Ethnic Imprint? Career Conversations with Indian women in New Zealand

Edwina Pio

AUT University, Auckland
edwina.pio@aut.ac.nz

Abstract

This paper seeks to explore the multi-textured career experiences of ethnic minority Indian women in New Zealand. Indians currently make up 2.46% of the population of New Zealand, and Indian women number 51,648 based on the 2006 census. Utilizing information from ten in-depth semi-structured interviews as the data set, the career trajectory of Indian women in the medical professions is described and analyzed, through the lens of scholarship pertaining to ethnic minority women and careers. Detailed conversations with the ten women are foregrounded against a background of interviews with one hundred Indian women across New Zealand. Tentative conclusions point to the success of the bridging program introduced for nurses, the ongoing dilemmas for doctors who were trained overseas, and the continuing impact of visible diversity discriminators in the client/professional and employee/organisational relationship. The paper’s contribution lies in highlighting the tensions and paradox of the ethnic imprint through ‘otherness’ in New Zealand.

Key words

Career, ethnicity, Indian, medical profession, New Zealand, ‘otherness’, women

Introduction

The population of New Zealand (NZ) based on the 2006 census consists of 4,027,947 individuals (Statistics NZ, 2006). Within this population are those of Indian ethnicity form 2.46 percent of the population. Indian women in NZ number 51,648. A number of these women who identify with the Indian ethnicity have been born in New Zealand and are third and fourth generation Indians. Indian women resident in NZ, have been born in countries such as India, Fiji, South Africa, the United Kingdom and Zimbabwe. Indians are believed to have been in New Zealand since the 1800s. The pioneer Indian men initially worked as scrub cutters, drain diggers, brick layers and water side workers, and later in market gardens and dairies. The early Indian women settlers were primarily housewives, though they also helped in the market gardens, and later in dairy shops. In the 21st century a number of Indian women work in the medical profession as doctors, nurses and pharmacists. Please see Table One: Indian women in Health care, Census 2006, below.
Table One: Indian Women in Healthcare, Census 2006

<table>
<thead>
<tr>
<th>Industry</th>
<th>Indian Women</th>
<th>% of Indian Women</th>
<th>Non Indian Women</th>
<th>% of Non Indian Women</th>
<th>Total Women in Industry</th>
<th>% of Women in Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>1,263</td>
<td>5.64%</td>
<td>34,032</td>
<td>3.957%</td>
<td>35,295</td>
<td>4.00%</td>
</tr>
<tr>
<td>Medical and Other Health Care Services</td>
<td>879</td>
<td>3.92%</td>
<td>44,166</td>
<td>5.13%</td>
<td>45,045</td>
<td>5.10%</td>
</tr>
<tr>
<td>Residential Care Services</td>
<td>702</td>
<td>3.13%</td>
<td>25,362</td>
<td>2.95%</td>
<td>26,064</td>
<td>2.95%</td>
</tr>
</tbody>
</table>

Source: Ethnic Group (Total Responses) (1) and Sex by Industry (ANZSIC06 V1.0) for the Employed (2) Census Usually Resident Population Count Aged 15 Years and Over; Table 8, 2006 Census of Population and Dwellings Ref EWJ 18636

In the developing world, of which NZ is a part, there seems to be a growing need for medical personnel, particularly since many of these countries have ageing populations. Moreover these countries do not seem to have the requisite numbers of medical personnel in their own populations. Hence, countries such as NZ have started seeking such personnel from other countries, including those classified as the developing countries, such as India. The OECD notes that in recent years there has been fear that there will be a brain drain of foreign doctors and nurses due to ageing populations in OECD countries (OECD, 2007). In New Zealand, like in Ireland the United Kingdom, Canada and Australia, the percentage of foreign-born doctors was more than 30% and in Australia, Switzerland and New Zealand the percentage of foreign-born nurses was more than 20%, at the turn of the century (OECD 2007, Aiken et al., 2004).

This qualitative study focuses on Indian women doctors and nurses in New Zealand and includes first, second and third generation Indians. The paper is structured as follows: the theoretical backdrop is presented, next the methodology, then the findings and discussion and finally implications for career professionals.

Theoretical backdrop

The etymology of career can be traced to the Middle French carrière, from Old Provençal carriera street, from Medieval Latin carraria road for vehicles, from Latin carrus car (Encyclopaedia Britannica, 2008). The words connotes a course, passage, an encounter, a profession, a field for or pursuit of consecutive progressive achievement especially in public, professional, or business life which affords opportunity for progress or advancement in the world, a profession for which one trains and which is undertaken as a permanent calling (Encyclopaedia Britannica, 2008; Oxford English Dictionary, 1989). Related terms included career girl/woman or one who works permanently in a profession, and careers...
master/mistress or a schoolteacher who advises and helps pupils in choosing careers (OED, 1989).

Career has also been seen as a patterned sequence of occupational roles through which individuals move over the course of a working life, implying increased prestige and other rewards, although not excluding downward occupational and social mobility (Oxford Reference Online, 2005). The word career has evolved over the years and today there is a body of scholarship around career studies with various dimensions of this concept given greater or lesser importance. Career literature has drawn extensively from the fields of anthropology, economics, ethnic studies, geography, history, management, politics, psychology, sociology and women’s studies. Hence when career is treated as an interdisciplinary subject it can be considered as a tapestry of interwoven threads (Colin, 2007). In a broad sense careers signify a pathway and movement along it (Colin, 2007), and are an unfolding sequence of events over a person’s work life (Arthur, Hall and Lawrence, 1989).

Five dialectic metathemes in career theory have been described as (Moore, Gunz and Hall, 2007): individual agency versus social determinism, process versus fit, fit for whom, i.e. the individual/organization, career as a social phenomenon/individual life story, and career scholarship as theory/providing help for individuals with their careers or vocational research. A kaleidoscopic perspective sees careers as always careers in context and includes the importance of ethnicity as a contextual component along with the consequences of homophile reproduction (Mayrhofer, Meyer and Steyer, 2007). These authors stress the importance of contextual variables, the use of various theoretical angles to increase understanding, a balanced approach between contextual and individual/organizational variables, and finally more research for topics in the shadow for example micro-political power games are stressed.

Some authors view careers as subjective or an “individual’s own interpretation of his or her career situation at any given time” (Khapova, Arthur, Wilderom, 2007, p. 115). Yet, career studies may be more a “perspective on social enquiry”, with a central concept being the effect on people of the passage of time (Gunz, Peiperl, 2007, p. 4). Hence career issues for the socially marginalized (Prasad, D’Abate and Prasad, 2007) focus on the sense of being away from the centre/mainstream and hence being deprived of the full participation and rewards due to being on the margins. There may also be the issue of stigmatization, otherness and subalternity for individuals in the margins. Such ‘othering’ conditions are “always socially constructed and discursively produced” (Prasad et. al., 2007, p. 171), but may be a shifting phenomena dependent on the zeitgeist of a particular period.

No doubt a key issue in the movement of health professionals is the recognition of their qualifications, skills and experience in tandem with ensuring appropriate quality and standards in the delivery of health care in the receiving countries. Host countries often have at least twice the number of nurses for their population than the source or sending countries (Aitken et al. 2004). However in source countries, factors like “poor wages, economic instability, poorly funded health care systems, the burden and risks of AIDS, and safety concerns”, push nurses to leave developing countries (Aiken et. al., 2004, p. 71). And the
higher wages, better quality of life and greater opportunities for their children, are attractive factors for pulling nurses to developed countries (Aiken et al., 2004). The OECD and extant scholarship suggest the need to increase training of health workers in developed countries, particularly where shortages exist, in order to attract sufficient numbers of the local population, to balance the movement of health workers globally (OECD, 2004; Aiken et al., 2004; Clinton et al., 2004).

In New Zealand, in the 1990s research indicates that a number of overseas trained medical doctors “were subjected to structural discriminator practices of the medical Council of New Zealand by which qualified medical doctors from non BASIC (Britain, Australia, South Africa, Ireland and Canada) countries were not allowed to register as medical practitioners in New Zealand” (Selvarajah, 2004, p. 5). However, based on the experience of the 1990’s the New Zealand authorities, both in immigration and in the medical field, have made a number of changes in order to speed up the process of recognition and utilization of the skills and experiences of health care professionals. For example foreign trained nurses need to go through a bridging program which assesses their competence (Nursing Council, 2005).

Yet international studies indicate that there is potential for certain career structures, such as rewards and workload to systematically and structurally disadvantage ethnic minority nurses and doctors (Oikelome and Healy, 2007; Gay and Bamford, 2007; Duffin, 2002).

Methodology

The methodology stems from the qualitative genre wherein a narrative approach has been utilized which emphasizes in-depth contextualized views of the perceptions and experiences of the participants in the study (Gartner and Birley, 2002). The researcher is a woman scholar of colour and hence has a strong consonance with the ethnic minority women in the study (Bhopal, 1995). Ten Indian women participated in this study – four doctors and six nurses. All the Indian women were legally resident in New Zealand and all had received their qualifications through English as the medium of instruction. The age range varied from 35 to 55 years. Access to these women was obtained through personal contacts, snowballing as well as contacts with the New Zealand Indian Association.

In-depth semi-structured interviews were conducted with an exploration of the following twin areas: entry into the world of work and career progression. The interviews were conducted at a mutually agreed upon place and time, and lasted from between 45 to 100 minutes. The interviews were taped and transcribed, along with extensive field notes, as well as a journal recording the researcher’s observations and reflections. Data analysis consisted of coding and searching for patterns, along with units of analysis which included: qualifications, family, organization, entry into the New Zealand medical field, training and development, career advancement. The analysis was conducted against the backdrop of a total of one hundred Indian women who have been interviewed in New Zealand over a period of six years.
Findings and Discussion

The interviews resulted in a layered multi-dimensional perspective that seems to be the result of the zeitgeist of the times and include individual and institutional factors with reference to entering work and career advancement. In exploring entry into the world of work, the women spoke extensively about their qualifications. For example *Leela*, a doctor, who was born in New Zealand, said: I was determined to be a doctor, but this meant that I would have to leave home to study (Auckland to Otago)...for an Indian family this was quite difficult as daughters are not generally allowed to stay away from home...however I have a number of New Zealand qualifications today under my belt, have worked in the hospital system and now have my own clinic...”

*Sheela* who was also born in New Zealand and was one of the first Indian nurses in New Zealand remembers “the inclusiveness and sharing of cultures with the Kiwi nurses and doctors and learning about Christmas puddings...” The family plays a major role in the Indian patriarchal system, particularly for girls, however being a doctor or a nurse also has status implications. Such implications need to be viewed against the backdrop of Indian immigration to New Zealand and the prevailing stereotype that Indian women generally work behind the counter in a corner dairy or convenience store (Pio, 2008). Indian women entering the medical professions tend to increase their standing in the community, and hence it is possible that this made it easier for the parents to give them permission to leave home.

Having New Zealand qualifications seems to be an important factor in the level of comfort that organizations have in recruiting doctors and nurses. Overseas qualified doctors seem to have a rather challenging time in getting their qualifications certified in New Zealand. For example, *Maureen*, born in India with Indian qualifications and more than seven years of practice as a doctor in India, said: I had to sit the IELTS exam twice despite the fact that the first time I had scored at the levels required...but I was unable to do my medical exams in NZ within two years and so I was told that my first scores on the IELTS were no longer valid as the time period had elapsed and had to sit this again...it was awful...” In a New Zealand study, reasons for not finding work, as given by medical professionals include: no local experience, too highly qualified and qualifications not suitable (Selvarajah, 2004). For these medical professionals, “their inability to normalise their lives and the frustration of not being able to practice their chosen vocation was causing personal problems such as feelings of inadequacy and hopelessness” (Selvarajah, 2004, p. 68).

*Sushila*, trained overseas as a doctor and was born in India, but she says “I did not have the energy to sit for the requalification in NZ, so I tried to get a job – any job – in the health care system, even as a lab technician, but was not successful...I became very disillusioned...later I secured a job working in a crèche...” It seems apparent that this doctor had to fit into the system and that the details of her specific case were largely ignored. It is possible that this was the result of ‘otherness’ wherein difference or strangeness connotes avoidance and/or incompetence, and the territory of the specific industry is zealously guarded.
Prafulla who was born overseas, but qualified in the UK as a doctor said: I had to secure a job in a rural location in NZ...the patients when they see my Indian name hesitate, until I tell them I have qualified in the UK and they hear my accent...” This extract indicates the importance given to the English language and associated connotations as for example a non-Anglo-Saxon name, which seems to automatically connote that the individual cannot speak/understand English, or have the appropriate level of competence. With reference to patients needing to be reassured regarding the competence of an ethnic minority professional, it is possible that this is the result of discursive practices (Prasad et. al., 2007) over a long period of time which tends to marginalize ethnic minority women. The Indian nurses also expressed the same hesitation which patients initially seem to have on seeing that they are Indian. However with the recent dearth of nurses and doctors available in New Zealand this comfort level is gradually stretching to include overseas qualified doctors and nurses.

The fact that discursive practices are dependent on demand and supply seems to be evident in the experiences of recently recruited Indian nurses (OECD 2007, Aiken et. al., 2004). Mrunal for example who was born and trained in India as a nurse says: I am very happy here...the bridging programme is wonderful and my colleagues in the hospital are helpful...we are well paid and I am encouraging my nurse friends in India to also apply for positions here in New Zealand.” This seems to be the general experience of these Indian nurses who are full of praise for the Bridging system and feel that they are well appreciated by their supervisors as well as patients and markers like accent and skin colour are downplayed as they feel that Indian nurses have a more caring and gentler approach to the patients and hence are often asked for by name. Many of the Indian nurses also tend to look out for the other Indian nurses and mentor them.

Successful completion of a competence assessment programme enables an individual nurse to demonstrate his/her ability to meet the Nursing Council of New Zealand’s competencies for his/her scope of practice, and overseas nurses may be required to complete a programme before registration in New Zealand (Nursing Council, 2005). Overseas registered nurses or nurse assistants seeking entry to the programme require written notification from the Council of the requirement to complete a competence assessment programme before registration. Approved English language assessments consists of the IELTS³ with a score of at least 7.0 in reading, listening, writing and speaking respectively; Occupational English Test (“OET”) with a B band in each section; a pass in the Commission on Graduates of Foreign Nursing Schools (CGFNS) examination; as well as demonstrating their ability to communicate effectively for the purpose of practising within their scope of practice. Mobility of health care professionals coincides with the mobility of highly skilled professionals, but for health workers relative pay in countries of origin and working conditions play a major role (OECD, 2004).

It seems apparent from this study that the New Zealand authorities seem to have the right equation for Indian nurses. It is also possible that the changing need for nurses ensured appropriate policies and their implementation. Needless to add, a proactive stance for jobs, through prediction of trends before shortages hit, would go a long way to ensure demand and
supply of employees and employment. In this context the long term skills shortage list is a strategic step in the right direction.

In considering career progression, the ethnic factor seems to come into play as some of the participants indicated that they are given less opportunities in terms of training and development and often have to argue their way through with their managers for such opportunities, after being by-passed a number of times by junior employees. As one participant said: “We are given the less important jobs...the paperwork comes to us...sometimes they are not even prepared to give us a chance...but we are of course committed to our profession”. Yet the overseas trained doctors commended the new things they learnt in the New Zealand health care system, particularly the easy access to expensive tests for patients, which “would only have been used in an emergency situation in India as affordability would be a big issue”. Moreover as one participant said, “Human life is given much more importance here and the patients are encouraged to discuss their situation and understand their medication”. One of the nurses said: “We are happy to share our experiences, because sometimes we have encountered situations with patients which our seniors have not, even though we have junior posts...the whites tend to move faster in the organization even though they have less experience than us...but in any case we love nursing”.

Overseas doctors tend to struggle to gain employment, as well as having a higher possibility of inequities within and between career grades (Oikelome and Healy, 2007). Unequal opportunities also exist in career advancement and skill development and training for overseas black and ethnic minority nurses, based on a study done in the National Health Service in the UK (Alexis and Vydelingum, Robbins 2006). Perceived barriers for ethnically diverse students indicate that while some of them did not experience prejudice and discrimination from their nursing teachers, this was encountered from staff and clients in the hospital during their practical sessions, and sometimes from their classmates, with feelings of alienation and loneliness and difficulty with the English language (Amaro, et. al., 2006; Gardner, 2005; Fletcher et. al., 2003; Seago et. al., 2005; Jimenez-Cook and Kleiner, 2005). Factors which influenced success among ethnic minority nursing students include self motivation and determination, the importance of teachers, peer support and ethnic nursing student associations (Amaro et al, 2006). Scholarship suggests the need for faculty education is stressed not only for success rates among ethnic minority health professionals, but also to recruit such individuals to care for growing numbers of ethnic minority populations (Amaro, et. al., 2006; Dennis. 2005; Wallen et. al., 2005; Iganski et. al., 2001; Gerrish, 1995; Grainger, 2006).

Overall the findings from this study point to the following themes: firstly a deep commitment to the medical profession, secondly the challenges of the registration process for doctors, thirdly the success of the bridging system for nurses, fourthly a sense of satisfaction to work in New Zealand coupled with varying degrees of frustration with career advancement possibly due to visible diversity discriminators and discursive othering. This issue of ‘otherness’ interesting has been a recurrent theme in the interviews with one hundred Indian women at work across NZ (Pio, 2008).
**Implications for Career Practitioners**

While this study is a small exploratory one, there are a number of implications for career practitioners. Firstly, there is the importance of understanding, at a deep level, the Indian patriarchal and caste system, in other words, the cultural background of the client and the client’s community. This would include some understanding of the legacy of Indian migrants in NZ. Secondly, being empathetically aware of the embeddedness of colonialism, which for example, results in the privilege of whiteness; English being the language of Empire, hence English as the medium of instruction in a number of educational institutions in India.

Thirdly, NZ as a country is becoming less white and less young, hence ethnic minority individuals will continue to be a part of the fabric of NZ life, due to miscegenation and migration. Fourthly it is essential for career practitioners to have an understanding of the pre entry qualifications and the bridges and bottlenecks in the NZ certification process for medical personnel and the need for appropriate mentoring, both in gaining professional qualifications and in organizations.

Finally, it is important that there is an awareness and sensitivity to discursive and socially constructed stereotypes of ethnic minority women. Scholars argue that “the business case for equal opportunities and positive action requires to be underpinned and bolstered by moral arguments for social justice if it is not to be swept away by changes in circumstances...such change requires commitment from those in organizations with the power to enforce policy change, monitor performance and deploy rewards and sanctions” (Ignaski et. al., 2001, pp. 313-314). In addition, long term thinking suggests the need to create leadership pathways for ethnic minority individuals, to serve as role models and mentors, to attract individuals to health care professions (Villarruel and Peragallo, 2004; Fuller and Bridgman, 2004; Golightly-Jenkins, 2003).

Career conversations with Indian women in NZ foregrounds the realities of these women in the medical profession, and highlights the pervasiveness of ethnicity’s permanent embrace in visible diversity discriminators. The ethnic imprint results in ‘othering’ and in the case of NZ does not generally connote competence and capability for professional Indian women. This is in sharp contrast to countries such as the USA where for example Asian Americans (which includes Indians) are considered the model minority (cf. Wong, Lai, Nagasawa and Lin, 1998). While being a ‘model’ has its own repercussions, there is a compelling requirement for individuals and organizations in NZ to rethink their constructs around ethnic minorities, to further enhance the country’s movement towards a truly equitable society where there is a greater match between rhetoric and implementation-in-action.
References

(Available from the author on request)

---

1 Specific health care industries have been selected for this table and the percentages are based on: Total Indian women (22,395 =100%); Total women in Industry (883,008 =100%); Total non-Indian women (860,813 =100%)

2 Data on Indians in NZ based on the 2006 census have been specially prepared for the author by Statistics NZ. The percentage calculations however have been done by the author.

3 International English Language Testing System (IELTS)