses as wearing a White mask with which they would smile and agree with their White colleagues as a way of being liked.

Being liked was a central theme in my interviews, and it was Marlene who exposed that “being liked by others” could in fact work in favour of IENs of colour and, therefore, create a space of resistance. Marlene had quickly learned that by being helpful and supportive to the needs of those within the dominant space, gave her opportunities to support other IENs and help them navigate their way within the system. Marlene describes this as follows:
No, there is nobody to offer them (newly recruited IENs) support unless you are able to identify yourself and [are] willing to help others. There are lots of people who struggle to get through the exam here and then to get a job is hard unless you have someone to recommend you; and then it’s quite hard. Only when there is an extreme shortage of nurses, they will fill in anybody, but otherwise, it is very difficult to get through in the market.

Marlene was fully aware of the political agenda at play, and for this reason she was able to address how the rules could be changed. Marlene’s experience resonate with by Bannerjii (1997) observation about how immigrant women are expendable and commonly used to address the economic pressures brought about by a neo-liberal agenda.

Arguably, Marlene’s position of being liked allowed her to cultivate spaces by which IENs could find support, and ways to toil through multiple obstacles that worked against them. By being liked, Marlene was able to use her expertise, while not being labelled a threat to those occupying the dominant space. However, for some of the nurses, to be liked by others, would create within itself additional challenges. Unlike Marlene who used a passive, non-violent approach like those of Ghandi and the Quakers (Shiva, 1999; Carey, 2012), Sarah and Gloria found that to be liked came with a price and that price required sometimes going against the grain (Ng, 1995).

According to Ng (1995), teaching against the grain refers to using methods of teaching that could contradict the Eurocentric styles of teaching and in so doing create transformativity. For example, the decisions that Sarah and Gloria made to report the unfair treatment by those in leadership was to go against the grain and challenge current nursing practices. Samantha also complained of unfair treatment by her fellow educators by going to the head of her department when she was treated unfairly by a senior educator. Although Samantha had support from other colleagues, she was going against the grain, even in accusing a White leader

In order to be liked, IENs of colour must appear to be in favour of the status quo. To go against the status quo, like Gloria, Sarah and Samantha did, can have an adverse effect on the individual (Ng, 1995). They have to draw off their own inner strengths to survive outcomes of such actions. Gloria shared some insight into ways to overcome such hurdles. She stated that:

I’m very confident as a Black woman. Um I don’t walk around with blinkers. Yes, I know there is racism and I know some people get positions ahead of you because they are preferred; that’s just a fact…you just know it (giggles). Don’t try to put me in the box
because I am going to break out of it. And don’t judge me because of how I look, or speak to me a certain way because you think I am not qualified enough.

For Gloria to survive the injustices imposed upon her, she was able to draw from her own sources of strength, which Wane (2011) refers to African feminism, a legacy passed down from generation to generation (See also Terborg-Penn, 1999; Wane, Deliovsky & Lawson, 2002). Gloria’s statement shows how colonialism still continues to treat women of colour differently; because they look different, they are treated as if they are not academically qualified (Flynn, 1998), when in fact, they all have qualifications that are equal to, or more advanced than their Canadian educated colleagues. For Sarah, there was a thin line between being liked or not liked, and which if not carefully managed could either silence IENs or label them as “trouble.”

As some participants endeavoured to be liked and integrated by their fellow colleagues, they were more often than not, seen as tokens. Gloria and Pamela stressed how on several occasions they would often be asked, where they obtained their qualifications and whether they were the same as the Canadian qualifications. Tokenism for the participants was an insult as they all considered themselves as hard workers and at times more productive than many Canadian nurses. Betty explained it this way when she said:

Back in India when you do your training, you have a lot of skills and you learn a lot harder. The instructors are so strict and when working in this country, I found that the nursing discipline was a bit more liberal in comparison to back in India. I found that I had mainly a lot more skills from where I came from.

Betty’s statement reveals the high value IENs gained from their training and education in their country of origin. And Betty’s statement was supported by Sarah who said;

It has been okay. I think I gained a lot of my experience in England. Had a lot of my positions are up here. I did the degree about two years later. I still think that my British training was more valuable.

For these reasons, Betty and Sarah along with the other nurses rejected tokenism as a false representation of their hard-earned abilities.

Tokenism is, therefore, called into question. Kanter’s (1970) work on tokenism raises some crucial points (cited in Yoder, 1991). First of all, tokenism primarily is a label given to a
marginalized person who is placed in a high position. A person who is considered a token is placed in a space where she/he is a minority; hence establishing a dominant space. However, this is not the case for IENs of colour. They are in a hybrid space where they continue to be marginalized. According to Yoder (1991), the public representation of equality and opportunity is only seen in the global context; for example, having a person of colour as Canada’s Governor General feeds into a positive image that supports Canada’s multiculturalism policies to the global world. Go (2005) continues to argue that in reality, people of colour are not presented with the same opportunities on a local level as that which is portrayed on a global level. The IENs I interviewed have been kept out of the spaces of leadership, and therefore, according to Yoder (1991) and Go (2005), they cannot be considered as tokens.

As IENs of colour occupy the hybrid space, they represent to the global world equality and opportunity, but in reality, they do not have the same opportunities as their White counterparts. They are not supported or groomed to propel upward into the seats of the echelons, but rather are strategically barred from such spaces. According to Tierney (1993), within the academy, there is a need for those in leadership positions to support marginalized groups who do not have the same opportunities as those who are privileged. For Marlene, the only way of receiving any type of support from those who were privileged was “to be liked by others,” and in being liked, she was then able to help IENs that were new to Canada. Similarly, Samantha found that the support of another nurse-colleague of colour was invaluable especially when trying to navigate her way through the nursing system. Sophia and Claudia, however, mentioned little or no awareness of racism or inequalities in their experience, and for this reason, there was no suggestion made as to ways of supporting their own colleagues of colour.

To be liked by others is a normal human need (Maslow, 1943). It allows social cohesion and team work. But, when race is involved, “to be liked” acknowledges a dominant space that controls those who occupy the subservient spaces found in the hybrid and the menial spaces. Applying Collins’ (2000) matrix of domination, it can be seen that IENs who occupy a hybrid space are privileged because of their qualifications, skills and experiences. Yet, besides this privilege, they are also oppressed as they have to “be liked” by others in order for doors to be opened for them.
As I have suggested, the privileges of being in a hybrid space comes with a heavy cost: for some, it is the loss of their own identity and a non-awareness of the oppression of their own colleagues; for others, it is the cost of being silenced or ostracized for speaking out and going against the grain. Hence, the process, “to be liked by others,” has led IENs of colour to both manipulate and master their space to work in their favour, while producing the process into a space of resistance. To be liked by others in a space of resistance is further made possible by multiculturalism policies that carve a space for such departments as the Department of Human Rights and Diversity to exist on a local level.

**Theme 2: Mirroring the Ideal Type**

The individual works of Giddings (2005) and Jacobs (2007) have disclosed the existence and function of an ideal type nurse discourse within the practices of Canadian nursing. Their works have provided answers to the oft-asked question: “Why is there a lack of women of colour in leadership positions?” Nursing has often avoided the critical eye of research as it pertains to the intersectionality of race, class and culture. One reason has been that as a gendered profession, cradled within a caring model, and influenced by mainstream feminism, nursing was able to ignore racism within its camp and concentrate instead on multiculturalism (Hassouneh, 2006). In light of Giddings and Jacobs’ findings—and the results of this current research—inroads have been made in exposing and challenging the hegemony of the ideal type. The ideal type is constantly challenged by IENs of colour that rename and reclaim the ideal type ideology.

The ability to rename and reclaim the ideal type has only been made possible by the influences of multiculturalism policies. Multiculturalism policies have created such spaces as the Department of Human Rights and Diversity; these include policies and guidelines like transcultural learning, equal opportunities when employing staff, and practices in cultural competencies (Leininger 1991; Canadian Nursing Association, 2010; Ontario Public Services, 2012).

Within this study, the participants disclosed one method by which they could rename and reclaim the ideal type; this was by “mirroring the ideal type.” Since the ideal type is systemic within nursing, IENs have refused to take the time to deconstruct the ideal type. Instead, IENs of colour have redefined the ideal type and juxtaposed the ideal type with multiculturalism policies
as a way of receiving its power and influence. A closer examination must be taken to determine how IENs of colour have come to “mirror the ideal type” and in so doing, create spaces of resistance.

The theme of mirroring the ideal type became apparent when the women were asked to define the ideal type. The exercise revealed two schools of thought. One group identified the ideal type as a nurse who was sufficient and reliable. Betty said that the ideal type was, “someone who is a perfectionist; that person should be punctual, approachable, trustworthy, skillful.” When presented with Giddings’ definition of the ideal type being White, middleclass and heterosexual, Betty disagreed by stating that:

I wouldn’t say that [the ideal type is White, middleclass and heterosexual], because with Canada being a multi-national country it shouldn’t be that a White woman should be the ideal type. Any person who has the qualities of a good nurse should be the ideal one.

Betty’s definition was supported by Diane who said that, “What I think, when the term ideal type is used, it doesn’t matter where you come from, once you are efficient and able to do the job that would be my ideal type.” Betty and Diane’s definition of the ideal type was based on nursing performance and, according to Betty; the issue of race was negated by Canada being a multicultural society. Sophia, who had not heard of the term, “ideal type”, began to see the ideal type as it relates to race when she said:

I don’t think I have really heard the term before. But it would mean that there is somebody who is the one ideal for certain things. So, it could mean that the ideal type could be anything, being negative, meaning that it could be a Black person, or if it is a position of power, then it might mean a male Caucasian. Some people would think that the ideal type could be Caucasian.

Sophia’s definition sheds light on the fact that when race was considered, the term ‘ideal type’ was seen as problematic. To assume that “the ideal type could be Caucasian” very much reflects colonial thinking. This assumption is supported by Mohanram’s view that the ideal type is a position of power (1999). Mohanram (1999), in her book, *The Black Body*, clearly shows that to be Black was to be fixed and, therefore, incapable of moving into leadership. Mohanram (1999) argues that leadership positions are spaces of intelligence, associated with the brain and a space by which colonial values have entrenched in the minds of its subjects that the Black body cannot occupy such spaces.
The idea of reclaiming and renaming the ideal type came from the second group of nurses who were able to identify the ideal type according to Giddings’ definition. Samantha described the ideal type as, ‘Caucasian, blue-eyed blonde, middle class’; however, her experience with the ideal type hegemony made it near impossible to identify anything positive about the ideal type unless she was the ideal type, and even that could be problematic. She said:

It is hard to think of the ideal type as being positive because of my experiences. Maybe the positive is that the ideal type is not the best person for the job. Negative slant is that I ask myself why can’t I be the ideal type, but this can be self-destructive.

Samantha’s sentiment about the ideal type is shared by Pamela, who also defined the ideal type according to Giddings’ definition when she said:

It [the ideal type] means light skinned, Caucasian middle-class, female, slim-built, possibly blonde hair and blue eyes. I always have at the back of my mind that I have to try harder. I’m not really what they are looking for and also, I really think it [the ideal type] does have an effect.

Sarah’s statement emphasizes the struggles that the participants experience in the space where the ideal type functions. Although some identified the ideal type, while others did not, they all experienced the aftermath of having an ideal type working within the space of nursing. Their experience mirrored that of the colonizer toward the colonized; of power and domination. IENs were able to reclaim some type of space by seeing themselves as the ideal type, as Samantha previously stated. Although most IENs did not see multiculturalism policies as influencing their positions, multiculturalism policies provided a space within which IENs were made aware of issues related to discrimination and racism (Dei, 2011). Since the ideal type is rooted in nursing itself, it may seem impossible to erase it. However, IENs were able to create a space of resistance by renaming and reclaiming the ideal type as being a description of themselves and their positive attributes.

IENs of colour are constantly made to feel that they should be grateful to be in Canada with further opportunities and the chance to occupy the space of respectability (Schick, 2002). The concept of “gratitude” is reinforced as a way for the colonizer to perpetuate control over the actions and behaviour of the colonized (Memmi, 1965). Mainstream feminism has perpetuated the notion of gratitude, by boasting that Canada is gendered profession that supports all women.
But mainstream feminism has also been instrumental in building a seemingly impermeable wall that keeps other forms of feminist-thoughts outside. Beside these barriers, IENs of colour have learned to be resourceful and preserve their own knowledges in order to mirror the ideal type through renaming it and reclaiming it to their advantage.

Although it may appear impossible to rupture and erase the ideal type within nursing, the very presence of IENs of colour brings the durability of the ideal type into question. They are able to do this through mirroring the ideal type. By identifying the ideal type as a coveted standard for nursing, IENs of colour have instead reframed the image of a White middleclass heterosexual nurse to one who is capable of working to the best of her ability, whatever her colour or culture. Hence IENs of colour are able to shift and reposition the definition of the ideal type within the confines of multiculturalism policies that promote equity within diversity.

Although multiculturalism policies have their own shortcomings, such as the inability to rupture the ideal type, these policies are capable of creating and maintaining a space within which the ideal type can be exposed and where IENs can, to some degree; challenge its power and control. Hence, it is important to note that, although in theory this is possible, in practice there are layers of difficulties that work in opposition of IENs of colour, one being the nursing curricular.

While conducting this research, and scrutinizing the literature on this topic, I realize how difficult it is to access work by different types of feminist writers in the area of nursing. The nursing libraries address numerous articles and books on all types of nursing issues, but there remains a limited supply on critical research studies that relate to racism and nursing. It is clear that mainstream feminism and the ideal type, to some degree, still dominate the nursing curriculum. I encountered several difficulties when trying to conduct this research, which indicates the difficulties that IENs of colour must face within a space dominated by the ideal type. Claire describes the difficulty that IENs of colour experience when she says:

We all need to learn and management too, to keep training on and how to deal with these issues, like how to communicate with nurses coming in from different backgrounds. In the academia world, very rarely do you find persons of colour coming into roles of management, in institutions at university. So even there, they need to have that changed. It’s very subtle, but it’s there.
The ability of IENs of colour to identify the problem, and then to rename and reclaim the ideal type, greatly credits their ingenuity to preserve some credibility within the hybrid space. Hence, the hybrid space becomes a space by which they can hold onto some level of leadership with the hope of making a way for those who follow after.

**Theme 3: Faith and Spirituality**

Spirituality continues to be a controversial subject within the academy and the nursing profession. Although spirituality has been closely associated with a historical trail of colonial oppression, for countless who have experienced oppression, spirituality has been a place of hope and healing (Dei, 1993; Agyepong, 2011). It has also connected IENs to a faith community within a foreign land. Yet, spirituality has been given little attention within Western nursing.

Within this research, spirituality was alluded to, both directly and indirectly, as a space of resistance that had been readily silenced within nursing practice. Therefore, within Western nursing where attention is given to a patriarchal-stream of science and mainstream-ethnocentric feminism, introducing Black feminist thought into the nursing arena, automatically creates a dissonance. Spirituality is a space within which resistance may occur through the lens of Black feminist thought. Because the model of care is a central component to nursing practice, the ideal type attempts to use the model of care to its advantage, by focusing on such issues as culture in the absence of spirituality (Watson, 1985). Spirituality is fundamental to many non-western cultures, because of its close alliance with one’s identity (Pattern and McClure, 2008). By preserving one’s spirituality, IENs of colour are able to preserve some of their identity. This is another reason that multiculturalism discourses could play a significant role-- in preserving IENs culture, as well as ones spirituality.

Spirituality has been defined by Neegan and Wane as, “a personal quest for meaning and for purpose in life that goes beyond the material and temporal dimensions of human existence and can include both beliefs and practices” (2007, p. 28). The notion of spirituality has often been used synonymously with religion and, therefore, has been viewed by some Western philosophers, such as Marx, as an “opiate of the masses” (Marx, 1843). Such ideologies do injustice to the experiences of those who remain marginalized by the West. The role that spirituality plays within the everyday lived experiences of women of colour cannot be solely studied and understood through Western eyes, but must be understood through their own.
Therefore, to negate the relevance of spirituality in the lives of the participants is to dilute their struggles and trivialize the strategies they use to successfully survive within a space that considers them outsiders.

On several occasions, it was common for four of the participants to gesture, comment and allude to the role spirituality played in their survival of an oppressive situation. At first, their gestures and comments was easily misunderstood as weaknesses rather than their strengths, as they started by first speaking about their challenges then about their faith and prayer. It would be easy to mistake faith and spirituality as “crutches.” But it soon became evident that these were areas of strengths and not weaknesses as they expounded on their ability to survive and face these challenges through prayer and faith. Diane’s experience is exemplary of this. Diane was one of the participants who had gained a Canadian degree in nursing, and occupied the hybrid space, but also expressed how she would often decline team leadership because of the politics that surrounded it. Referring to her experience as mentioned in chapter six, Diane stated the following:

You know what; they were always looking to see what you could do and what you could have accomplished. Yes you’ll find the other staffs were looking to see what your practice is like. Actually I have refused positions of leadership... and you know what it is, you know I just want to come, do my work and go home; instead of getting into the red tape and the White tape and all those different things that are going on. Diane’s experience demonstrates one who had been worn down by being “policed” by the ideal type. Many of the participants in the study expressed the same feelings; being watched and scrutinized. Diane’s response, though, was somewhat different. Diane’s refusal to be involved in “the red-tape”, as she called it, was another method used by those in the dominant space to exude their power and control (Senigaglia, 2011).

IENs of colour have developed multiple ways in which to address issues of unfair treatment in the work place. Diane’s method of survival was unconventional in Western thinking. Unlike many of her colleagues who were outwardly verbal about the unfair treatment they were receiving, Diane’s form of resistance was to use faith and spirituality. She explains:

At that time it was changing over that all nurses have to have their degree as an entry level into nursing. So I decided to go at that time to get it. I remember when I first started in an acute care hospital on a medical surgical unit, and I was the only coloured nurse there, on
that unit. It was, what would I say, for me it had its challenges. You are the only one there and you seem a little uncomfortable. But anyhow as being, from a Christian background you know you always had God with you and you always strive for efficiency. And that is what kept me.

By not complying to the conventional methods of resistance—“fight” mode—Diane was able to overcome through the work ethic of striving for efficiency (Weber, 1958), but more so, through the discourse of spirituality. The discourse of spirituality draws together historicity of one’s past and culture (Collins, 2000; Wane, 2011). Hence, Diane draws from the multiple methods of resistances that spirituality has used within history. Diane’s resistance comes from a peaceful core of resistance. Diane was able to become efficient within a space that was critically scrutinizing her practice. Diane was functioning in a-practice-within-a-practice. She had imposed her spiritual practices, which her counterparts were not accustomed to and within which they were unable to identify or control her.

Black Feminist Thought addresses the relationship of spirituality, activism and resistances within the space of oppression. Wane describes how spirituality is “rooted in a particular geographical space, a place they call home or sacred, a place cherished by family members...or a place that the women remembered or cherished with fond memories” (2011, p. 162). For this reason, spirituality has found a strong footing within the study of Black Feminist Thought.

The approaches that the participants use within the spirituality discourse vary. For example, Diane used a somewhat passive resistance toward the oppressive influences she experienced. Diane’s approach has been widely advocated by racialized spiritual leaders such as Ghandi, Jesus Christ and Martin Luther King. Not all of the participants had taken the passive approach. Gloria, for instance, became more active in addressing issues of racism and injustices, and in so doing, she found a relief in her own spirituality and faith. Gloria stated that:

When I came with a degree, they were intimidated by it. They always were talking about they wanted to know where I did my training and qualifications; how many years experience I had. It was more like a competition…um… and I suppose how I spoke and how I carried myself, being a Christian, and the conversations I didn’t get into, I was different. Even though I got on well with them, there were certain things I didn’t get into. It was not appropriate. It can be quite stressful in nursing: going on your knees and praying for the stressful situations and asking God to get you through. When people see me they
say you’re so calm in the situation, but they don’t know what’s going on inside. Yes, praying really- really helped me; it helped me through my nursing; praying and my faith.

According to Gloria, her spirituality provided a buffer by which she could maintain her identity and not be assimilated. As she expressed an outward appearance of being calm, inwardly she had struggles that were absorbed by her spiritual dimension, and this is supported by findings in Patton and McClure’s study (2008). Pattern and McClure (2008) found in their studies that spirituality “not only serves as a coping mechanism, but also may promote healthy living and identity development to foster meaning of diverse experiences” (p. 44). The different approaches that the women showed within the spiritual discourse demonstrate the heterogeneity of spirituality in addressing their culturally diverse needs. Therefore, spirituality plays an essential role in their healing and identity.

Another important role that spirituality played within the lives of the participants was that it provided a community by which they could belong and reclaim their identity of leadership. It was a space within which they were their own leaders and the ideology and powers of the West could not enter as the dominant. Gayle (2011) refers to these spaces as spaces of worship or churches. Within the space of worship, Black women have been dominant, and it was here that they found a place to call home. According to Wane (2011), there are sacred places created that instill deep roots of one’s sense of being. The alliance with a faith community within a place of worship is a solace for many IENs that are new to Canada. As carriers of culture, women of colour have been the matriarchs that have guided and developed their children’s spiritual framework and likewise have become some of the strongest of activists. Gayle (2011) refers to the life of Maria W. Stewart and demonstrates how her spirituality became a compelling force within the Black community and on a level of political change.

Arguably, then spirituality and faith within nursing practice has become a space of resistance, to which Dei (1993) adds that it is capable of “decolonizing” colonial thinking. For Dei, decolonizing of colonial thinking is made possible by introducing other forms of knowledges within education. Therefore, spirituality becomes essential within the pedagogy of learning.

To ignore spirituality is another way in which ideal type thereby can refuse to address the needs of newcomers in its space and, in so doing, maintain authority over its nursing practice, even as the presence of multiculturalism policies provide a space for IENs of colour to discuss
cultural diversities and hence spirituality. Such festive holidays as Diwali, Ramadan and Easter are each spaces that sustain spirituality and identity under the security of human rights and diversity. Nursing, therefore, needs to address ways in which it can engage faith and spirituality within its practice as a means of understanding those who use the healthcare system, as well as those who provide services.

**Theme 4: Valuing their Heritage**

Generally, Indigenous people have valued their heritage through the indigenous knowledges¹ that have been handed down to them through the various forms of the arts, music, dance, play and storytelling (James, 1993; Collins, 2000; Wane, 2005; Prendergast, 2011). IENs, in this study, have been influenced by colonial infiltration. To believe, however, that they are, therefore, alien to all forms of indigenous knowledges would be to deny the creativity and skills of their ancestors. Their ancestors had cleverly preserved nuggets of their culture through the pedagogy of arts and entertainment, which they even performed to their slave masters and used to escape from their masters during colonial reign. As culture-bearers, IENs of colour, who come from colonized countries such as Africa, India, the Caribbean and those internally colonized within the U.K. have all experienced the mental effects of colonialism (Ogundipe-Leslie, 1994; Terborg-Penn, 1995). However, Terborg-Penn (1995) argues that the ingenuity of preserving their ancestral knowledges under the nose of the colonizer demonstrates the sophistication of their heritage.

The survival of the participants’ culture is significantly dependant on the interlocking relationships of women; by that I mean, mother, daughter and even the community mother (James, 1994; Collins, 2000; Wane, 2004). This interlocking relationship is sustained even when IENs find themselves relocated or displaced. Their heritage remains a major component in connecting and networking with their community, while valuing who they are. This was evident in Gloria’s experience.

Gloria was born and educated in Britain. Her parents were from the Caribbean, and now as a first generation of Caribbean children born in Britain, Gloria’s parents immediately instilled within her core values as a Black girl growing up in a White country. As a minority, Gloria says her mother would constantly remind her of who she was and what she could be. Gloria’s experience depicts the important role that she and her parents and their own community play in
aiding the success of people of colour. Gloria’s parents reinforced knowledge transfer by instilling values in Gloria that had been handed down for generations. The ethics of hard work is common within African indigenous knowledges and this is what Gloria had to draw on in order to survive the onslaught of difficulties she would face as a Black woman in a White space.

Gloria’s ambition to be a nurse was also paved with a series of difficulties and it was the support of those within positions of power that helped her:

I remember going through nursing and being pointed out by a White teacher that I should do SEN (State Enrolled Nurse) ² and that is when I went to the Black teacher and he helped me. I had to study harder, but my tutor, the White nurse told me I should do my SEN and I said no, I wanted to do my RN. I remember when I did my nursing exam and passed the first time, that was a huge thing for me. That was an ideal type…that was a blue-eyed, blond hair, not all of them, they were her favourites, one in particular, but they didn’t pass, they had to do the exam again. Yes, they tried to steer me off into the enrolled nurse position. After I had to do extra tutoring and so, she picked it up and she never brought it up again that she wanted me to go to a lower position.

Once again, Gloria’s experience in entering nursing supports Tierney’s (1993) argument that marginalized people need to be supported to reach leadership positions, because they face barriers that are not commonly felt by those from the centre. Fortunately, Gloria’s support came from a Black teacher, who recognized the difficulties she faced and helped navigate her through the system. Samantha was not as fortunate as Gloria. Samantha describes how she was unfairly treated; she had to rely on the support of another colleague of colour, since there was no one in leadership to support her. Samantha’s experience shows how operational practices are in place to work in opposition to nurses of colour. Preference was blatantly given to the White educator and Samantha was refused a voice to defend her case. As positions of leadership remain White spaces, all of the women in this study echoed the obvious lack of women of colour in leadership.

One way of valuing IEN heritage has been through knowledge transfer. People of colour have multiple ways to transfer knowledge that are often not understood by those within the dominant space. Collins (2000) and Prendergast (2011) have shown that knowledge transfer frequently occurs through the simple daily tasks that mothers and daughters share. These moments shared between mothers and daughters are involve not merely the transfer of knowledge, but also the transfer of culture and identity (Collins, 2000; Prendergast, 2011).
As IENs enter the practices of Canadian nursing, they often expect similar levels of support to what they have been used to within their own communities. They are often bewildered and disillusioned to find that within a gendered and caring profession such as nursing, the community support they are accustomed to, are not necessarily common practice within nursing. Whereas Jacobs identifies this support is common among White leaders who groom and support other White nurses (2007). The need for support cannot be over-estimated. Drawing from my own experiences, I recall that as someone born and educated in the United Kingdom, I had already been indoctrinated into the colonial way of thinking. For this reason when I was told that I did not have Canadian qualifications or experience, it was inevitable that I should seek to please those in power by obtaining these. Having very little support within nursing, I returned to the academy as a way of achieving Canadian academic qualifications. But strangely enough, it was on entering the academy, other than nursing that I began the process of decolonizing my mind. To do this, however, I needed the right professor to support me through this process.

It was in my second semester that I met my advisor, Professor Magnusson, who understood my inabilities to unlock the multiple knowledges I had within me, and without her support, it was near enough impossible to be emancipated in mind and spirit. As a White woman, in a position of power, she exemplified the teachings of Tierney (1993). She recognized where I was coming from and the difficulties I faced in entering a new space. She assisted me in amalgamating my history and culture within this new space of learning. As she encouraged me to draw on my experiences from within, it was then that I had an “eureka” moment; it was then that I was able to value my heritage and express my voice and knowledges within my work.

When conducting this research, it became increasingly evident to me throughout writing up the findings that there was a link between the valuing of one’s heritage and one’s identity. If one placed high value on her heritage, she commonly embraced her identity. For Claudia who was ashamed of her heritage, found it difficult to embrace her identity, and tried to be a “Canadian” as much as she could. Notwithstanding, those who value of their heritage also recognized and valued the skills and experiences they brought with them to Canada. And it was these skills and experiences with which they readily and proudly identified themselves. This was further demonstrated in the creative ways they used to resist the status quo and their determination to challenge injustices. What became evident among the eight who valued their
heritage was the three ways in which they were able to create seats of resistance. These I term the three R’s: Remembrance, Resilience and Restoration.

4:1. Remembrance

Within the discourse of remembrance was a space within which IENs of colour preserved their identities through the stories they shared about arriving to Canada. These stories formed the backdrop of who they were, where they were coming from, and how they arrived in Canada. The trajectory of events revealed a series of similarities they shared and methods they used to survive. Sharma and Wright (2008) describe migration as a form of decolonization. As IENs enter Canada from neo-colonial spaces, they enter a new space with new challenges. However, Sharma and Wright (2008) fail to recognize that when IENs migrate, they enter another neo-colonial space, which is manifested by the ideal type within nursing. This became apparent as the IENs in my study recalled the reasons they left their countries and what they gave up in order to arrive at where they are today. They were leaders who made decisions and influenced policies in their original countries; they were the intelligentsia in their homeland. But now they are locked in a pseudo-leadership position, which I have labelled the hybrid space that cunningly limits and prevents them from influencing nursing policies.

As the participants reflected on their past, they entered a new framework that could not be contained within mainstream nursing. Campbell and Gregor (2002) address the importance of reflexive practice within the context of research; Smith (2006) points out that the woman’s experience is essential and authentic data; therefore, as these women reflected on their past experiences, their memories were crucial in creating an understanding of work and their daily lives. By remembering their lifestyle in their previous countries, they were able to do a comparative analysis of their lives in Canada. It must be noted, however, that there is a danger when recalling the past to produce an idealistic picture and fail to recall the problems that influenced them into leaving. An example is Betty. Betty spoke strongly about having a better educational system in India, yet when asked why she left India, she said for a better lifestyle and education.
Black Canadian Feminist Thought (BCFT) could be another effective tool, along with understanding Smith’s work on reflexive learning. BCFT, as a critical framework is a stranger within nursing research and studies, and for this reason it is not used to unpack issues of race, gender and class within the practices of Canadian nursing. With the growing body of IENs who occupy spaces in Canadian nursing, I would argue that BCFT is vital, because it contextualizes the historical experiences of IENs of colour who have to work under neo-colonial nursing practices.

4.2. Resilience

Gayle (2011), in her study of women of colour and spirituality, established that women of colour were greatly resilient even when they were persecuted or banned from using their innate spirituality as a means of resistance. Furthermore, Wane (2011), refers to their resiliency as self-determination. In her interviews with five women, Wane (2011) found that self-determination was made visible in their role as activists within their community. Likewise, IENs of colour have a history of resiliency which is evident when Marlene shared how she would advocate for IENs by assisting their transition to Canadian nursing practice.

IENs of colour have undergone major life changes through the migratory process. Historically, they have experienced three major migrations that are worth noting. Within the first wave of migration, IENs were recruited to England after World War II. This major shift brought with it a climactic and cultural shift as women of colour who were educated by the British, were slotted into low paid jobs with no status (Prescod-Roberts & Steeles, 1980; Ryan & Webster, 2008). Regardless of the calamities they faced, they were resilient and secured a permanent position in a place that did not want them as citizens, but only short-term workers (Prescod-Roberts & Steeles, 1980).

The second migratory wave occurred following the adoption of Canada’s first multiculturalism policy. Canada’s recruitment of IENs served to redeem Canada’s image within the eyes of the new global economic order. But IENs of colour of this period too, found themselves slotted into low paid jobs with loss of status (Calliste, 1993). Despite their challenges, they created within them, a sense of collectivity, which Wane refers to as true activists when she says:
Collectivism, one of the principles of Black Canadian Feminist Thought, brings collective forces together and the fundamentals of a community that evoke the notion of the communal sharing of pain, struggles, triumphs and vision (2011, p. 265).

IENs of colour are visionary, and despite the trials they have faced in the past, they are willing to explore new challenges. Therefore, in 2001, IENs of colour entered Canada again to mend Canada’s nursing shortage. The studies showed a repeat of the experiences that these nurses had faced in the earlier waves; yet they were resilient and self-determined to survive regardless. Pamela summed up the resiliency of IEN nursing by first observing the problem Canada has by low representation of Blacks in leadership. She provided a solution to the problem when she said:

It seems to me that persons of colour have the lower status typed positions, and there are very few [White] people in those positions. That, in itself is bad for clients to see these things, because if they are giving only the colored people the bed side work then it does not come off as professional. If there were more colored people in higher positions then there might be a higher response. Recognition should be given to colored nurses whatever colour they are. They shouldn’t be treated in ways that suggest that they cannot reach those levels. I think that the same kind of principles [should be] used in teaching, I think students need to see a diverse faculty, not just diversity in colour. But the students are able to talk about issues in relation to some of the real issues that students may have. Such as issues of racism-- should be allowed to be discussed, which will affect the health of the students and the clients. They need to actually understand what clients go through. They need to understand why people do the things they do.

As nurses like Pamela identify the problem within nursing, they become examples of resiliency, addressing the real issues, and giving solutions to real problems. Because resiliency is neither dormant nor weak, these women continually show resiliency in their everyday lives. They are repeatedly “wrestling with the past and present, wrestling with theory and practice, wrestling with politics and spirituality so that our lives can be richer and society more just” (hooks and West, 1994, p. 4).
4:3. Restoration

Within the tenets of nursing practice, restoration is not usually discussed as it relates to racism and class inequality. For example, Sophia who was content with the status quo and boasted that she was well-liked, opened a new branch of way of thinking within the context of this study. Her inability to recognize forms of racism could very much show a level of restoration within herself. Although Sophia’s experience was somewhat different than the others, I could not avoid noticing a free spirit of contentment. In trying to analyze her reaction within the context of the majority, I must admit that on one hand I wondered if Sophia had reached the level of restoration. For one to feel restored is undoubtedly based on the person’s interpretation of restoration. However, on the other hand I could not fail to wonder if Sophia could have been in total denial.

Restoration is crucial to this study, because it allows us to embrace the views of participants like Sophia whose views seem alien to the experiences of others. Sophia’s experience cannot be ignored. Is it possible that she did not share the same experiences as those from her community? Was Sophia’s experience different from the others by chance? Or did Sophia’s outlook on life play a significant role? Could it be that Sophia had created her own methods of survival? Although her own methods were different than the other participants’ methods, she does in fact expose the multiple ways IENs of colour are capable of addressing challenging issues.

Nevertheless, the similar experiences and values that IENs of colour share gives credence to the role multiculturalism policies play within Canadian nursing practice. All of the participants in this study wanted restoration and this was significantly reflected in their answers to the final question. They all wanted to see representation of women of colour in spaces of leadership, and spaces of leadership meant spaces where decisions were made on a policy level. They noticed the lack of representation of nurses of colour at the top. For this reason, restoration could only occur by creating equity; having nurses of colour at the top and not only at the bottom.

Summary

IENs of colour have been subjected to different forms of colonial domination. Yet, in the midst of it all, they have preserved some knowledges that have been handed down to them. It is these knowledges that they draw upon to survive the neo-colonial spaces that they continually
find themselves in. IENs of colour play a crucial role in challenging colonial practices that govern much of today’s Canadian nursing. They not only challenge the role of the ideal type, but also preserve a space through multiculturalism policies by which issues of inequalities and social injustices can be disputed. By practising the three R’s (remembrance, resilience and restoration) in their everyday lives, IENs of colour are able to survive the dialectic relationship of the ideal type and multiculturalism policies. As they remember their journey, they are made resilient through the multiple knowledges handed down to them. They continually pursue ways for restoration to occur; whether it is systemically or individually. Restoration is central to the process of decolonizing the mind. And for this reason, IENs of colour who occupy the hybrid space of nursing are not prepared to accept the status quo, but are capable of carving out spaces of resistance against the odds.
Chapter 8

Recommendations and Conclusion

Introduction

Current studies reveal that by 2022, Canada should expect another nursing shortage, which will significantly impact healthcare services. As Canada focuses on ways of recruiting and retaining new nurses, multiculturalism policies continue to play an important role in attracting highly educated, skilled and experienced internationally educated nurses (IENs).

Most of Canada’s IENs come from the Philippines, Eastern Europe, India, the Caribbean and the United Kingdom. With the exception of the Philippines and Eastern Europe, IENs come from countries that were formerly colonized by the British Empire or from the UK where they were internally colonized. These IENs share many similarities with Canadians due to their past colonial connections. Besides these similarities, however, studies show that IENs are treated differently from their Canadian counterparts. As these nurses are predominantly women of colour, they often find themselves in low paid and menial nursing positions, with little to no prospects of entering leadership positions, or as in my research, front line management positions.

The Problem of Study

An ideal type nurse is considered White, middleclass and heterosexual, and so IENs of colour find themselves competing for a space that they once occupied as leaders in their homeland. Canada continues to maintain its favourable image within the global community by excluding these nurses from leadership and selecting some to enter the “hybrid space.” The term hybrid space was identified by the author of this thesis and is not found in nursing literature. The term, the hybrid space refers to a nursing space where nurses have some autonomy over or leadership in their work, yet remain frontline workers who are not involved in making policies. The hybrid space comprises public health nurses, clinicians, clinical case coordinators and team or unit leaders. Although these nurses work on the frontline, they are also able to make some decisions pertaining to their practice.
The hybrid space works in favour of the dialectic relationship that exists between the ideal type and multiculturalism policies. The ideal type is homogeneous and systemic due to its colonial roots, whereas multiculturalism is heterogeneous and partly in opposition of colonial values. I argue that strangely enough, the ideal type and multiculturalism ideologies form a union. On one hand, multiculturalism policies are unable to rupture systemic practices, but can carve spaces by which equitable practices can occur. On the other hand, however, the ideal type suggests holding on to an unfavourable image of Canada’s homogeneous past and can only be camouflaged by the presence of multiculturalism policies. The dialectic relationship that exists between the ideal type and multiculturalism policies can best be understood through the lens of Canada’s IENs of colour. In this study, IENs of colour have not only identified the current dialectic relationship between the ideal type and multiculturalism policies, but have also exposed the impact of such a relationship on their everyday lives within the workplace.

Qualitative Methodological Approach

A qualitative anti-racist feminist approach was conducted to address the experiences of 10 IENs of colour living in Canada within the past 10-24 years. Each IEN came from either a resource-extraction country, or were born in the United Kingdom to parents who were from a resource-extraction country. All the participants were women of colour, internationally educated and who arrived after the first multiculturalism policy was adopted in 1971. At the time of this study, all the participants were working within nursing. All had one or two degrees in nursing, which they had obtained from their home country, from Canada or from both countries. The participants were recruited using the snowball sampling approach. I asked the participants from my former Master’s research study to disseminate my study information and request for participation within the community of IENs. Once the participants were selected, an in-depth interview was conducted on each; and participants were asked nine in-depth semi-structure questions, which lasted between 45 to 90 minutes. All participants were informed about the importance of confidentiality, the use of pseudonyms and safety procedures. In addition, in writing up the results, locations or incidences were changed to protect their identities, and all information was kept securely stored.
After being informed of their rights to withdraw from the interview at anytime, the participants all agreed to their interviews being recorded. Once the interviews were audio-recorded, they were taken and stored within a safe, locked cabinet. A small token of appreciation was given to each participant at the end of each interview.

The results of the study included identification of the ideal type and multiculturalism ideologies at play within Canadian nursing practice. For the participants, multiculturalism policies were beneficial for the migration of IENs to Canada and into its nursing workforce. Not all saw the relevance of multicultural policies in navigating their journey into their nursing positions that they eventually occupied, nor could all identify the ideal type as a term, but they all related incidences that were descriptive of the ideal type; this was manifested in situations where they were made to feel ‘not good enough’ or ignored. Overall, each participant saw a need for more nurses of colour to be represented in leadership spaces. They were aware that nursing leadership was all White and each participant was concerned that this did not represent Canada’s multicultural image.

From the data analysis, seven themes emerged. The first three focused on the challenges IENs of colour faced within the practice of Canadian nursing as it related to the ideal type and multiculturalism policies. The second set of themes addressed how IENs of colour were able to create spaces of resistance as a way of coping. The study also showed that IENs of colour were resourceful. Initially, they all came to Canada with comparable qualifications, experiences and skills as their Canadian counterparts. However, under extreme circumstances they also arrived with additional resources that made them resilient and capable of creating spaces of resistance.

The participants in this study once occupied spaces of leadership in their home countries, from which they influenced nursing policies and practice. Yet, in coming to Canada they were now slotted into the hybrid space, a compromised space that gave them limited autonomy while working on the frontline. By having IENs of colour in frontline work, their frontline role became indispensable, because they were able to work with diverse cultures that use Canada’s healthcare service. Their omission from spaces of leadership where policies were made for Canada’s heterogeneous society raised my consciousness that the ideal type was capable of sustaining the cappuccino principle; meaning White nurses at the top and nurses of colour at the bottom.
The Findings

From the study, it is clear that multiculturalism policies continue to play an important role in the recruitment of nurses. Multiculturalism policies seem to influence the decision of many IENs to come to Canada, and multiculturalism policies create spaces by which issues of inequity and discriminatory practices can be challenged. But the findings exposed that multiculturalist ideology was not as useful as initially thought. A danger still persists in the unexpected dialectic relationship between the ideal type and multiculturalism policies. Although they have created a co-dependent relationship, these discursives continue to co-exist as hegemonic. For this reason, the danger of one becoming more dominant than the other for its own dominant purposes.

The issue of dominance was made clear through the interviews with the participants, who had initially seen the visible benefits of multiculturalism policies, but later could not see how they were supported their journey in the workplace. At the same time, however, most of the participants could not easily define or see the ideal type, but could visibly describe the effects of the ideal type on their everyday working lives; thus providing data on the visibility/invisibility of multiculturalism policies, and the invisibility/visibility of the ideal type within Canadian nursing practice.

Conclusion

This research study is relevant for Canadian nursing today and in the future. With projections showing a decrease in Canada’s birthrates and an increase in its ageing population, the projected nursing shortages will significantly and severely compromise Canada’s already threatened healthcare system. It is in Canada’s best interest to address these issues imminently. Presently, Canadian nursing is like a revolving door; as it recruits it loses, and this recruitment and loss is a financial strain on the Canadian economy as well as in IENs well-being. To prevent this loss, this study offers several recommendations to be considered in Canada’s nursing plans for recruitment and retention, and for the effective integration of IENs into Canada’s nursing workforce.
Recommendations

I have six recommendations, which are as follows:

I. Further studies are needed into issues relating to inequalities within Canada’s nursing practice. This will help to flag issues that impact the methods and processes used for recruiting and retaining nurses. In addition it will address ways of making the recruitment and retention process economically resourceful for Canadians.

II. Further attention needs to be paid at unearthing and challenging colonial practices that continue within Canadian nursing. First the ideal type needs to be identified within nursing as a way of deconstructing colonial practices through its policies and curriculum.

III. New spaces are needed to introduce other forms of frameworks and pedagogies within the Canadian nursing curriculum. These new spaces will have a direct impact on Canadian nursing practice. Such frameworks as antiracist feminism and Black Canadian feminist thought can add to the changing image of nursing and produce nurses who are more adaptable to globalized changes.

IV. Marginalized voices need to be brought to the forefront as they have remained silent for so long. These voices can offer lessons in resiliency and restoration that are a part of healing and growth for both the nurse and the patient alike.

V. The need for more women of colour in policy-making leadership positions has been shown to be relevant in reflecting Canada’s pluralistic society. This can be effectively done by equally grooming IENs of colour for leadership positions as their Canadian counterparts are groomed.

VI. This study can also be used as a springboard to promote and advance nursing scholarly studies, which will be relevant for human resources.

With currently no published studies into the dialectic relationship of the ideal type and multiculturalism policies during the completion of this thesis, there are, however, growing
debates among IENs that question the ideal type. Therefore, it is hoped that this study will support further work on multiculturalism and in finding ways that it can better support IENs of colour. It is further hoped that multiculturalism policies will take the lead in providing equal opportunities for those nurses who have so much to offer with their comparable qualifications, skills and experiences. By reflecting diversity in the area of leadership and introducing other forms of pedagogies, Canada will undoubtedly benefit within the economic arena as well as advance another step in retaining its respectability among other countries within the global community.

The Researcher’s final reflection.

As I complete this thesis I am compelled to also bring my journey to a point of departure. The array of emotions that have followed me as I have thought about their stories, felt their frustrations and even listened to their laughs, all these have accumulated into one final thought: how proud I am of these women who have taken authority over a space that was given to them and they have made it their own. They continue to carve out new routes for others to follow even though they may never leave this space. For me, this maybe a departure from my thesis, but it is an awakening to new journeys that will centralize and position the experiences of these women above the policies and cultural spaces that have been constructed to keep them silent.
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### List of Acronyms

**ARF**: Anti-Racist Feminism  
**BFT**: Black Feminist Thought  
**BScN**: Bachelors of Science in Nursing  
**CES**: Comparative Education Services  
**CIC**: Citizenship and Immigration Canada  
**CICIC**: Canadian Information Centre for International Credentials  
**CM**: Canadian Multiculturalism  
**CMAJ**: Canadian Medical Association Journal  
**CNA**: Canadian Nursing Association  
**CNO**: College of Nurses of Ontario  
**CPHI**: Canadian Population Health Initiatives  
**EN**: Enrolled Nurse  
**IEN**: Internationally Educated Nurses  
**NAFTA**: North American Free Trade Agreement  
**PCT**: Post Colonial Theory  
**PHHR**: Public Health Human Resources  
**RN**: Registered Nurse  
**RNAO**: Registered Nurses Association of Ontario  
**UK**: United Kingdom  
**UN**: United Nations
Appendix 1

Chapter 1

Terms and Definitions

1. **BLACK**: The term refers to people of African descent; however in Britain, the term Black is a political term and incorporates anyone who is not White. As this study is conducted in Canada, the term for Black could be confusing; therefore, I will use women of colour to refer to visible minorities and Black to refer to people of African descent. Black Feminist Thought will be used as a theoretical framework to address issues that involve women of colour and not just Black women.

2. **CANADIAN EDUCATED NURSE**: These are nurses who are educated as Registered Nurses in Canada and have achieved a Bachelor of Science Degree in Nursing.

3. **DEVELOPED COUNTRIES**: The term developed and developing countries have many political connotations to it; in other words, who says certain countries are developed and more advance than others? However, to move away from the political connotations, I will use the term developed to refer to countries recognized within the G8, which includes Canada, the United States, the United Kingdom, France, Germany, Italy, Japan and Russia. This is based on their economic wealth and positions within the global economy.

4. **DEVELOPING COUNTRIES**: refers to countries that have been categorized within the global economy as “poorer countries” and often as third world, or underdeveloped, such as the Caribbean, Africa, India, etc. Although the term is very debatable, it is only used to describe the economic disparities and global recognition of certain places.
5. **DIVERSITY:** This refers to both racial and cultural differences.

6. **EUROCENTRIC:** This term refers to seeing through a European perspective and culture. It also refers to European hegemony and knowledge as seeming superior to other groups.

7. **INTERNATIONALLY EDUCATED NURSE (IEN):** These are Registered Nurses who have received their qualifications in nursing abroad. They have come with the basics of an undergraduate degree in nursing and have had their qualifications recognized as equivalent to Canada’s undergraduate nursing degree. Some, however, had entered as RNs with a Diploma in nursing before the provincial government’s changes; therefore, IENs may also be nurses who have achieved their undergraduate degree in Canada, but had the Diploma in nursing and experience in another country rather than in North America.

8. **INTERNATIONALLY EDUCATED NURSE OF COLOUR:** Same as IEN, but these are nurses that are considered visible minorities according to Statistics Canada.

9. **NURSING LEADERSHIP:** Refers to registered nurses who occupy positions of leadership and a degree of power and authority. These nurses have to make decisions and may occupy management, supervisory or educator positions.

10. **RACE:** Race is a social construction and therefore carries multiple meanings in reference to who is using it. Race also entails the treatment of one group of people by another which encompasses power and control, and inequality in treatment by one group to another.
11. **RACIALIZED:** To label a group of people who were not labelled before. It has been criticized that it has been seen as used for racial identities and in extreme sense to dehumanize certain people.

12. **REGISTERED NURSE:** This refers to an individual who has graduated from an accredited college or university with an undergraduate degree in nursing or a degree from abroad that is recognized by a department within the university that verifies foreign credentials as the equivalent of a Canadian nursing degree. One must be then registered by the Provincial College of Nurses in order to practice as a Registered Nurse (RN). Presently all provinces, except Quebec, require an undergraduate degree in nursing. However, before 2005, it was not mandatory to have a degree in nursing; therefore, there are still nurses working as RNs with a diploma in nursing. These women are unable to work in leadership positions within nursing. This research will refer to those with an undergraduate degree in nursing (Canadian Nursing Association, http://www.cna-aiic.ca/en/becoming-an-rn/).

13. **RESOURCE-EXTRACTION COLONIES:** This refers to people of colour who were either Natives or taken different countries that were colonized by the British Empire. These countries wealth and means were used to further the British Empire and many immigrants of colour were shipped like cargo to such countries as manpower for their workforce. These countries include such countries as, the Caribbean, Africa and South Asian.

14. **ROLE OF POTENTIAL LEADERSHIP POSITION:** These are nurses that are not in management or supervisory positions, but are in occupations that allow them to potentially apply for these positions based on their length of experience and their further qualifications.
15. **SETTLER SOCIETIES:** This refers to the first White settlers who migrated to countries such as Australia and Canada. The countries they migrated to were once occupied by their own Natives and colonized by the British Empire. The White settlers took ownership of the countries and practiced their own Eurocentric culture. They continued as leaders in such countries even at the end of colonial domination after World War II.

16. **VISIBLE MINORITIES:** This term refers to people who are not White in colour or race, and does not refer to aboriginals. Statistics Canada lists those who are considered as visible minorities as Chinese, Filipino, Black, South Asian, Southeast Asian, Latin American, Japanese, Arab, Korean (Statistics Canada, 2012; http://www.statcan.gc.ca/concepts/definitions/minority01-minorite01a-eng.htm

17. **WHITE:** These are people who are not considered people of colour as defined by Statistics Canada. They are otherwise known as Caucasian, the majority originate from Europe. The word White, however, does carry political connotations as historically, some groups were not considered White (i.e. Italians, Hungarians), but are now considered Whites (Jakubowski, 1997).

18. **WOMEN OF COLOUR:** This term originates from the United States and refers to any woman who is non-White. Its aim is to give an alternative term in place of other titles that have been considered by some to be derogative, such as minority.
Ontario application requirements:

International nurses in Ontario must submit an application form and supporting documents to CNO to demonstrate they have met the seven criteria required to become a nurse:

1. Completion of an acceptable nursing or practical nursing program (or equivalent)

2. Evidence of recent safe nursing practice

3. Successful completion of a national nursing registration examination

4. Evidence of fluency in written and spoken English or French

5. Registration or eligibility for registration in the jurisdiction where they completed their nursing program

6. Proof of Canadian citizenship, permanent residency or authorization under the Immigration and Refugee Protection Act (Canada) to engage in the practice of nursing

7. Good character and suitability to practice, as indicated by the CNO’s Declaration of Registration Requirements and a Canadian criminal record synopsis. For additional information see, College of Nurses of Ontario (2010).
Appendix 3

Introductory letter of Recruitment

Title:

Invitation to participate in a research study about internationally educated nurses of colour and their experiences of working in leadership positions within Canadian nursing.

Message:

My name is Nadia Prendergast and I am an internationally educated nurse living and working in Canada for 10 years. I am presently at the University of Toronto and carrying out research on the experiences of internationally educated nurses of colour who are working in leadership positions within Canadian nursing. If you are able to answer yes to the following questions below and are interested in participating in my study or have any questions then please contact me before March 30th, 2012 at either my home telephone number (9 -XXX -XXXX) or by email at nprendergast@utoronto.ca
Internationally educated nurse in this study will only include Registered Nurses and not Registered Practical Nurses.

1. Would you describe yourself as an Internationally Educated Nurse (received your nursing qualifications elsewhere other than Canada)?

2. Would you consider yourself a woman of colour (also called a visible minority)?

3. Do you have an undergraduate degree from another country?

4. Did you have to update your qualifications to a Canadian nursing undergraduate Degree?

5. Do you presently or have you previously occupied a position of leadership, or potential leadership within Canadian nursing within the past 12 years?

6. Do you come from a country that was once colonized by the British Empire or have parents from an ex-colony, but you were from the UK (e.g. India, certain parts of the Caribbean, the U.K., Africa, etc.)?

If you do not fit the description above, but know someone who does, please forward this letter to them. Thank you.

Yours Sincerely,

Nadia Prendergast (March 15, 2012)
Hello Participant,

My name is Nadia Prendergast and I am a PhD Candidate at the Ontario Institute of Studies in Education at the University of Toronto. I will be working on my final dissertation that will be conducted under the supervision of Professor Jamie-Lynn Magnusson. My research is entitled, ‘The Multicultural Policies: Identifying the Dialectic of the “Ideal Type Within The Practice of Canadian Nursing.”’ It will explore the experiences of internationally educated nurses (IENs) in light of equitable practices brought about by multiculturalism policies. However, the apparent existence of an ideal type within nursing appears to hinder equality within its practices. Therefore, this study will investigate whether IENs identify the existence of the ideal type in their nursing experience within Canada and if so, it will examine how this has impacted their nursing practice. The study will also examine the role multiculturalism policies have played within nursing practice. The findings from this study will be used to assist those involved in influencing policies and nursing curricular designs to address the needs of the voices of IENs in their decisions. The interviews will focus on IENs as yourself and give you an opportunity to share your experiences. You will be interviewed alone and the interview will be audio-taped with your consent. The interview is expected to last no longer than an hour. All information will be kept confidential and you will not be identified in the research. Pseudonyms and altered circumstances and locations will be used to protect your identity. You have the right, at any time, to withdraw from the study or
refrain from answering any questions asked in the interview without giving an explanation. This will in no way affect your rights or compromise your confidentiality and anonymity. Likewise, all data collected from you will be deleted from the studies. I plan to interview ten participants and once the information has been transcribed, I will contact you by phone or email to arrange for you to receive a copy of your transcript for you to read. This will give you the opportunity to make any changes you wish to the transcript or if you wish to withdraw from the study. Once you have agreed for your transcript to be used in the study, you will have a week to decide if you wish to withdraw from the study or make any further changes to the transcript. Should you choose to make any changes or withdraw at this time from the studies, your rights will not be affected, your confidentiality and anonymity will be protected, and all information gathered at this point will be deleted from the findings.

For the interview, semi-structured questions will be used. To protect your identity and maintain confidentiality, all digital data will be encrypted in line with the University of Toronto’s policies. The interviews will be held at either your home or a local coffee shop/library where we can book a private room which will be according to your individual choice. All information (audio tapes, transcripts, rough hard copies etc) will be securely locked and stored, in a cabinet drawer in my home, and only my supervisor and I will have access to the data. After 5 years all information will be safely destroyed by shredding and recycling. If you voluntarily decide to participate in this study, you will in no way be judged or evaluated for your honest contribution to the study and neither at any time will you be at risk of harm.

If there are any issues that arise during the interview that mention or allude to harm toward any individual; this will also include reasonable suspicion of child abuse, or intent to cause serious harm to oneself or another, or other duties that might relate to other registered health care professionals. I am obliged to report malpractice or sexual abuse by a registered health care professional.

As the study focuses on a specific group of nurses, there is an inclusion/exclusion criteria outlined within the introductory letter of recruitment which you will have to have met to be a participant in this study. There is also the possibility that based on the research, I will submit my study to be published and presented at conferences. For this reason I wish to assure you that your identity will be protected and kept confidential. As a gesture of appreciation for your participation into this research, a Subway meal gift card of $10 and travel tokens (if you have incurred any costs
for travel to and from the interview) will be given to you at the end of the interview. If, however, you withdraw from the interview or from answering any questions, you will still be presented with travel tokens (as required) and a Subway meal gift card as a gesture of thanks.

Once you have signed the Letter of Consent, you may keep a copy of the Letter of Consent for your personal records. If you have any questions about the study, please call me on phone or email me at, or alternatively, you can contact my thesis professor, Professor Magnusson by phone or by email (contact details given at the end of this letter).

If you have any questions related to your rights as a participant in this study or if you have any complaints or concerns about how you have been treated as a research participant, you may contact the Ethics Review Office at ethics.review@utorontol.ca or 416 946 3273. If you would like to participate in the study, please return your signed consent in the envelope provided by April 15th.

Thank you.

Nadia Prendergast, PhD Candidate at OISE/UT  Professor Jamie-Lynn Magnusson
Theory and Policy Studies Department  Dissertation Supervisor
The Ontario Institute for Studies in Education  Ontario Institute for Studies in Education
University of Toronto, 6th Floor, room 6-134  University of Toronto,
9-XXX-XXXX  416-923-6641 x2216
252 Bloor Street West,  252 Bloor Street West,
Toronto, Ontario, Canada M5S 1V6  Toronto, Ontario, Canada M5S 1V6

nprendergast@utoronto.ca jmagnusson@utoronto.ca

Nadia Prendergast (March 15, 2012)
Appendix 3

Please tick the following:

Do you wish to participate in this study? Yes___ No____

If yes, please complete the information below, fold your paper and return it to me in the stamped address envelope provided or complete it by email and sign it at our first interview meeting.

I consent to participate in the study entitled “The Multicultural Policies: Identifying the Dialectic of the “Ideal Type Within The Practice of Canadian Nursing.”

__________________________________              ______________________
Nurses’ Printed Name                                                             Date
Nurses’ Signature

I consent to being audio-taped when interviewed.

____________________________
Nurses’ Signature

If you wish to have a copy of the research findings, please tick  ______

In order to contact you about the interview can you complete the following information:

Contact number __________________________ and/or email __________________________

Nadia Prendergast (March 15, 2012)
Hello Participant,

My name is Nadia Prendergast thank you for contacting me about your expressed interest in participating the research I hope to conduct on the experiences of internationally educated nurses (IENs). Well let me first tell you more about myself and the research. I am a PhD candidate at OISE, University of Toronto, in the department of higher education. For my dissertation, I will be exploring the experiences of internationally educated nurses (IENs) of colour in the practice of Canadian nursing. I will be addressing the issues of equity and equality, in light of multiculturalism and the concept of the ideal type nurse. Upon completion of my research, there is the possibility of publishing the findings. I would appreciate if you could volunteer to participate in this research, which will involve a semi-structured interview. The interview will centre on women of colour as its participants who are internationally educated nurses. You will be interviewed alone and the interview will be audio-taped with your consent. The interview is expected to last no longer than an hour. All information will be kept confidential and in no way will you be identified in the research. I am expecting to interview ten participants and once the information has been transcribed, I will contact you and arrange for you to receive a transcript of the interview. I will give you time to read your transcript and give consent to use it in the study. A further week will be given to you if you wish to make any changes. After the week, no further changes will be made.

The questions that will be asked in the interview will focus on the experiences of IENs of colour in leadership positions within Canadian nursing. If you choose to participate in this study and if you find any of the questions upsetting or uncomfortable, you may stop participating or
refrain from answering any questions whenever you wish, and no explanation will be required of you. All of your data will be safely destroyed and not included in the study findings if you wish to withdraw at anytime. The interviews will be held at a safe place according to your individual choice, such as your home, a local library or coffee shop with a private meeting room. All information will be kept securely locked, with no reference to your name or any other detail that could potentially identify you. After 5 years it will be safely destroyed. If, however, your information is needed for further research, you will be contacted for permission to use your work. The study will be conducted under the supervision of Professor Magnusson at OISE/UT her email address is: jmagnusson@oise.utoronto.ca (416-923-6641 x2216).

Do you have any questions about the study? Do you need some time to think about participating? Please contact me in a few days after you have made your decision and we can arrange a suitable time to meet… my contact address is:

Nadia Prendergast PhD Candidate at OISE/UT

Theory and Policy Studies Department, The Ontario Institute for Studies in Education

University of Toronto, 6th Floor, room 6-134, 252 Bloor Street West, Toronto, Ontario,

You can also call me at a later time on 9xxx-xxx-xxxx or email me at, nprendergast@utoronto.ca or if you have any questions related to your rights as a participant in this study you can contact the Ethics Review Office at ethics.review@utorontol.ca or 416 946 3273.

When you indicate your interest, I will contact you and we will arrange to meet. I will also bring the letter of consent for you to sign that you understand what we have discussed. Thank you for your assistance.

(Nadia Prendergast March 1, 2012)
Appendix 3

Semi-structured Questions

1. How long have you been living in Canada?

2. What were the reasons for you coming to Canada?

3. When you came to Canada, what was your experience in trying to find a job in nursing?

4. Describe your experiences as an internationally educated nurse of colour practicing within Canadian nursing from the time you started until now.

5. Canada was the first country to have a multiculturalism policy. When you hear the word multiculturalism, what does it mean to you?

6. Have you ever heard of the term, the ideal type? What does it mean to you?
One writer described it to mean that in nursing there is an ideal type of nurse, she is White, middleclass and heterosexual. The argument she presents is that unless someone fits those criteria she will feel excluded within nursing. What are your thoughts and experience on this view?

7. As you are in a position of leadership, or a position that offers opportunities for leadership, explain how the following have impacted your position today,
   - Multiculturalism (positively/negatively)
   - The ideal Type (positively/negatively)

8. As a woman of colour, how have the following supported or not supported your journey to the position of leadership that you now occupy?
   - Multiculturalism (positively/negatively)
   - The Ideal Type (positively/negatively)

9. Are there any changes that should be made in Canadian nursing practice to produce a more equitable treatment for nurses? Give reasons for your answers

(Nadia Prendergast March 1, 2012)