Exploring Professional Nursing Issues and Nurse Migration in Guyana: A Qualitative Study

Maureen Anthony, Jean Gash, Carla Groh
University of Detroit Mercy

ABSTRACT

Background: While it is known that migration of registered nurses from Guyana occurs often, little is known about professional nursing issues in Guyana and how these professional issues may influence the decision to migrate.

Purpose: The purpose of this study was to explore the role of female nurses in health care in Guyana, their working conditions and salary, the image of nursing in Guyana, and nurse-physician relationships and how these factors may influence the decision to migrate.

Methods: Nine female Guyanese nurses participated in a focus group with the authors. The focus group was recorded and transcribed verbatim.

Results: Three themes related to nursing professional issues were discussed: low perceived public image of nursing, lack of professional autonomy and poor nurse-physician relationships. All participants stated that they know nurses who have migrated from Guyana and that economic issues and desire to join family members who have migrated are the main factors in making the decision to migrate.

Conclusions: The findings suggest that the public image of nurses, working conditions and relationships with physicians are less than desirable for these nurses. Although economic issues were attributed to be the primary reason for migration from Guyana, the authors question whether improved working conditions and collegial relationships with physicians may act as a magnet to retain some nurses in Guyana.

Key Words: Guyana, Nursing Image; Professional Issues; Nurse Migration; Qualitative Research

Introduction

Guyana, located on the northeast coast of South America, is the only English speaking country in South America. It has a diverse population of approximately 747,884 people (Bureau of Statistics, 2012), the largest group being of East Indian descent (43.5%) followed by African descent (30.2%), mixed heritage (16.7%) and Amerindians (9.2%) (Bureau of Statistics, 2002). Guyana is classified as a lower
middle-income, developing country with many health problems. For example, life expectancy in Guyana is 61.5 years for men and 66.9 years for women (World Health Organization [WHO], 2013a). Infant and maternal mortality are high, as are malaria, HIV/AIDS, mental health disorders, suicide, substance abuse and chronic diseases such as ischemic heart disease, cerebrovascular disease, neoplasms and diabetes (Pan American Health Organization, 2012a). Although registered nurses in Guyana are capable of playing an integral role in health promotion and disease prevention, migration out of Guyana has adversely affected the ability of nurses to impact population health (Anderson & Isaac, 2007). According to WHO (2013b) the rate of nurses to population in Guyana is 23 nurses per 10,000 compared to the United States with 94 nurses per 10,000. This low number of nurses in Guyana is due in part to migration to high-income countries, where pay and working conditions are better (Anderson & Isaacs, 2007; Pan American Health Organization, 2012b).

The International Council of Nurses (2007), while acknowledging that nurses have always migrated to other countries and have the right to migrate, has concerns about the state of the healthcare system left behind from the loss of experienced nurses. On the other hand, according to the World Bank (2011), when people migrate across international borders the result is a boost in world income. This boost in income is attributed to remittance from the immigrants back to the home country, which reduces the level of poverty. For example, in 2010, the remittance inflow to Guyana was $309 million USD (13.7% of the GDP) and was ranked 16th in the world in relative terms (Kumar, 2013). Roberts (2006) reported that approximately 64 percent of remittance recipients in Guyana earned less that $1500 USD per annum, supporting that remittance has a positive effect on poverty reduction for many of the recipient families. Kingma (2001) acknowledged that nurses migrate for many reasons including professional autonomy, quality of life and the ability to support their family. Anderson and Issacs (2007) suggested that when people are satisfied with their work, earn a living wage, and have opportunities for advancement in their home country, the pull to immigrate may be decreased.

Little is known about nursing in Guyana, and how professional and other issues may influence the decision to migrate. The purpose of this study was to explore the role of female nurses in health care in Guyana, their working conditions and salary, the image of nursing in Guyana, nurse-physician relationships, and how these factors may influence the decision to migrate. This study was funded by the Women and Genders Study Feminist Scholarship Grant at the University of Detroit Mercy, which supports scholarly projects that critically examine the place of women and/or gender in culture and society. Therefore
the study was limited to female nurse participants.

Method

A qualitative design was chosen to explore professional nursing issues in Guyana and how these might influence the decision to migrate. The researchers invited nurses at a Guyanese hospital to participate in a focus group. The study was advertised through word-of-mouth (as we visited the various units) and nurses were asked to pass information about the study on to other nurses. In consideration of their time the nurses were offered $20 USD for their participation. Institutional Review Board (IRB) approval was obtained through our university and permission was obtained from nursing leadership at the hospital in Guyana. The focus group took place during the nurses’ lunch hour and lunch was provided. The purpose of the study was described to the participants and written consent for the focus group participation and the audiotape was obtained. The participants were assured of confidentiality within the bounds of a focus group, and were assured that they could withdraw from the study at any time. Participants were encouraged to share only information with which they were comfortable disclosing and were asked not to share any information disclosed during the focus group. They then completed a short demographic questionnaire containing questions about age and length of time in nursing.

The focus group was conducted with the three nurse researchers present, conversations were recorded using two audio recorders and the researchers took notes to record any nonverbal communication. The focus group meeting/discussion lasted 70 minutes. The audios were later transcribed word-for-word and the digital audio file was destroyed. No participant names were recorded on the transcript. A semi-structured interview schedule with open-ended questions was used to guide the focus group. Prompts and probes were used to explore deeper levels of meaning. Questions included:

1. How do you feel the public views the profession of nursing in Guyana?
2. How do you feel female nurses are perceived within health care in Guyana?
3. Do you personally know any nurses who have migrated?
   a. If so why do you think they did?
4. What do you think might keep nurses from migrating away from Guyana?
5. How would you describe nurse-physician relationships in Guyana?

To ensure trustworthiness of the results, two of the researchers conducted a second interview with two of the participants who were particularly verbal during the focus group. The second interview served as a member check to verify that the researchers’ understanding of the focus group data was correct. It also allowed the
researchers to follow-up on themes that emerged in the focus group from the questions asked. The data were contemplated as a whole and in parts on repeated occasions during a six-month period by the three researchers. A line-by-line method of analysis (Miles & Huberman, 1994) was used to code, categorize and analyze data. Words, phrases and sentences were labeled and themes were identified.

**Results**

Nine female nurses ranging in age from 24-67 years (x̄ = 32.5) participated in the focus group. Their years in nursing ranged from 1 year to 45 years (x̄ = 10.6). One participant did not reveal her age or number of years in nursing. All participants worked at the same Guyanese Hospital and all had graduated from the hospital diploma program. One participant had completed a BSN and a second participant was enrolled in a BSN completion program. Four major topics were explored: low perceived public image of nursing in Guyana, lack of autonomy in nursing practice, poor nurse-physician relationships, and migration of Guyanese nurses.

**Low Perceived Public Image of Nursing**

When questioned about their perception of the image of nursing held by the public, the participants felt that in the past, nurses were held in much higher regard by the public than they are today. Their perception was that this image problem was understandable given that some nurses project a less than professional demeanor. The evidence they provided of this decline in public opinion is illustrated through the following quotes:

“Years ago someone driving by would never see a nurse walking down the road and not stop and offer a ride. But not anymore.”

“We have a younger population of nurses now who have taken to go to night clubs and bars in their uniforms.”

“Because of the way we have been conducting ourselves in public, that is why the perception has changed.”

Upon further questioning, the participants related that it is their perception that, to the public, “a nurse is a nurse” and this was further enforced in that Registered Nurses and nurse assistants both wear white in their hospital, although only nurses wear a cap, and the nurse assistants wear a green band on their arms. Despite these differences in uniform, the nurses did not feel the average patient or visitor would recognize that a nurse has been educated and has a high level of expertise.

When asked about their perception of how nursing is perceived by other health care providers in the hospital setting (examples given
were pharmacists, physicians and nurse aids), they felt nursing is not recognized as a profession equal to others. These quotes illustrate what was expressed:

“I think that some persons, that they don’t realize the level where nurses are trained.”

“I think nursing is perceived at the lower level. Anyone can be a nurse. It’s as if you can’t even think. The nurse is the lower class of the ladder.”

One recurring theme throughout the discussion was the need for change to occur from within the profession of nursing. The nurses recognized that their professional behavior on the job could do much to improve or diminish the perception and standing of nursing. The following quotes illustrate this theme:

“We need to speak up to let them know what we know.”

“I think as nurses we are shy to step forward and say what we think and offer an opinion.”

“Back in the day when I was trained, it was different. You didn’t ask questions. But as you become more mature, you realize that is not the right thing to do. You need to ask questions and step in and do something.”

“For me part of the onus is on the nurse herself. Continually show persons that they are competent at what they are doing.”

Nursing education at the bachelor’s level has only been available for the last ten years in Guyana. Until recently, bachelor’s degree completion for diploma nurses was limited to managers. Although bachelor’s level education is now available to all registered nurses, the program is not organized in a format that is convenient for working nurses. Classes are offered during regular daytime working hours, requiring the nurses to work split shifts. The nurses expressed their hope that as more nurses are educated at the bachelor’s level, the professional image of nurses in Guyana will improve.

“Now as nurses are going to the university, they are showing more levels of maturity. They are not afraid to step in and ask questions on behalf of the patient because that is what we are supposed to do.”

Lack of Professional Autonomy/Poor Nurse-Physician Relationships

One theme that emerged throughout the focus group was the lack of professional autonomy in nursing practice. This was often described as the result of the dominance of physicians in health care in Guyana, and the resulting poor nurse-physician relationships.
These two themes are very much entwined and thus are presented together. The participants voiced frustration that they were not able to use the skills they learned in nursing school to independently assess patients and be active participants in the development of patient care plans. This was most often attributed to physicians disregarding their input. The following quotes illustrate both the lack of professional autonomy and the dominance of physicians in the hospital hierarchy.

“I remember distinctly one physician said to me: what qualified me? (to assess the patient). I got angry and I let him know I knew what I was doing and I was right.”

“Occasionally there are battles (with other professions) but not significant. It is usually with the physicians not viewing nurses as part of the health care team.”

We also questioned the participants about the role of gender in nurse-physician relationships. Most nurses are female, although there are male nurses, and most, but not all physicians are male. Initially they discounted the influence of gender, indicating that there are women in all professions and “whether it’s law, teaching, women can stand on their own.” But upon further reflection, one nurse made the following comment:

“You know, I think it is a bit gender related. Because very rarely do we have a problem when we go to one of the female physicians and make a suggestion. It’s always the male ego we have to deal with.”

Migration from Guyana

When asked if they knew nurses who had migrated away from Guyana, all of the participants stated that they knew many nurses who had migrated. They agreed that low pay was the primary reason for migration. The
participants stated that the typical monthly nursing salary was the equivalent of $250 to $300 USD at the time of the study. In comparison, according to the participants, the typical family physician would earn 4 to 5 times as much with an estimated salary of $1500 USD per month. They also stated that in addition to low salaries, another reason some nurses migrate is to reunite with family members who have already left Guyana. When asked what countries nurses typically migrate to they named the Caribbean Islands of Trinidad and Barbados with fewer going to England. One nurse quoted a monthly salary of $5000 USD for nurses in some of the Caribbean countries. When asked why they themselves had not migrated, they cited loyalty to and love for the hospital where they are employed, and commitment to family who remain in Guyana.

Discussion

The themes that emerged from this focus group: low perceived professional image, poor nurse-physician relationships, and limited professional autonomy are not unique to Guyana. Roberts and Vasquez (2004) asserted that perceived public image is actually a mirror of how nurses perceive themselves. This suggests that much can be done from within nursing to reverse the perceived negative image. Results of a study by Takase, Kershaw and Burt (2002) suggested that nurses who perceive nursing to have a poor public image are more likely to have low self-concept. These researchers also found a positive correlation between engagement in professional activities and self-concept. The Guyanese nurse participants stated that there is a professional organization in Guyana (Guyana Nurses Association), but felt that membership and participation were low. Greater involvement in professional organizations by nurses in Guyana could potentially help reverse this circular phenomenon of low perceived public image and low self-concept. Increasing educational attainment at the bachelor's degree level may also increase professional image and autonomy for these nurses.

In terms of professional image within the hospital setting, the participants identified that they didn’t sense the patients or visitors differentiated nurses from nurse assistants, despite that only registered nurses wore the nurse cap. This is consistent with a 2008 study by Albert, Wocial, Meyer, Na, & Trochelman in which 499 U.S. patients and visitors found that the participants rated pictures of nurses in white uniforms higher in the ten professional traits being studied: confidence, competence, attentiveness, efficiency, approachability, caring, professionalism, reliability, cooperativeness and empathy. The findings of this study suggest that reserving the white uniform for registered nurses and changing the uniform of nurse assistants to another color may help the public and patients.
identify registered nurses and improve the public’s image of nurses in Guyana.

Nurse-physician relationships have also been identified as a factor affecting job satisfaction and retention for American nurses, although perhaps not as overt and acrimonious as what has been described by the Guyanese nurses in the focus group. Anthony and Barkell (2007) analyzed 105 years of letters to the editor of the *American Journal of Nursing* and found difficult nurse-physician relationships to be a theme that persisted throughout the history of modern nursing. Even in 21st century America, a perceived gender liberated country, referring to a female physician as a nurse is considered an insult (May, 2007).

The information provided by the participants of this study with regard to nurse-physician relationships was corroborated by the blog of an American nurse who volunteered in Guyana. She wrote:

“When I initially began work here the doctor/nurse relationship was bothersome to me. There is great respect for doctors here (completely deserved) but I have seen it taken to an extreme in which nurses are afraid to question a doctor’s order, even if they suspect it to be an error. I have seen a doctor throw a chart and say ‘lazy, lazy nurses’ because a temperature was not charted on the vitals sheet” (Graves, 2012).

Rosenstein (2002) surveyed responses from 1,200 nurses, physicians, and hospital executives and found that daily interfaces between nurses and physicians intensely affected nurses’ morale. Most respondents saw a direct connection between dysfunctional physician behavior and nurse satisfaction and retention. The study by Rosenstein suggested that nurse-physician relationships must be remedied in order to improve morale and nurse retention. The participants of our study cited loyalty to the hospital they are employed at as one of the reasons they have chosen not to migrate. This suggests that improved nurse/physician relationships and improved working conditions in Guyana could be a more important factor in retention than previously thought.

Poor nurse-physician relationships are also known to negatively impact patient safety when nurses are afraid to communicate important patient information. Dunn et al. (2007) examined the root cause of medical errors at a Veterans Medical Center and found that 70-80 percent of 7000 adverse events were the result of communication failure. Sutcliffe, Lewton, and Rosenthal (2004) also found that 90 percent of the errors they studied were related to communication failures. Using face-to-face interviews with medical residents, the researchers explored medical mishaps and their contributing causes. They concluded that vertical hierarchical differences can impede communication “particularly when one party is
concerned about appearing incompetent, does not want to offend the other, or when one party perceives the other is not open to communication” (Sutcliffe et al., p. 193).

Poor nurse-physician relationships may also be indicative of the more fundamental issue of gender inequality for all women in Guyana and for nurses in particular. As in many countries, Guyanese women assume the major responsibility for the well being of their families and overall care giving. In addition, women oftentimes bear the economic brunt of meeting the family’s daily needs (Jones, Bifulco, & Gabe, 2009). This dual responsibility is the result of several converging economic and social factors. Guyana is classified as a lower middle-income developing country (World Bank, 2013) with a reported gross national per capita income of $3410 USD in 2012. Moreover, unemployment rates for Guyanese men are consistently around 21 percent (United Nations Statistics Division, 2013). Based on these economic factors and the limited number of safety network programs, women must work to financially support their families. Nurses, in particular, may feel pressured to migrate to developed countries knowing that their remittance home can reduce poverty for their family in Guyana (Jones et al., 2009).

The major social factors that influence gender inequality in Guyana are related to government rule and religious practices. Guyana’s first sighting by Europeans was in 1499, and the country was ruled by the Spanish, Portuguese, French, Dutch and British until the 21st century. It was not until May 1966 that Guyana gained independence from the United Kingdom (The Commonwealth, 2014). British rule at that time was male dominant and protocol driven: women had few rights or privileges. Religious practices also reinforced gender inequality. About 57 percent of Guyanese are Christians with the largest dominations being Pentecostal (17%), Roman Catholic (8%), Anglican (7%), and Seventh Day Adventist (5%). Other religious groups include Hindu (28%) and Muslims (7%) (Bureau of Statistics, 2002). The aftermath of British rule and the fundamental beliefs of the religions practiced in Guyana resulted in a society that was hierarchical in nature with male authority and dominance and female submission. Although in recent years, Guyana’s government has initiated several programs aimed at improving gender equity (Pan American Health Organization, 2012b), based on history and experience, we know that change takes time and persistence for full equality to occur.

As stated earlier, nursing in Guyana is an almost exclusively female profession, and is not immune to gender inequity in the workplace. Workplace factors include low pay, poor working conditions, lack of resources, and limited career opportunities. For example, salaries for nurses in Guyana range between $200 and $500 USD per month, the lowest of all
the Caribbean countries (Kurowski et al., 2009). In addition, nurses who remain in Guyana (rather than migrate out to higher paying countries), experience increased work demands as they struggle to cover registered nurse vacancies as approximately 30 percent of funded positions go unfilled (Kurowski et al, 2009).

The Guyanese government has acknowledged the importance of gender equity as one strategy for stabilizing the economy. In 2009, the Women and Gender Equality Commission was established as one of the Four Commissions for the Promotion and Enhancement of Fundamental Rights. The first annual report was presented June 30, 2011 with specific recommendations related to domestic violence, sexual harassment in the workplace, and discrimination (Staebroek News, 2011). The World Gender Gap Report which quantifies the magnitude of gender-based disparities across countries and tracks their progress over time, ranked Guyana 42nd out of 135 participating countries in 2012 (Hausmann, Tyson, Bekhouche, & Zahadi, 2012). The goal of gender equality in Guyana has the potential to significantly impact the working conditions, status and salaries of nurses in Guyana and lessen the migration of nurses to high-income countries.

Summary

The focus group format resulted in in-depth discussion on the topics of interest and the presence of the three researchers kept the discussion focused. The researchers were also able to direct questions at more reticent participants and use prompts and probes to elicit additional or clarifying information. This study is limited in that all participants worked at the same hospital and graduated from the same diploma school of nursing. A larger and more diverse sample may have provided additional important data, which would possibly allow additional insight or greater saturation of the content and transferability. It is also possible that some participants weren’t comfortable sharing their feelings and experiences in this format. Two of the participants were nursing supervisors and this may have caused some reluctance on the part of the participants who were staff nurses to be forthcoming during the focus group. As the participants were Guyanese and the researchers were American, there may have been issues related to culture that were unrecognized. In addition, the participants were asked to speculate on the motivations of nurses who have migrated and reliability of their remarks cannot be known. Finally, this study raises the question of whether poor working conditions may contribute to the decisions to migrate. While the participants in this study indicated that the main reason behind migration of Guyanese nurses was economic, they also stated that they remained at their current place of employment due to loyalty and love for the hospital. Additional research is needed to further
investigate factors that could improve workplace conditions and decrease migration from Guyana. Future research should also focus on nurses who have already migrated from Guyana, their perceptions of the professional issues that emerged during the focus group, and their thoughts and suggestions on what interventions/strategies could be implemented that might stem the out migration of nurses from Guyana.

The people of Guyana deserve a nursing workforce that is empowered to work to its full potential. Nurses who remain in Guyana have much to offer their country in terms of knowledge and expertise. According to the participants in this study, nurses in Guyana are constrained by poor public image, a power gradient that favors physicians and lack of professional autonomy in practice. In addition, large numbers of nurses migrate out of Guyana for better pay and working conditions elsewhere. It is reasonable to theorize that improved working conditions and collegial relationships with physicians could act as a magnet to retain nurses in Guyana.

References


