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| RESEARCH ARTICLE

Leadership and Employee Cultural Perceptions: A Study of West African Migrant Nurses

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| ABSTRACT

Studies suggest that migrant nurses from the black and minority ethnic (BME) groups working in the United Kingdom have variously reported negative experiences at work. To learn more about the nature of these experiences, this study explored in detail the experiences of a purposive sample of fifteen (N-15) West African migrant nurses working in selected independent nursing homes in the UK. Data collected was managed and analysed using the interpretative phenomenological analysis (IPA) process to focus on the nurses' in-depth perceptions through lived experiences on interactions and with managers and colleagues from a different cultural background to further interpret and meanings the nurses attach to these interactions and relationships. Findings suggest the nurses' sensitivity to managerial and leadership styles at their workplaces. These sensitivities were observed in relation to identified four elements of behaviours and processes at work thematically noted as follows: manager-subordinate relations, channels for the communication of authority, management of organisational processes and age-related values. There are indications of high value significances the nurses attached to the power distance and collectivist cultural values which are consistent with their aboriginal value orientations which informed perceptions and interpretations of experiences at work. The findings have important implications for understanding the organisational leadership styles adjustments needed for the effective management of the well-being of migrant workers in destination countries for optimal engagement. Further practical suggestions include ways of supporting migrant nurse employees in adjusting to destination countries cultural practices at work while also recognising and validating their attachments to cherished aspects of their own indigenous cultural values, especially in multicultural sensitive society such as the United Kingdom.

| KEYWORDS

organisational leadership, cultural orientations, Interpretative phenomenological Analysis (IPA), West African migrant nurses, United Kingdom.

| ARTICLE INFORMATION

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Introduction

In 2021, approximately 13% of nurses in the National Health Service (NHS) (Baker, 2021) and 20% of nurses in the adult social care sector in the United Kingdom (UK) (Fenton *et al.*, 2021) came from regions outside Europe, in particular South Asia, Southeast Asia, and Sub-Saharan Africa. It is therefore a matter of concern, both for the wellbeing of the nurses and their contribution to health services in the UK, that numerous studies have found that minority ethnic migrant nurses report negative experiences at work (Adhikari and Melia, 2015; Likupe, 2015).

The negative experiences include feeling that their skills are devalued and that they are not offered challenging responsibilities or opportunities for training and promotion (Adhikari and Melia, 2015; Alexis and Vydelingum 2005), feeling that their work is not trusted (Allan & Larson, 2003; Likupe, 2015), and suspecting discrimination and racial prejudice from managers, colleagues and patients (Allan *et al.*, 2009; Likupe and Archibong, 2013). In contrast, although there is little comparative research, migrant

nurses from Western countries (Farcas & Gonçalves, 2017; Leone *et al*., 2020; Rodriguez-Arrastia *et al*., 2021) and black British nurses (Isaac, 2020) have largely positive experiences of working in the NHS.

Communication issues related to cultural differences, national differences in nursing practice and promotion procedures, and lack of understanding and support from managers have been put forward as reasons why some migrant nurses fail to thrive in their host countries (Allan and Larson, 2003; Balante *et al*., 2021; Tuttas, 2015). These barriers tend be seen as acculturation problems that can be overcome with better pre-recruitment information and induction and adaptation courses (Allan and Larsen, 2003). However, Allan and Larsen also noted the need for a closer examination of migrant nurses' experiences at work to generate 'culturally implicit data' (Ibid:29). According to Taras *et al*., (2013), implicit or tacit cultural values determine how people perceive or react to events and can be resistant to acculturation. Consequently, a better understanding of how cultural values shape migrant workers' perceptions, judgements and sense-making may help to explain emotional reactions and responses and provide a better basis for support.

This study followed findings from a qualitative study (Uwabuike,2021) on West African migrant nurses' working in nursing homes in the UK. There is paucity research on the experiences of African nurses in the UK and no research to our knowledge on West African nurses, but a survey of internationally recruited nurses in NHS hospitals in England (Alexis, 2015) found that African nurses were more likely than nurses from other non-European countries to report discrimination and lack of support at work. Our study of the nurses' accounts of their lived experiences at work examined the reasoning behind their emotional responses to events with a view to understanding more about the phenomenology of their experience (Markus & Kitayama, 1991)

Cultural values

Cultural values in the context of this research refers to widely held, shared values and beliefs that are characteristic of national or societal cultures. Variation in ontological definitions of cultural values (e.g. Hofstede, 1980; Leung and Morris, 2015; Schwartz, 1999), methods of measurement and the location of samples (Van Pinxteren, 2020), make the classification of 'national culture' debatable so our analysis of differences between West Africa and the UK is based on the cultural characteristics which have been most reliably identified in surveys and scholarly analysis. Studies based on dimensional theories of national culture (Hofstede,1991; House et al., 2004; Schwarz, 2009) converge on the importance attached to *hierarchy or power distance* (holding values that support the unequal distribution of power, authority and wealth) and *collectivism or embeddedness* (adhering to the values and behaviour of the collective rather than being autonomous) in sub-Saharan Africa (Munene *et al*., 2000; Wanasika *et al*., 2011). People in high power distance cultures have greater dependence on authority, are more likely to conform to predetermined roles, be tolerant of inequality and expect decisions to be made by people at the top of the hierarchy (Doney et al., 1998). People in low power distance countries like the UK (Hofstede, 1980; Spector, 2001) expect to participate in decision making, have freedom to make their own decisions and have relatively egalitarian relationships with people in higher positions.

Studies suggest nurses moving from a high-power distance culture to a low-power distance cultures appear to find such change disconcerting. Choi *et al*. (2019) found that migrant nurses from high power distance cultures working in New Zealand found it hard to adjust to the informality of management-subordinate relations and some experienced the lack of direction from supervisors as a lack of care and support. In collectivist cultures, the close social framework enhances group goals and processes of decision making. Individuals have a long-term, moral obligation to their group which fosters a strong attachment and defines their identity (Triandis, 1995). In individualist cultures, such as the UK, value is placed on a sense of autonomy and personal accomplishment and members of the society are expected to maintain independence within the context of a loosely knit social framework (Triandis, 1995). Connor and Miller (2014) provided an example of the cultural dislocation of Filipino nurses working in the USA who experienced loneliness and missed the feeling of community and support provided by their extended families.

Sub-Saharan African countries have been described as patriarchal and patrimonial based on ascribed characteristics such as gender, social status, and age (Adisa *et al*., 2019; Wanasika et al., 2011) and African leadership, though consultative to an extent, rests on the same patriarchal and hierarchical system (Muchiri, 2011). Patrimony has been criticised for allocating jobs or positions of power based on favour rather than merit (Ntibagirirwa, 2009`) but combined with collectivism it gives rise to paternalism in so far as 'leaders are expected to be considerate, forgiving, and supportive of followers' welfare' (Wanasika *et al*., 2011, p. 235).

Ntibagirirwa (2009) argued that paternalism may be a source of authority for managers in Africa. Another important community value which may be important for understanding the beliefs and behaviour of West African nurses is respect for the elderly (Beugré and Offodile, 2001). In an analysis of management practices in Africa, Mangaliso (2001) noted that age is associated with wisdom and older employees found it awkward to take instructions from a younger person.

Negative work experiences

Studies of migrant workers provide evidence of conflicts between their values and those of their host countries. For instance, people from collectivist countries report feeling uncomfortable with taking personal credit for success, putting themselves forward and speaking out in the way that is usually expected in their work roles in individualist societies (e.g. Connor and Miller 2014; Xu *et al.,* 2008). Similarly, people from hierarchical societies can be reluctant to challenge people in authority (e.g. Deng and Xu 2014; Lai *et al.,* 2017) and feel disconcerted when they think their own authority is being questioned (e.g. Connor and Miller, 2014; Likupe and Archibong 2013).

Most people adjust to new practices and ways of interacting, but value differences take time to resolve and can give rise to the stress, loneliness and depression reported by cultural migrants (e.g., Choi et al., 2019; O'Brien and Ackroyd, 2012). Deep-seated, cultural values are slow to change with value acculturation being "close to negligible in the first 10 years" (Taras *et al.*, 2013, p. 147), but it is possible for people to retain cherished, core values while adapting to most practices in the host culture. For instance, Fu (2014) argued that Chinese scientists working in universities in Canada were able to retain their Chinese values of interpersonal harmony and avoidance of conflict whilst welcoming the Canadian values of transparent, interpersonal work relationships and professional freedom.

Studies of migrant workers usually cover several different nationalities and focus on the problems experienced by migrant workers, which include differences in work practices, language difficulties and experiences of racism, as well as conflicting cultural values. Consequently, little is known about how cultural values influence the perceptions and feelings of people from defined countries or regions, especially from Sub-Saharan Africa. The data collected in the study provides detailed, first-hand accounts of West African nurses' experiences and an opportunity to understand more about their perceptions of events at work from their own cultural perspective. The aim of the research was to provide a better understanding of how migrant nurses made sense of events, especially in interactions and relationship with their managers, with a view to informing and developing cultural sensitivity in employers and co-workers.

Method

The findings reported in this paper in part draws from a broader research project (Uwabuike, 2021]) which investigated West African nurses' reasons for moving to work in the UK, their perceptions of their experiences at work, and how they managed conflicts between their prior expectations and actual experiences. This study as part of the broader study focuses on their perceptions of the cultural values power distance and leadership styles and in their workplaces.

Design: The study employed a qualitative, phenomenological approach to explore the participants' perceptions and interpretations of their experiences at work. The data was collected in individual, semi-structured interviews and analysed with the method of Interpretative Phenomenological Analysis (IPA) (Smith *et al.*, 2009) to focus on in depth rather than breath subjective conceptions of events.

Context and Participation: The participants in this study were migrant nurses working in nursing homes who have responsibility for the general wellbeing of the residents in their care as well as their medical needs. In an average size nursing home, employing 5-6 nurses (Allan and Vadean, 2017), shift work means that nurses will often be working on their own with a team of carers, including British (81%) and white (75%) (Skills for Care, 2021). The West African nurses in the study worked in selected number of independent nursing homes in the Southeast of England and mostly worked under the management and leadership of white British managers. The sample is purposive and consisted of fifteen (N=15 nurses) made up of three males and twelve females with ages from 38 to 52 years with an average age of 46 years. The participants' nationalities were as follows: Gambian (3), Ghanaian (4), Nigerian (5), Senegalese (1), Sierra Leonian (2). There are few, scholarly, cultural which matched these countries based on comparisons of cultural values. Additionally, data from the Hofstede Insights Country Comparison app (Hofstede Insights, 2021) for Ghana, Nigeria, Senegal and Sierra Leone and research on Gambia (Dierick *et al.,* 2018; Gambia Country Review, 2021) highlighted similarities in cultural values across that has all five countries with high levels of power distance values and low levels of individualist values.

Participants' recruitment: The nurses were recruited via advertisements posted on notice boards in nursing homes and disseminated at Afro-Caribbean migrant nurses' association meetings. The recruitment notice provided information about the research aims (to understand more about West African migrant nurses' experiences at work in the UK) and the method of data collection. The recruitment effort was also reinforced through the snowballing process. Ethical approval for the study was obtained from the university's ethics committee and informed consent was obtained from the participants.

Data collection: The data for this study was collected in the second set of interviews in the broader research project (Uwabuike, 2021) which explored in part the reasons and expectations of the migrant nurses on their migration to the United Kingdom. The second set of interviews explored the nurses' feelings about their experiences at work. These second set of interview questions gathered background information about their work environments (e.g., 'Tell me about the persons at your workplace that you have direct interaction with in performing your daily tasks?'). The interview was then loosely structured around a few questions to elicit accounts of the nurses' interactions with their British managers and colleagues that had had an impact on their feelings (e.g., 'Can you talk me through specific incidents, actions or behaviours involving you and your manager or colleagues at work which made you start reading meanings into them?', 'Can you tell me how such actions or behaviour made you feel in terms of your emotions and reactions at the time?'). The focus on emotions was deliberate as cultural values have been found to predict emotions more strongly than attitudes and behaviours (Taras *et al.,* 2010), so accounts of events that had an emotional impact might best reveal cultural interpretations. While shared identity (The first author shares similar value background with the nurses) proved an advantage in gaining access to the participants and establishing appreciable levels of trust, it posed its own challenges (Kamenou, 2007; Kenny and Briner, 2010). Given the possible familiarity attraction which the nurses could feel that, hence possible challenges of less inclinations to explain in details issues which to them, would be of obvious knowledge to the researcher, the researcher made efforts to detach while using prompts and probing techniques to encourage the respondents to explain further their thoughts. Most of the nurses chose to be interviewed at home when they were not on duty at work. Each of the interviews lasted approximately fifty-five (N-55) minutes, using digital recording devise which enabled very fine details from the interviews to be collected.

Data analysis: Interpretative phenomenological analysis (IPA) has flexible guidelines, but it is common for researchers to work through several consecutive stages. After first reading the transcripts to identify changes in tone and emotive elements of the accounts that helped to indicate the meaningfulness of events for the nurses the transcripts were re-read to record keywords and phrases which held an emotional significance for the individual nurses and were relevant to the research question of how cultural values might inform their perceptions of events and processes at work (Smith and Osborn, 2015). In the next stage keywords and phrases were interpreted, to generate 'descriptive themes' which described issues of importance for the nurses (Smith *et al.*, 2009). The final stage addressed the evidence for shared themes across the accounts which might indicate shared cultural values. Smith *et al.* (2009) suggest that for a descriptive theme to be considered recurrent, it should occur in at least half of the interviews. In the present analysis, the threshold was set at two-thirds of the accounts or at least ten of the nurses' interviews. These recurrent emergent themes were then used to create 'superordinate themes' which identified central issues that underpinned the descriptive themes and related to shared or cultural values.

Findings: The analysis of the data resulted in six superordinate themes. Three of these described how *perceptions of power and leadership* in the workplace, *relationships with co-workers* and *ways of managing conflict* appeared to relate to cultural values. The other three described how the nurses responded to and coped with conflicts between their expectations and experiences (Uwabuike, 2021). Only the findings that relate to *perceptions of power and leadership* are reported in this paper. All the respondents expressed concerns about the style of management, use of authority (particularly the lack of reliance on a formal, hierarchical power structure), and levels of respect in the nursing homes where they worked. The superordinate theme, 'Power and Leadership', was based on a cluster of four descriptive themes that described their dissatisfaction with these issues:

- Manager-subordinate power relations
- Organisational lines of authority
- Effective management of organisational processes
- Age-related values at work

Each of these themes are described and explained below with reference to relevant interview quotes using pseudonyms to protect the participants' confidentiality and anonymity.

Manager-subordinate power relations*:* Many participants expressed concern about the social relationships they observed between the manager and the carers at work. On a surface level, they felt that interaction and familiarity with subordinates could have an impact on discipline at work and effective management control:

> *''The manager is supposed to be the person that has authority so that she/he can deal with all matters at work decisively, but where the manager socialises quite very easily with junior subordinates and colleagues, it becomes difficult for the person to deal with issues when they arise'' (Irene)*

> *''If someone who is supposed to be on top is always chatting with the carers, sometimes on things not related to work, how can it be easy to manage the home properly?'' (Mam)*

However, their stories also revealed how they felt the friendly relations between the manager and the carers threatened their own authority over the care staff by subverting the command structure and making the nurses feel marginalized:

> *''I don't know whether they* [care staff talking during Amie's handover briefing to the next care team] *feel that I don't know what I am saying (…) but they should listen to me because I led the shift. They have no knowledge of nursing (…) But my problem is that the manager sometimes will be there and will not stop them''. (Amie)*

> *''Even when the manager takes any of the carers out to smoke[1], no one cares to tell me that they are going out (…) and I will be struggling on my own till they come in at their own time''. (Adama)*

In addition to the threat to their authority, the nurses argued that their managers' friendly interaction with the care staff led to other negative effects on the quality of their working lives such as lack of respect (quote from Peace), inequitable allocation of work (Mam), and lack of opportunity for development or using skills (Adama):

> *''These carers are also very arrogant during my handover sometimes; they will be giggling during my handover in the morning (…) They will be distracting others while I am talking during handovers''. (Peace)*

> *''We work like donkeys and some people will not do nights or weekends. The manager cannot even use her position to treat people equally. The manager is supposed to use power so that everyone will be treated equally''. (Mam)*

> *''Even when some visitors come to visit, the manager will ask the* [care] *team leader (…) to take them round even when I am around. When they come to my unit, I will just be looking at them''. (Adama)*

The nurses seemed particularly upset about not having the same level of social interaction with their managers.

> *''The carers can always tell her* [manager] *what they want like changing their rotas, but I cannot''. (Mam)*

> *''It feels sometimes that one is left on his own. The manager finds it much easier to be with the white carer's discussing even what you, as a nurse, should be discussing with the manager. In many cases, the carers know more about what is happening in the home than you, the nurse''. (Bash)*

In practical terms, the lack of familiarity prevented them from accessing favours and other resources and being included in appropriate organizational networks. In more personal terms, they felt excluded from conversations that would have helped them to feel more involved at work and there were hints of sadness that their managers did not care about them:

> *''The communication between the manager and the carers are much more open than my communication with the manager even as a nurse''. (Mary)*

> *''Our conversations are only about few minutes as if she is in a hurry for it to end, but she relates very well with the other staff because they go out to smoke together at any time. (…) I know she is not supposed to be down to earth with me, after all, she is the manager, but she is free with others, why not me too?'' (Adama)*

The nurses' accounts of exclusion extended to not being consulted or listened to, even when their own reputation was at stake:

> *''There was a time some white carers who work during the day reported to the manager about something that they said were not done properly at night, but the manager did not ask me about it, but it was almost the talk on everyone's mouth''. (Peace)*

> *''At a point, I was almost giving up when a carer refused to do simple things I asked her to do but instead went to the manager and lied against me. The manager was sarcastic and made me feel I was harsh on the carer when I responded to*

[1] Smoking is not allowed inside workplaces in the UK.

the manager about the carer's behaviour towards me. The manager did not listen to me; instead, made me feel I am aggressive''. (Bose)

In summary, there were three aspects to the nurses' perceptions of manager-subordinate power relations: Firstly, that social relationships between managers and subordinates disrupt the appropriate exercise of authority, secondly, that their own authority could be undermined by social bonds between their managers and the care staff, and thirdly, that their exclusion from these social interactions and informal networks placed them in a vulnerable position because it deprived them of management support and positioned them as outsiders.

The nurses felt that socialising between managers and subordinates contributed to a loss of work discipline, as evidenced, for example, by care staff not paying attention during the handover to the new care team. This could result in lost information and mistakes being made. The socialising could also jeopardise interest-free management, allowing bias and discrimination to creep into management decisions. The nurses' concern about the social relationships between the mangers and carers may be driven by their anxiety about their own position and relevance in the power and authority dynamics in their workplaces. They felt there should be a clear distinction between the manager and the carers which, by extension, would encourage the carers to appreciate the nurses' roles as nurses-in-charge.

Organisational lines of authority: Many nurses reported that their managers did not deal directly with them and preferred to pass instructions or gather information through their carer colleagues. The lack of direct contact was experienced as offensive and upsetting:

''Sometimes she [manager]*will tell other staff to come and pass information to you and I feel not so good when people come across to me and tell me about this as if they are giving me instructions. In my anger, sometimes, I will neglect the information because I feel the manager knows how to reach me directly instead of using my juniors to pass the information to me''. (Joyce)*

''On several occasions, the manager bypasses me to ask the white carers about issues that happened during my shift, and I feel humiliated and, or not being recognised''. (Joke)

The informal communication conflicted with the nurses' expectations of a formal channel of communication through the normal chain of command and caused them to feel a loss of the management responsibility they had anticipated:

''Some of these team leaders (…), now feel that nurses cannot tell them what to do (…) because they think they know everything from the manager''. (Jenny)

''When some of the carers will be talking to each other on some matters that they know I can handle, they will be saying to themselves, don't worry, I will find out from Sharon [manager] *This is even when I am there with them …. and they will go and get the answer from her, the manager, instead of* [her] *telling them to go to me'' (Peace)*

Without access to the information given to the carers, the nurses felt handicapped in exercising their roles as nurses-in-charge and unsure about the appropriate allocation of responsibility. This made for an unsettling environment with the nurses feeling wary of what might follow for them:

''Sometimes, you don't know who the manager is asking to do something because she will be like saying, can someone make sure that this and that is done, without mentioning my name, but in your mind, you know she was referring to you because I am supposed to be the nurse in charge'' (Mary).

The nurses' accounts suggested they had prior expectations of fostering relationships with their managers, as key members of the organisation, and were puzzled and disappointed by the lack of communication:

''The manager spoke to me few times and would not speak to me from then on without a white carer being around. I said, hmmm … maybe it will change, but my brother, it has continued to be like that even up to today that I am speaking to you … how many years now''. (Joke)

In the absence of a direct and exchange with their managers, the nurses' feelings of inclusion in the affairs of running the home were compromised. Some nurses interpreted the way the managers avoided contact with them and dealt with them through the carers as a deliberate attempt to isolate them from mainstream organisational happenings.

Effective management of organisational processes: The experience of being excluded from formal and informal communications and left in the dark that was described in the first two themes, caused the nurses to feel anxious about how organizational processes were managed. The following interview extracts illustrate the nurses' concerns about lack of transparency:

> *''Sometimes no one tells me what is happening, even if it concerns me. It's all about gossiping. If anything happens or you do something, no one, even the manager, cannot even discuss with you. We are human beings; we can make mistakes and even the manager makes mistakes (…), but if I make mistake, the manager will not tell me, but every other person will know about it''. (Joke)*

> *''If you see them* [manager and carers] *together,* [you] *know they are gossiping about somebody. Nothing is open, maybe because they don't want you to know what they know. (…) Sometimes, they will arrange on what they want to do but you won't know about it''. (Joyce)*

Part of the nurses' concern was that informal flows of information, like gossip, could damage the way they were perceived by colleagues, but they also felt the lack of formal lines of communication was a problem for effective management. In the following case, the way that instructions were relayed to a nurse via a carer led to a mistake that was blamed on the nurse:

> *''There was an incident where we had to admit an elderly resident. He needed this oxygen facility, and this was supposed to have been included in the pre-assessment, but because the manager used a white carer, who she just promoted as team leader to manage the admission, this was not included (…) Instead of accepting mistakes, she and the carer made, she was putting me under pressure of I should have known. How would I have known?'' (Bose)*

The nurses related stories of how biased management of processes had led to the wrong people being blamed or rewarded:

> *''When white staff do mistakes, it will be normal, but when you do a simple one, the whole people will be talking about it. Many times, I have seen a white carer make mistakes, and the manager will be like … 'emm, don't worry, darling, you know what you are doing, don't you', and will let go …hmmm, but when a black staff does even* ***a*** *very minor mistake, the whole home will be talking about. Do you know, sometimes, you will be surprised to hear a resident ask you about the issues when you go into their room to support them. You be like, where did that come from?'' (Amie)*

> *''People here want to take credit alone sometimes even when you are part of that success. They won't mention your name (…) There are times when I have shown a white team leader how to manage something and when the relatives came, the manager said it was the team leader who did it well. Instead of the team leader at least saying something on the role I played, she was only smiling, and I stood there disappointed and upset''. (Mary)*

The nurses felt that the lack of formal and transparent processes for managing daily, operational issues, where no one is assigned responsibility, led to a blame culture in which the social relationship between the managers and carers increased the risk of the nurses being blamed. From this perspective, the nurses' desire for organisational structures that ensure that the responsibilities for tasks are clearly identified is understandable.

Age-related values at work: The final theme describes the nurses' concerns about lack of recognition of age in their workplaces. The following quotes describe the respondents' displeasure when young carers did not accord them the respect that they believed was due to older colleagues at work:

> *''I am sure I am older than both my manager and all the carers working with me. But the way they treat you, you cannot even think they know that I can be their mother or big sister. If they understand that, at least, they will say let's respect her''. (Mam)*

> *''Sometimes, some carers, who by far are my junior in age, talks to me anyhow, without any form of respect, at least for my age. They also find it difficult to take my instructions to do something and they will go to the manager to ask her what she wants them to do''. (Jenny)*

> *''That girl can be as young as my daughter and cannot even respect my age and yet has the strength to report me to the manager''. (Azeez).*

These responses reveal the nurses' beliefs that generational gaps should be respected, and older people accorded more authority, and their dismay and disapproval that deference due to age was not recognised by the young carers or supported by their managers.

In some cases, the nurses were appalled by behaviour that departed from the norms they associated with young people in their home countries:

> *''There was a time, a young white carer came into the kitchen, and I was there with another one who was not talking to me. But when the other one came in, if you see what she said and did… hmmm, you will be surprised. First, she did not even greet, she starts saying in a sarcastic way that it is like people are 'nicking' biscuits from the kitchen and looked at the other and both started giggling and went outside…very disrespectful''. (Mam).*

> *''Brother, you need to experience it to feel it. If a girl passes documents or any stuff for that matter to you with a left hand, in my tradition and culture, it is very insulting and disrespectful. There is this girl, she is in the laundry, any time she wants to pass anything to me, she would use her left hand without even any eye contact. Sometimes, these things would drop off because my hand had not reached before she releases it. She does not show any apologies'' (Tunde).*

> *''In fact, any elderly person that can give you instructions, you have to use those words of Sir or Madam for them. This is one thing that surprised me because everybody calls each other by their names. It is rude to call your senior even in your family by his or her name … Ah, no, you cannot do that. Even as I talk to you now, I am imagining when I get back home and my younger brothers and sisters calling me by name''. (Bash)*

Whilst the nurses might be reacting to differences in customs between their home countries and the UK, the strength of feeling in their responses suggest that cherished values have been disregarded. Respect for elders is important in African countries as the experience and wisdom associated with age underpins a reciprocal relationship between the old and young (Beugré and Offodile, 2001). In return for respect, older people have a duty of care towards younger ones. Consequently, the nurses' accounts suggest they were upset not simply by the disregard for age but by the loss of a social value they believed was important for maintaining harmony at work.

Discussion

Perceptions of power and leadership: The analysis of the nurses' accounts revealed their doubts and anxieties about the style and structure of management in the nursing homes which we have summarised in the superordinate theme of 'power and leadership'. The four descriptive themes (manager-subordinate power relations, organisational lines of authority, effective management of organisational processes, age-related values at work) illustrate the importance of the value the nurses attached to positions of power and how their managers exercised authority in their organisations. The first theme describes the nurses' belief that power, and decision making should be attached to position and flow from the top of the organization, the second that authority should be exercised through formal, hierarchical channels of communication, and the third that effective and fair management depends on a formal structure for authority and communication. The final theme of 'age-related values at work' is less obviously related to the effective control of the organization but it echoes the nurses' concerns about the lack of respect for their position and seniority.

It is possible to see how each of the descriptive themes reveal the influence of cultural values on perceptions. The first theme, manager-subordinate power relations, which suggests the importance the nurses placed on formal, hierarchical power structures may reflect their cultural background of high-power distance in organizations in West Africa where respect for hierarchy, role-based authority and less participatory leadership is seen as normal (Akanji et al., 2020; Wanasika et al., 2011). Social relationships between managers and junior staff presented a challenge to the West African nurses, who were susceptible to a conventional sense of subordination to those in authority as a show of loyalty and recognition. In their view, it was inappropriate for the managers and junior staff to share social activities at work because an informal relationship would make it difficult for the manager to ensure compliance to work instructions.

The conflict between the informal relationships in the nursing homes and the nurses' cultural expectations may also have presented a personal threat as the nurses felt the manager-carer relationship did not provide a conducive environment for the

exercise of authority or respect for their own position as nurses-in-charge. Furthermore, the bond between the carers and the managers created perceptions of 'us versus them' relationships and fears of discrimination. The nurses perceived themselves as outsiders with less opportunity to influence their managers' views on resource allocation and development opportunities; a legitimate concern given the evidence that minority ethnic groups and migrant workers have less access to influential networks in organizations (Siebers and van Gastel 2015) and may be informally excluded from tasks and opportunities to gain experience (O'Brien and Ackroyd, 2012).

Whilst leadership in West Africa is typically autocratic it is also paternalistic (Muchiri, 2011; Wanasika *et al.,* 2011) with leaders having a responsibility to guide and support their staff (Akanji *et al.*, 2020). Consequently, the nurses expected their managers to guarantee their authority and provide them with fair and protective support. Without the same friendly access as the carers to management support in their duties and development, which the nurses considered their due as senior members of staff, their sense of security was damaged, and they became sentient of their own weaker position and relevance in the power dynamics of the workplace.

The second theme, 'organizational lines of authority', described the nurses' perceptions of formal, management communication in the nursing homes. A key element was their anxiety about the absence of official channels of communication and direct information from the managers which added to their perception of themselves as outsiders and created a further sense of alienation. They were also unhappy about their managers not taking time to discuss work issues with them and resented the way that instructions and feedback were conveyed via care staff, which they saw as poor management practice. Their lack of access to information about work issues and the day-to-day management of the nursing homes blocked them from participating in decision making and even understanding what was going on at work.

In a collectivist culture, where identity is based on relatedness to family groups or communities, the lack of a relationship with a significant other, such as the manager, can lead to feelings of isolation and distrust. As Marcus and Kitayama (1991, p. 231) argued in their analysis of relatedness, 'Maintaining one's relationships and ensuring a harmonious social interaction requires a full understanding of these others, that is, knowing how they are feeling, thinking, and likely to act in the context of one's relationships to them'. The perceived absence of a normal flow of communication, within the proper chain of command, increased the nurses' perception of exclusion from organisational processes and, by extension, their lack of trust in the management processes. In particular, the management practice of seeking information from the carers rather than the nurses was upsetting possibly because it made the nurses feel they were not trusted.

The third theme, 'effective management of organizational processes' was connected to the second theme, as the nurses' related faults in the management of organization processes to the lack of formal channels of communication. They cited occasions on which instructions relayed indirectly via carers had led to mistakes and muddied the allocation of responsibility leading to the nurses being blamed for events that were beyond their control or not credited for their role in successful outcomes. The nurses also disapproved of the way that gossip replaced feedback and direct communication. They described hearing about mistakes, made by themselves, from gossip rather than their managers. In this way the absence of opportunities for discussion with their managers meant that operational problems were not addressed, and the nurses' reputations were damaged. Being targets of gossip also excluded them from the nursing home community and a positive identity as valued members of the collective.

The final theme of 'age related values at work' relates to the nurses' perception that seniority generally (both age and position) should command relative control and respect. Age is associated with wisdom in Sub-Saharan Africa (Beugré and Offodile, 2001) and respect for older people is sacrosanct even in workplaces (Mangaliso, 2001). Therefore, the nurses felt that being treated indifferently by the young carers in their team represented a show of disrespect which the managers should recognise and address.

Whilst demonstration of respect for older people is common across cultures, there is evidence that young people Sub-Saharan Africa gain more enjoyment from communicating in a respectful way with older people (Giles *et al.*, 2005), perhaps because of adherence to cultural norms of respect. Therefore, the West African nurses in this study may have interpreted the different style of communication from their young colleagues as deliberately rude or uncaring. In time, it is possible the nurses would adjust to less communication deference in UK workplaces, but the lack of respect for age may have contributed to their perception that their seniority due to position and expertise was not being recognised.

The influence of cultural values on perceptions of power and leadership: Clearly, many practices in the nursing homes were contrary to the nurses' expectations of management and leadership processes and styles experienced at work in their home countries. Culture shocks were evident in some accounts of their experiences, but if it was just a case of being faced with different practices, we might expect the nurses to reflect on how they felt when they first arrived and how they felt now. Instead,

the findings suggest that the nurses held on to their original cultures of communalist values in their attitudes towards work processes and interactions at work. These perceptions and reactions suggest that their experiential value conflicts rather than just their misplaced expectations. Whilst these values might be summarised as power distance and collectivism, it is important to understand the cherished values embodied in these concepts, such as predictable responsibilities and associated prestige, paternalistic management, communal support and a sense of belonging. Faced with different cultural practices, such as social relationships between senior and junior staff and informal channels of communication, it is not surprising that they disapproved of the way the nursing homes were managed, but the absence of a paternalistic and caring manager who took an interest in their well-being suggests a major cause of dissatisfaction.

Limitations of the study and suggestions for further research

While this exploratory study has provided insights into the cultural beliefs and perceptions of the sampled West African nurses through the adoption of an in-depth phenomenological approach, it would be of value for further incremental studies adopting more samples of West African migrant workers in other occupations. The study has related the nurses' desire for hierarchical but paternalistic management to an interaction between their cultural values of power distance and collectivism, it would also be of value to perhaps adopt a different research design to capture expectations of other migrants from other regions and countries associated with high power distance and collectivism cultural values. It is likely that people's perceptions of leadership are influenced by a complex mixture of cultural values and experiences that may be unique to their cultural and personal backgrounds. A better understanding of how cultural values shape perceptions of work experiences could also be achieved by comparing people from different cultures. Further adoption of an ethnographic research could also provide further insights on the subjective experiences of migrant workers and vignette methods integrated to examine perceptions of the same events in people from different cultural backgrounds.

Further, it is important to note that we cannot assume that the negative experiences of the nurses in this study stem from their subjective, cultural perceptions. Perceptions of being loaded with extra work, denied opportunities for skill use and being excluded from communications could result from racial prejudice and discrimination. Recent research found evidence that stereotypes and prejudice encouraged intergroup biases in the NHS in the UK (Woodhead et al., 2022). Language issues may also have been a problem. Previous study (Brunton *et al.*, 2020) findings of migrant and host country nurses working together in New Zealand suggests problems with understanding each other's language was the most common frustration in teamwork and could put the accurate communication of clinical requirements at risk. Potentially, managers may have involved care staff in relaying instructions and collecting feedback because they found it hard to understand the nurses or felt the nurses might not understand them. Further investigation of the perspectives of co-workers and other nationalities on the kinds of events and interactions described by the nurses might shed more light on the causes of events.

Practical implications

The negative experiences described by the participants in this study are a cause for concern and indicate an urgent need for support for West African nurses in nursing homes in the UK. One of the incidental findings to emerge from this study was the nurses' perceptions and senses of isolation from communications and social groups at work. Given the nature of these perceived isolations, it is not surprising that they craved a supportive relationship with their managers. For members of a group that thrives on communal existence, patriarchy, and paternalism, it suggests as normalcy for their expectations of a strong relational exchange with one's manager. The study recommends their managers' appreciation of this social interactional sensitivity towards adopting styles that are crucial in driving inclusivity at their workplaces and not overlooking the needs of migrant workers.

The nurses in this study were very attached to their home countries and their cultural values, hence an adaptation program designed to solely achieve acculturation into the host country's cultural values would be enough. Instead, the current study data suggest supporting the argument (Balante et al., 2021) that acculturation programs should have cultural sensitivity as a central focus with a view to supporting a multicultural workforce rather than expecting migrant nurses to adapt to the host country culture. This approach integrates diverse members of the workforce into the planning and promotion of cultural sensitivity by ensuring that members of migrant groups are represented in the hierarchy of the organization or in professional associations. Given the size of most nursing homes, professional nursing associations and charities that support the care sector, which already provide valuable data on diversity, could be instrumental in developing such acculturation programs. In the short term, managers of nursing homes could take simple, proactive steps such as holding frequent informative chats with the nurses and trying to include them in group discussions. Furthermore, it is essential that the managers have regular, direct contact with the nurses to relay instructions rather than relying on their indigenous care staff.

Conclusions

The analysis of cultural values in this study provides further insights into the negative experiences of African nurses in the UK reported in earlier studies (Alexis 2015; Likupe 2015; Likupe and Archibong 2013) and addresses the gap identified by previous authors (e.g. Allan and Larson, 2003) in our understanding of how cultural values influence perceptions of work events. The nurses' accounts of their experiences revealed their concerns about the lack of formal manager-subordinate relations, clear lines of authority and respect for seniority, which, in their view, compromised the management of organisational processes. These findings may be explained by the nurses' attachment to West African values that emphasise group and communal affiliations, and authoritarian but paternalistic leadership. Given the migrant nurses' cultural value backgrounds which supports paternalistic leadership in West Africa, the nurses had anticipated they would have a close and supportive, supervisory relationship with their managers. When this did not materialise, their senses of being and belonging appear questionable within the circumstances, especially on issues of authority as nurses in-charge of their shifts. The suggested consequences of these included amongst others, self-isolation and withdrawal from organisational socialisation, hence exclusion from organizational communication and decision making.

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