

The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India

BARBARA DICICCO-BLOOM, PhD, RN

University of Medicine and Dentistry—Robert Wood Johnson Medical School

The purpose of this article is to describe the experiences of a group of immigrant women nurses regarding their life and work in a culture other than their own. Semistructured, in-depth interviews were conducted with nurses who were born in Kerala, India, educated in India, and are actively employed as nurses in the United States. The participants told stories that were about (a) the challenges of living between two cultures and countries, (b) the racism they experience, and (c) their marginalization as female nurses of color. This study underscores the continuing inequities of our health care system. Our challenge is to establish a more just and effective environment for those who provide care as well as those who receive it.

Keywords: race; gender; Kerala; nurses

I have not been treated badly [as an Asian Indian], but I know I am not treated the same as the other [White] nurses. . . . Nobody learned my name for 4 months when I first came, and when they did . . . they shortened it and pronounced it wrong. I finally stopped correcting them. . . . I think I am the hardest working nurse on the floor, and three times, my supervisor has requested a promotion for me, and yet, each time someone else has been promoted instead who I knew, and everyone knew, did not deserve it. They were all White. Even my supervisor thought this was wrong. . . . People were telling me, "How come she got it instead of you." That made it worse.

—A participant

One of the challenges facing our health care system is the social inequity within our society that impinges on the daily lives of minority health care providers, including nurses.

Although the racism toward minority nurses has received little attention in the United States, there is a small but growing literature among Canadian scholars that focuses on the occurrence of racism among nurses (Calliste, 1996; Cry & Goodyear, 1999; Hagey et al., 2001). Despite the evidence that racism is pervasive in our health care system as well, there is little information about the experiences of immigrant nurses as members of diverse groups in the United States. Among the growing number of minority health care providers are Asian Indian nurses. Although there are no specific statistics on the number of nurses from India, about 25% of the 28.5 million immigrants living in the United States are from Asian countries (United States Census Bureau, 2001). This study focuses on the results of interviews with a small group of nurses from Kerala, India, for the purpose of gaining knowledge about their experiences as nurses, non-White women, and immigrants.

In 1996, a total of 915,900 immigrants were admitted into the United States, of which 493,142 were women (Kramer, Tracey, Ivey, 1999). Asian Indians are now the third largest group (44,859 in 1996) coming to the United States (U.S. Immigration Service, 1979, 1996). New Jersey is one destination for Asian Indian people. Between 1990 and 1997, 36,331 immigrants from India settled in New Jersey (United States Census Bureau, 2000).

Large numbers of nurses who were born in and received their early education in Kerala traveled to other Indian states to obtain their professional degrees, after which they emigrated all over the world. Kerala boasts the highest literacy rates in India (Franke & Chasin, 1994; "Professor Is There," 1999) and maintains highly progressive educational programs that produce highly competitive émigrés to the United States and Europe (Franke & Chasin, 1994). Nurses have been one of the largest emigrant groups from India to the United States, and many have settled in Pennsylvania and New Jersey.

LITERATURE REVIEW

There is a significant body of health-related research on women immigrants with the focus on gender-related health concerns (Im & Meleis, 1999, 2000; Jones, Jaceldo, Lee, Zhang, & Meleis, 2001; Meadows, Thurston, & Melton, 2001). Other studies focus on the challenges faced by professional and health care institutions that educate and employ immigrant nurses (Brink, 1990; Grossman et al., 1998; Malone, 1997; Oulton, 2001; Torres & Castillo, 1997; Yam & Rossiter, 2000). The focus of these challenges is generally not on advocacy for immigrants but rather on the struggle of institutions to maintain an effective workforce and to train competent nursing personnel.

An issue not addressed in the literature is the experiences of immigrant women of color and immigrant women nurses of color as victims of racism. This literature also neglects the experiences of women's lives outside of nursing. The fact of racism based on place of origin and skin color are interpreted daily for Asian Indians in the United States as they are for many immigrants. Indians are socially constructed as people of color, and they are vulnerable to ethnic discrimination (Kramer et al., 1999; Mediratta, 1999).

In the context of increasing demographic diversity, in-depth information about the experiences of individuals from various minority ethnic groups is necessary to revise our health care system in ways that support cultural sensitivity and comfort for all health care system participants. This study explores the racial and gendered experiences of 10 Asian Indian immigrant women nurses. Their stories are not necessarily generalizable to the larger group of nurses from Kerala or to other immigrant populations. They are, however, examples of manifestations of "othering," which are demonstrated every day in various ways by individuals who perceive themselves as members of the dominant culture when interacting with those they perceive as "different."

The choice of immigration affects the personal and professional lives of individuals, and most of the theoretical frameworks that explain the experience of immigration portray it as a negative experience. For example, immigration is described as (a) an ongoing transition resulting in disequilibrium (Im & Meleis, 2000; Meleis, Sawyer, Im, Messias, & Schumacker, 2000; Schumacher & Meleis, 1994) and/or (b) the cause of marginalization with the negative attribution of "being different" (Halls, Stevens, & Meleis, 1994). A closer look at most of the health research on immigrant women subtly portrays the participants as vulnerable; this portrayal, however, is based on the action of immigrating and the fact of their gender as opposed to the manner in which a society responds to these designations (Cervantes, Keith, & Wyshak, 1999; Hyman & Dessault, 2000; Im & Meleis, 2000; Lalchandani, MacQuillan, & Sheil, 2001; Small, Rice, Yelland, & Lumley, 1999). The literature contributes to our knowledge about immigrant women's health experiences, but for the most part,

it portrays linear patterns of identity based on the assumption of individual agency. The literature does not address the context of the vulnerabilities of immigrant populations, because it does not focus on the politics of a society that marginalizes certain types of difference.

The issue of racism is also obscured by the fact that the literature about immigrant women and nurses' lives usually ignores the fact that during the last decade, most immigrants were socially constructed as non-White (United States Census Bureau, 2000). For example, work by Choudhry (1998, 2001) explores wellness issues among middle-aged Asian women and elderly Asian Indian women living in Canada.

Noting the complexity of the experiences of minority nurses is important to appreciate concurrently the impact of immigration status, gender, and race. According to Hegde (1998), separately studying the impact of these issues on women's lives results in reductionism or even erasure of the total experience of ethnic women. There is little health-related research focusing on immigrant women as complex persons with vulnerabilities as well as strengths and with lives intricately connected to both their country of origin and to the United States. According to Fine (1987), Davis & Fisher (1993), and Hegde (1991, 1998), women's lives are complex from the perspective that there is never just oppression along intersecting axes, such as race and gender, without the counterbalance of resistance. Furthermore, those who are oppressed may promote the same oppression toward others while they are fighting oppression themselves (Hegde, 1991, 1998).

This study attempts to explore how the inseparable axes of race, gender, and immigration status interrelate for a group of immigrant Asian Indian nurses who have come to live and work in the United States.

METHODS

Semistructured interviews with open-ended questions were conducted with 10 South Asian nurses who were contacted through a snowball sampling technique. The unstructured format allowed for a depth of exchange and a candor that enabled the women to talk freely about their lives and the challenge of living and working as immigrant women nurses in the United States. The methodological objective was to impose as little a priori categorization as possible that might limit the field of inquiry (Fontana & Frey, 2000). I met the nurses in their homes by their choice. My identity as a nurse, a mother, and a woman was central to the relational dynamics of the interviews. I was conscious of my position as a middle-class White woman. For reasons of our sameness and differentness, they were eager to speak with me. There was a rapport and an involvement that characterized our engagement as some of the issues they raised around motherhood, marriage, and nursing were also significant in my life. For the issues that were not similar, there was the opportunity and the

TABLE 1
Demographics of Nurse Participants (N = 10)

<i>Residence</i>	<i>Married Preimmigration vs. Postimmigration</i>	<i>Age</i>	<i>Home Owner</i>
New Jersey (<i>n</i> = 7)	Pre (<i>n</i> = 5)	40-44 (<i>n</i> = 4)	Yes (<i>n</i> = 9)
Pennsylvania (<i>n</i> = 3)	Post (<i>n</i> = 5)	45-50 (<i>n</i> = 6)	No (<i>n</i> = 1)

apparent enthusiasm to explain and to be understood. The conversations were initiated with one introductory question: "What is it like to be an immigrant woman and nurse in the United States?"

The process of obtaining participants was based on a snowball sampling. The initial contact was made with the South Asian Nurses Association in New York State. They gave my phone number to their contact person—a nurse from Kerala—in New Jersey. She shared my phone number with a nurse friend from Kerala who was living and working in New Jersey. This nurse called me, and I set up the first interview. I did not interview the friends or family of interviewees but rather followed different leads that resulted in participants that did not know each other or were not otherwise related. The 10 participants all worked in different institutions and all had graduated with their nursing degrees from a hospital-based program in India before coming to the United States. This is the only type of education that was available in India at the time these women earned their nursing degrees. They were all middle income by their own report, and all but one owned their own home. They had been in the United States for 20 to 25 years. They all lived and worked in New Jersey or Pennsylvania near Philadelphia. They were members of intact nuclear families, and they all visited India at least every 3 years (see Table 1).

Although an effort was made to collect data with variation, the criteria for participation resulted in a homogeneous group based on the fact that all participants (a) were between 40 and 50 years of age (they immigrated between 1965 and 1985 when large numbers of nurses from India were recruited to ease the nursing shortage), (b) were all Christians (they stated that their religious affiliation reinforced a service orientation), and (c) were all married to men with "white collar" occupations. Twelve nurses were asked for interviews. Two offered to be interviewed if I would get permission to use their work time. I was not in a position to make this offer so they declined.

Sources of data included transcribed, tape-recorded interviews. I reviewed transcripts of previous interviews while I was in the process of collecting new data. The analysis involved an iterative process in which I collected and reviewed the data on an ongoing basis, looking for the reports of critical episodes when gender, race, and/or immigration seemed salient for the women participants. I then selected key cases for review with an expert in Asian Indian women's stud-

ies. Together, we analyzed the data, discerning and refining the patterns that were emerging regarding immigration, race, and gender. When recurrent patterns were evident, the full data set was reexamined for consistency and completeness.

FINDINGS

The dominant themes that emerged from the content analysis were (a) cultural displacement—a foot here (America), a foot there (India), a foot nowhere; (b) racial experiences/alienations in the work place and at home; and (c) intersections of categories—being a female nurse, an immigrant, and non-White. Writing text tends to concretize and order the descriptions of experiences in ways that may not reflect the superimpositions of themes when actually lived. Although I have created categories for the purpose of organization, gender, race, and immigration issues are intertwined throughout the interviews—especially in the final category—because of their inseparability from each other in these women's lives.

Cultural Displacement: A Foot Here, a Foot There, a Foot Nowhere

Most Asian Indian women follow their husbands to the United States; the decision to emigrate is usually made by the male partner (U.S. Bureau of the Census, personal communication, 2000). The pattern of the women in this study is different, however. They pursued their education with the intent of economic independence, and they were confident of success if they emigrated. Some of them emigrated after marriage and the others came to the United States and married later. In all cases, the women were highly motivated to emigrate either as single or as married women. As one nurse stated, "Sometimes you feel like you belong in two places at once and sometimes you feel like you don't belong any place at all" (a participant).

Case 1. Amini is a 43-year-old nurse, a wife, and a mother of two sons. She is the second oldest of six siblings, all of whom still live in India with her mother. She is responsible for orientation and education programs for nurses' aides in the hospital in which she has worked for 12 years.

Amini spoke at length about her close relationship with her father and how he supported her decision to attend nursing school. She described herself as different than other Kerala "girls" because she wanted a serious education and most of the girls she grew up with just wanted to get married. She discussed the difficulty she experienced in maintaining a

close relationship with her family because she has had such a different life than her siblings. She discussed that she does sometimes feel different as an immigrant in the United States, but her feeling of “distance” from her family of origin was worse. Amini described an experience surrounding her father’s death. She was in the United States when he died of a massive heart attack 10 years ago. The family went ahead and had the funeral without notifying her until 1 month after his death. They felt they were “protecting” her from feeling the need to come home for the funeral. Amini began to cry as she described the experience of finding out about her dad and the anger she still feels toward her mother and siblings. “I will never forgive them. They said that I had been away for so long. . . . They just thought it was better this way. How could they think that?” The feeling of loss was compounded by the fact that when she decided to go home to be with her family several months after her father’s death, the supervising nurse acted as if she did not believe her story.

Amini: Just because I am from India doesn’t mean I don’t have a father who died.

Investigator: What did your supervisor say?

Amini: She said, “You mean you lost your father all the way in India?” I said, “Yes, he died two months ago, and I would like some time off to visit my family.”

She gave me a strange look, and I felt like no one thought that I had a family just because they were far away. It made me feel so alone. I realized that they didn’t think I was human. Just because my home is on the other side of the globe, they didn’t think I was human. How could anyone lie about something like that?

Case 2. Theresa is a 49-year-old wife and mother of two sons and a daughter. She has worked as an operating-room nurse for the past 10 years at a local hospital. She is the second born and has seven siblings. Theresa came to the United States 20 years ago. Her description below of her relationship with her daughter reflects the shifting back and forth and the here/there of her interpersonal life between an adopted home and her home of origin. The split between what she tolerates from her daughter’s demonstration of new values and what she insists on for her sons reflects the rupture with the old country and conversely, a continuity with its values.

Theresa: I prefer to keep my own culture, but my daughter wants to change.

Investigator: What does that mean to change?

Theresa: If I tell her to select a boy from India to marry, it is difficult. She has seen boys selected from India who come here, and they want their coffee and they are demanding and she is not willing to do that.

She wants a boy who is Indian who was born here. The girls I want for my boys? I do not want a girl who has lived here all her life.

Investigator: So you do not want a girl for your sons that is like your daughter?

Theresa: (tears well up in Theresa’s eyes, but her jaw remains set). No, I do not. She cannot (represent) that Indian background. My sons must marry girls from back home.

You know, the bible says in Chapter 11 that the women has to cover her head and the man doesn’t have to. . . . Well, my daughter said “what does that mean?”

I said it is self-explaining. She doesn’t want to accept that. Indian women have a special place in the family and Christian women especially. She is trying to be independent. She comes on weekends but lives in her own apartment. She is a loving girl.

Investigator: And your sons?

Theresa: They have accepted their lot. They understand how it is.

Investigator: Accepted?

Theresa: They are not happy, but they will not go against me.

Although Theresa speaks about disappointment with her daughter’s choices, her actions support her daughter’s resistance to potential male dominance and oppression in marriage. Theresa welcomes her daughter home on weekends and later acknowledged that she helps her with her apartment rent. “My husband does not know about this.” Support of her daughter’s freedom is enacted in conjunction with the traditional limitations placed on her sons in relation to marriage.

Theresa’s experiences reflect her ambivalence about the norms and values of her new home and her daughter’s independence, and at the same time, they demonstrate her need to feel connected with the traditions of her home of origin through her sons. On one hand, she supports her daughter’s nontraditional behavior; yet at the same time, she requires her sons to accept more traditional norms for their marriages.

Both Amini and Theresa’s stories resonate with many of the stories told by participants, reflecting here/there conflicts that are the daily experiences of these women’s lives.

Experiences of Racism: Alienation in the Workplace and at Home

How Indians view themselves and how Westerners, both White and non-White, view them is complex.

Case 3. Ann is a 50-year-old wife and mother of two daughters. She has been an operating-room nurse at the same hospital for 15 years. Ann describes how she is treated at work.

Ann: There is the White nurse, and she will do things for her friends [White nurses]. They will give more freedom to their friends. If you have a Black nurse in charge, then you have Black freedom.

Investigator: Where does that put you?

Ann: These days, I think I am in the middle. I don’t get it [affiliation] either way.

Investigator: What do you mean?

Ann: I am never the top priority. Usually, the person in charge is White. I feel like I am treated better than the Blacks. White is the top, and Black is the bottom. I am somehow this blend.

In several instances the participants reported that their own experiences with racism were of small consequence compared to the pain and fear they suffered for their children.

Case 4. Meena is a 46-year-old wife and mother of two sons. She is a part-time in-service instructor of nurses' aides as well as an obstetrical nurse; she has worked at the same hospital for 15 years.

Meena's son had been accepted to medical school. He was invited to a friend's house on July 4th, and as he entered the driveway, several White boys, who were acquaintances at school, were setting off firecrackers. The police came as her son was exiting the driveway in his car. They stopped and handcuffed him, but they only questioned the other boys who were in possession of the firecrackers. The boys said that Meena's son had just come on the scene and had not been involved with the firecrackers. In spite of this, the police took Meena's son to the police station although he did not have any firecrackers on him. The other boys were left alone. The parent of one of the White boys was in the house at the time and was never made aware of the incident in her driveway. Meena began to cry and shake as she reported this to me, and we focused on this event and how she might handle it for the remainder of the interview.

Meena: I am afraid to fight them, but we have to prevent him from having a police record. I just do not know what to do? How do you get protection? It was not until my boys were teenagers that I realized that they are in danger. My neighbors have been wonderful, but other people . . . ?

Case 5. Teena is a 50-year-old wife and mother of a son and daughter. She has worked as a pediatric nurse for 26 years in the same hospital.

Teena is light skinned, and her husband is dark. Her daughter Neru is very dark skinned. Indian boys in the United States reportedly will not date her. She suffers from the racist and sexist responses of some male Indians who objectify women and pursue those who are light skinned even if they are dark so that their children will be light skinned. Teena predicted that her daughter would fall in love with the first man who loved her, in part because of her low self-esteem around the issue of her color. Teena's daughter is dating an Ethiopian boy with whom she is serious. Teena will not meet him or have him to the house. She does not know how to introduce the idea to her sisters and brothers that her daughter has become interested in a "Black boy."

Teena: I am close with my daughter and I trust her, but I don't know how to deal with my family. They would never understand what my life is like in the United States. I can't explain this to them. The boy is probably very nice, and I'd like to meet him. If I do, then I have to tell my family or it is like I am keeping a secret. I am really upset. I am very close to my family in some ways, and I don't want to hurt my daughter. She has been seeing him for a year and a half.

It is Teena's presumption that even though her daughter is dark, her family will see an African American partner for her as unacceptable based on his skin color and/or race. Teena is faced with experiencing first hand the pain racism has caused her daughter. She also faces the challenge of treating her daughter's potential partner fairly despite her family's value system. Her facial expression of profound helplessness during this part of the interview was totally in contrast to the self-described strong, independent woman who left her family in India and came to the United States to earn money and help support seven siblings back home.

Intersections of Categories: Being a Female Nurse, an Immigrant, and Non-White

All the participants attended nursing schools between the ages of 16 and 17 years old. They traveled far from home (Kerala is on India's most southern tip) to partake in high-quality nursing programs, which 15 to 35 years ago were in central and northern India. They lived away from home for up to 6 years before completing their schooling. For all, this was the first experience away from home and/or family. Several of the women described their choice to pursue nursing as the only acceptable way to avoid an early arranged marriage. They stated that there were few options for women when they were young, and three women added that they felt that "things in India haven't changed all that much." They are all Christian and have all attended Christian nursing schools. I perceived the participants as highly intelligent based on their reported achievements and their capacity to communicate. They were all top students, and in several cases, they were reportedly the best students in their nursing classes of 40 to 50 people. Given these facts, it was notable that these women were unable to negotiate for themselves more advanced positions in the nursing profession in the United States.

Their life conditions and the circumstances they faced within the United States nursing profession were, according to them, "insurmountable" with respect to advancement.

Case 6. Aleecia is a 44-year-old wife and mother of one son. She has worked for 10 years as an operating-room nurse. Sometimes she runs the operating-room suite even though she is not eligible to be a supervisor because she does not have a university degree.

Aleecia spoke of her experiences as a nurse in relation to the lack of reimbursement for tasks she performed that were outside of the realm of her job description according to hospital policies. She spoke of the fact that when she was in India, she had 6 years of training and spent many years delivering babies in villages in India. She describes herself as having been able to handle many emergencies unassisted. She also addressed the issue of racism and sexism on the job.

Investigator: When you came to the United States your designation was associate-degree nurse, not professional-degree

(baccalaureate) nurse even though you had many years of experience functioning independently. How did you react?

Aleecia: I was sad because I wanted to become a midwife, but I couldn't afford go back to school for 4 years and start all over again.

Investigator: What does it mean to have an associate degree instead of a professional degree in nursing?

Aleecia: It doesn't mean a lot when you work in the OR [Operating Room], and sometimes I am the supervisor. I am the person in charge on the weekend because the supervisor, who has a master's degree, is off. I have been doing this for 10 years.

Investigator: Are you paid as a supervisor during that time?

Aleecia: No, and several of the new OR nurses are men, and they don't really listen to me. If people don't listen to you, and they don't do what you ask, it is really hard to run a place.

Investigator: Why do you think they don't listen?

Aleecia: I don't know . . . maybe because I am a woman or because I am from India?

Investigator: Really? (long silence)

Aleecia: I don't have proof. It's just a feeling.

Case 7. Sara is a 42-year-old mother of a daughter and a son. She has worked for 13 years on the same pediatric floor at the same hospital. Sara spoke about the sadness she experienced when she did not get a promotion based on what she hesitated to but finally called "racism."

Sara: I never thought I was treated badly because I am Indian, but now that you ask why I think this happened, I recently didn't get a raise and promotion, but I didn't want to think I was being treated differently, but I guess it was [long pause] racism. I don't want to make an issue of it, but I was nominated for nurse of the year at my hospital two times. I have a certificate to show you. A White girl and I both applied (for a position) this past year. She is known to be lazy, and she has less experience than me, and she got the job.

The supervisor—he is a White man—he told one of the people I work with that he does not trust people who were educated outside this country. I have proven myself over and over. What do we have to do to get recognized? What makes me mad is I would never have been able to do all the things I have done if I had stayed in India. . . . We own a house, my children have gone to college, and yet . . . here, I feel like I don't belong.

The anguish of racism and oppression was countered by the material rewards these women described as the result of years of hard work in the United States. They all own homes in middle-income neighborhoods, and all but three of the 21 children of these women have attended college. Several had graduated from Ivy League schools, and five were in medical school at the time of the interviews. The women spoke of the fact that coming to the United States gave them and their children opportunities that they perceive would have been unavailable to them in India based on their gender, family circumstances, and class status. And yet, a few of the women shared their ambivalence about their choices.

Anne: Sometimes I wish I could know what it would have been like if I stayed [in India]. But I also have to remember how it

would probably have been. Still, it is hard to know. One can't know where the other fork in the road would have lead.

DISCUSSION

According to Sherwin (1992), the organization of the health care system does not merely reflect the power and privilege structures of the larger society, it perpetrates them. In spite of these processes, the women in this study displayed resilience and agency by staying at their jobs and attaining economic and social stability. Their reported stories, however, underscore the fact that some nurses pursue the strategy of establishing their superiority over even more disadvantaged groups. These ethnocentric perspectives continue to undermine members of ethnic communities that are part of the health care system, and in so doing, the system is robbed of its full potential.

The reality of the lives of these Indian women takes place at the intersections of gender, immigration status, and race. For immigrant women of color, this can mean trying to balance multiple, even contradictory, ways of being (Hegde, 1998; Mani, 1993; Yuval-Davis, 1997). We see these women at the paradoxical point where they demonstrate resilience to adapt to new challenges, yet at the same time and for a complex set of reasons, they reproduce the patriarchal structures of the past. I did not focus exclusively on the experiences of these women as nurses within the health care realm or just as immigrants, but I expanded the interview into their larger life space to give voice to their experiences as multidimensional people.

As I spoke to these Asian Indian women, it was clear that the process of relocating involves difficult and unsettling cultural negotiations. Claiming a position in the present interfaces with reclaiming traditions of the past. These women feel conflicted; their homes are so far away in both miles and social distance (third world) that members of the dominant culture do not acknowledge them as having familial relationships. Concurrently, these women perceive their own families as viewing them as too far away (first world) to receive consideration for the similarities of their lives as well as the differences. On one hand, the participants express feelings of being nowhere; conversely, they express the feeling of being in two places at the same time. The relationship that some of these women have with their children reflects the swinging back and forth between the values and norms of the here and there. The resistance to old, oppressive values expressed by Therea's support of her daughter's freedom is juxtaposed to her desire to maintain the traditions of the past that are reflected by the constraints she imposes on her son. Teena's extreme concern about her family's reaction to having a "Black boy" date her beloved daughter, who, in turn, has experienced the pain of racist structures, is stunning for the dilemma it poses.

These women's stories about nursing are incriminating of the nursing profession, and the examples reflect the issues of

racism in our larger society. In spite of their success, the difficult and painful here/there narratives of these women address the conflicted and ongoing experience of being an immigrant and an other (Hegde, 1998). Educational and workplace policies put in place by nursing have supported the marginalization and exploitation of minority populations. Sexton (1981) addresses the fact that one of the outcomes of "segmentation" within the nursing profession (i.e., the differentiation within a profession that supports the emergence of a nonprofessional strata) is that lower grades of workers may do work on one shift or in one workplace that is done by those in higher grades at other times or elsewhere, and they do so without additional pay. They are given responsibility without established authority or remuneration. Nursing has supported educational and workplace policies that have resulted in the reinforcement of class and racial/ethnic inequality. Society's triple designation of being a woman, an immigrant, and non-White creates exponential forces maintaining a state of marginalization that can be continually debilitating.

CONCLUSION

This study sheds light on the experiences of a small group of immigrant women of color who are also nurses. The jarring between two existences—the here and the there—expresses the tensions that are part of the daily lives of immigrants. The dual realities of immigrant life are compounded for Asian Indian women by what it means to be a woman and a woman of color. Given the multiplicity of forces acting at any given time on the life of immigrant women, it seems insufficient to explore their lives from the perspective of any one of their identities alone. The immigrant women's literature and nursing literature often explore the issues of immigrant women from a unidimensional perspective, which presents a simplistic view of their circumstances. The literature on immigrant nurses is even less relevant insofar as it studies immigrant women nurses from the perspective of a needed workforce. For nurses who are very different from the majority of nurses in their ethnic, racial, and cultural background to practice nursing to their fullest potential, they must have opportunities that are commensurate with those afforded to nurses who represent the majority. The short-term response to assessing the needs of those considered to be part of the group designated as "diverse" is to continue gathering information about their experiences not only as health care providers but also as people living in the United States. This information can then be used to assess and utilize their strengths and to determine the challenges they face in functioning at their fullest potential as individuals. The larger issues of racism, sexism, and other prejudices against immigrants are not confined to nursing or health care. Overcoming them is our mandate as members of a democratic society, and a broad and comprehensive definition of cultural sensitivity in all aspects of life will be required for us to move forward as a nation of highly diversified peo-

ple. Nurses are in an advantageous position to advocate for their colleagues, for themselves, and for those for whom they care. Our numbers give us untapped power as both information gatherers and interveners in a process of change that will be essential to meet the health needs of our increasingly diverse population.

REFERENCES

- Brink, P. (1990). Cultural diversity in nursing: How much can we tolerate? In J. McCloskey & H. Grace (Eds.), *Current issues in nursing* (4th ed., pp. 658-654). St. Louis: Mosby.
- Calliste, A. (1996). Antiracism organizing and resistance in nursing: African Canadian women. *The Canadian Review of Sociology & Anthropology*, 33, 361-369.
- Cervantes, A., Keith, L., & Wyshak, G. (1999). Adverse birth outcomes among native-born and immigrant women: Replicating national evidence regarding Mexicans at the local level. *Maternal & Child Health Journal*, 3(2), 99-109.
- Choudhry, U. K. (1998). Health promotion among immigrant women from India living in Canada. *Journal of Nursing Scholarship*, 30, 269-274.
- Choudhry, U. K. (2001). Uprooting and resettlement: Experiences of South Asian immigrant women. *Western Journal of Nursing Research*, 23, 376-393.
- Cry, M., & Goodyear, J. (1999). What would you do? When clients are abusive. College of Nurses of Ontario (CON statement on racial abuse). *Communique*, 24, 33.
- Davis, S., & Fisher, K. (1993). Power and the female subject. In S. Davis & K. Fisher (Eds.), *Negotiating at the margins. The gendered discourses of power and resistance* (pp. 3-20). New Brunswick: Rutgers University Press.
- Fine, M. (1987). Silencing and nurturing voice in an improbable context: Urban adolescents in public school. In H. Giroux & P. McLaren (Eds.), *Schooling and the politics of culture*. Albany, NY: SUNY Press.
- Fontana, A., & Frey, J. (2000). The interview: From structured questions to negotiated text. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 645-672). Thousand Oaks, CA: Sage.
- Franke, R., & Chasin, B. (1994). *Kerala: Development through radical reform*. New Delhi, India: Promilla.
- Grossman, D., Massey, P., Blais, K., Geiger, E., Lowe, J., Pereira, O., et al. (1998). Cultural diversity in Florida nursing programs: A survey of deans and directors. *Journal of Nursing Education*, 37(1), 22-26.
- Halls, J., Stevens, P., Meleis, A. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in Nursing Science*, 16(4), 23-41.
- Hagey, R., Choudhry, U., Guruge, S., Turriffin, J., Collins, E., & Lee, R. (2001). Immigrant nurses' experience of racism. *Journal of Nursing Scholarship*, 33(4), 389-394.
- Hegde, R. (1991). *Adaptation and the interpersonal experience: A study of Asian Indians in the United States*. Unpublished doctoral dissertation, Ohio State University.
- Hegde, R. (1998). Swinging the trapeze: The negotiation of identity among Asian Indian immigrant women in the United States. In D. Tanno & A. Gonzalez (Eds.), *Communication and identity across cultures* (pp. 34-55). London: Sage.
- Hyman, I., & Dessault, G. (2000). Negative consequences of acculturation on health behavior, social support, and stress among pregnant Southeast Asian immigrant women in Montreal: An exploratory study. *Canadian Journal of Public Health*, 91(5), 357-360.
- Im, E., & Meleis, A. (1999). A feminist critique of research on menopausal experience of Korean women. *Research in Nursing & Health*, 22, 410-420.
- Im, E., & Meleis, A. (2000). Meanings of menopause to Korean immigrant women. *Western Journal of Nursing Research*, 22, 84-102.

- Jones, P., Jaceldo, K., Lee, J., Zhang, X., & Meleis, A. (2001). Role intergration and perceived health in Asian American women caregivers. *Research in Nursing and Health, 24*, 1313-1444.
- Kramer, E., Tracey, L., & Ivey, S. (1999). Demographics, definitions and data. In E. J. Kramer, S. L. Ivey, & Y.-W. Ying (Eds.), *Immigrant women's health: Problems and solutions* (pp. 3-18). San Francisco: Jossey-Bass.
- Lalchandani, S., MacQuillan, K., & Sheil, O. (2001). Obstetric profiles and pregnancy outcomes of immigrant women with refugee status. *Irish Medical Journal, 94*(3), 79-80.
- Malone, B. (1997). Why isn't nursing more diversified? In J. McCloskey & H. Grace (Eds.), *Current issues in nursing* (5th ed., pp. 574-579). St. Louis, MO: Mosby.
- Mani, L. (1993). Gender, class and cultural conflict: Indu Krishnan's knowing her place. *Our feet walk the sky* (pp. 32-36). San Francisco: Aunt Lute Books.
- Meadows, L., Thurston, W., & Melton, C. (2001). Immigrant women's health. *Social Science and Medicine, 52*, 1451-1458.
- Mediratta, K. (1999). How do you say your name? In P. G. Min & R. Kim (Eds.), *Struggle for ethnic identity: Narratives by Asian American professionals* (pp. 77-86). Walnut Creek, CA: Alta Mira.
- Meleis, A., Sawyer, L., Im, E., Messias, D., & Schumacker, K. (2000). Experiencing transitions: An emerging middle range theory. *Advances in Nursing Science, 23*(1), 12-28.
- Oulton, J. (2001). At issue: Ethical recruitment. *International Nursing Review, 48*(2), 78.
- Professor is there to write as Kerala learns to read. (1999, Summer). *Carpe Diem Alumni Life*, pp. 1-2.
- Schumacher, K., & Meleis, A. (1994). Transitions: A central concept in nursing. *Image, 26*(2), 119-127.
- Sexton, P. (1981). *The new nightingales*. New York: Enquiry.
- Sherwin, S. (1992). *No longer patient. Feminist ethics and health care*. Philadelphia: Temple University Press.
- Small, R., Rice, P., Yelland, J., & Lumley, J. (1999). Mothers in a new country: The role of culture and communication in Vietnamese, Turkish and Filipino women's experiences of giving birth in Australia. *Women's Health, 28*(3), 77-101.
- Torres, S., & Castillo, H. (1997). Bridging cultures: Hispanics/Latinos and nursing. In J. McCloskey & H. Grace (Eds.), *Current issues in nursing* (5th ed., pp. 574-579). St. Louis, MO: Mosby.
- United States Department of Health and Human Services, Division of Nursing. (2000). *National Sample Survey of Registered Nurses*. Washington, DC: Author.
- Yam, B., & Rossiter, J. (2000). Caring in nursing: Perceptions of Hong Kong nurses. *Journal of Clinical Nursing, 9*(2), 293-302.
- Yuval-Davis, N. (1997). Women, ethnicity and empowerment. In A. Oakley & J. Mitchell (Eds.), *Who's afraid of feminism: Seeing through the backlash* (pp. 77-98). New York: The New Press.

Barbara DiCicco-Bloom, PhD, RN, is an assistant professor in the Department of Family Medicine at the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School. She received her PhD in nursing from New York University in New York City. Her research and teaching interests include critical feminist theory and its application to nursing and cultural competence in the delivery of health care. She has made several trips to Kerala, India, where she taught at several nursing and health care institutions about women's issues and the spread of HIV. She plans to visit Kerala again in the near future to explore the process by which nurses are recruited from Kerala nursing schools and hospitals and then brought to the United States to work in its health care system.