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A PHENOMENOLOGICAL STUDY OF THE LIVED EXPERIENCES OF FOREIGN EDUCATED NURSES WORKING IN THE UNITED STATES OF AMERICA

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by

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Dedication

Dedicated to Maya Satish for the support to begin and sustain this endeavor.

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A Phenomenological Study of the Lived Experiences of Foreign Educated Nurses Working in The United States Of America

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The overall goal of this study was to explore and describe the lived experiences of foreign educated nurses (FENs) working in the United States of America (US). Since World War II, the US has recruited FENs to fill recurring workplace vacancies of registered nurses (RNs). Despite this long history, few studies have examined the lived experiences of FENs who face challenges of different languages and communication styles, cultural diversities and lifestyle practices, and professional and workplace expectations. A review of literature about challenges facing other foreign-educated professionals revealed high levels of acculturative stress related to workplace role ambiguity, unclear expectations, and communication barriers and the necessity of investigating their lived experiences to guide future support programs. These findings supported the significance of this exploratory and descriptive study that employed a phenomenology of practice research approach to answer the question: What are the lived experiences of foreign educated nurses working in United States of America? A purposive sample of 20 FENs immigrated to the US from The Philippines, India, and Nigeria within the last five years was recruited for the study. Primary data were the narratives collected during interviews. Data were collected until saturation and redundancy were observed. Assigning code numbers, interviewing participants in private places, and maintaining all study materials in locked files were methods used to protect confidentiality. Interview data were transcribed, coded, and clustered during thematic analysis guided by Giorgi (1985). Findings were six emergent themes that captured the essences of 17 conceptual categories: *Dreams of a better life, Difficulties of the journey, A shocking reality, Rising above the challenges, Feeling and doing better, and ready to help others*. Truth value and scientific rigor of the study were evaluated using the standards of: (1) descriptive vividness, (2) methodological congruence, (3) analytical preciseness, (4) theoretical correctness, and (5) heuristic relevance (Burns & Grove, 2003) and Lincoln& Guba's (1985) criteria of trustworthiness. Berry and Kim's (1988) model of acculturation was found to be a fitting context for the comparison of this study's findings with extant knowledge about acculturative experiences of immigrants.

Table of Contents

List of Tables

List of Figures

CHAPTER I

Introduction to the Study

The purpose of this chapter is to introduce the problem that was studied, discuss its significance to the discipline of nursing, and suggest the contributions its findings may make to programs that support acculturation of foreign educated nurses working in a variety of health care delivery systems in the United States of America. The problem, aims, research questions, summary of the background and significance, overview of the philosophical foundation and methods, overview of study's methods and sampling strategies, and assumptions and limitations that influenced this study are presented.

THE PROBLEM, SPECIFIC AIMS AND RESEARCH QUESTIONS

The Problem

Statistical data from National Council of State Boards of Nursing (NCSBN) (2007) reveal that during the past three consecutive years, 2005 through 2007, one out of every five nurses, who took the licensing examination (NCLEX-RN) to become registered professional nurses (RNs) in the United States of America (US), was foreign educated. Government, public and private health care agencies and corporations in the US have actively recruited Foreign Educated Nurses (FENs) to work in their facilities since World War II. Several experts have suggested that levels of FEN recruitment activities abroad are at their highest when there are critical shortages of RNs in US workplaces (Bola et al., 2003; Daum, 2001; Kingma, 2007). Given the current shortage of RNs in US workplaces and projections that the nursing shortage could reach one million in number by the year 2020 (National Center for Health Workforce Analysis [NCHWA], 2002), recruitment of increasing numbers of FENs promises to provide much needed relief for overstretched and understaffed nursing services in the US. Despite increased efforts and successes with recruiting FENs, very few studies have been conducted to examine their lived experiences, including relocation, challenges presented by unfamiliar

surroundings, languages, cultures, social networks, acculturative stress, and workplace expectations. More research is needed to elicit and analyze the stories of FENs that reveal the real challenges they face in their daily lives. Findings are expected to guide future programs and interventions that will assist them with acculturation, assimilation, and overall health and well-being.

To determine what knowledge is already known about the lived experiences of FENs and other foreign educated professionals, a literature search was conducted. However, the results of the search yielded only a small number of articles about research studies conducted in the US. In a national level study conducted under the direction of Commission on Graduates of Foreign Nursing Schools (CGFNS) (Davis & Nicholas, 2002), it was found that many foreign nurses had difficult and often painful experiences while adjusting to the American way of living and practicing nursing. Major difficulties were identified in the areas of language, knowledge of traditions, customs and actual nursing practices with patients. A dearth of literature in this specific knowledge set that involves the discipline and practice of nursing, combined with increasing numbers of FENs coming to America to work, suggest that a phenomenological study of their experiences is warranted.

Specific Aims and Research Question

The overall goal of this study was to explore and describe the lived experiences of foreign educated nurses (FENs) as revealed in their stories of coming to, living in, and working in the US. Given the history of the migration of FENs to the US and forecasts that recruitment will continue into the foreseeable future, formalized plans and programs must be developed by the US nursing community to ensure the successful integration of FENs into mainstream American nursing. At this time, the US has no formal guidelines or programs that address the needs of FENs and there are no mechanisms in place that guide and protect FENs from neglect and exploitation by recruiters and employment agencies. Furthermore, each health care system and agency in the US has its own unique set of objectives that most often fall short of addressing adjustment, support, and acculturation needs of FENs who join their nursing staffs.

It is important to assess the fullest dimensions of what an FEN needs in terms of knowledge, skills, and support to achieve a successful transition into American life and American nursing practice. The diversity of the client population in the US complicates the challenges faced by FENs. Role ambiguity, unclear expectations, and communication barriers may also be sources of stress for FENs. Acculturative stress as it is sometimes called will be addressed later in this dissertation. Though many countries provide adaptation or induction programs for FENs, it is interesting to note that the US does not address this area of need, thereby placing FENs at a disadvantage and exposing their patients to uncomfortable situations. However, without substantial research efforts, we can only speculate about what daily life and workplace stress might be like for FENs. Basic research that aims to elicit and interpret their lived experiences is needed. Therefore, to arrive at a beginning understanding of the lived experiences of FENs living and working in the US, the specific aims of this dissertation study were developed to:

1. understand the subjective interpretations of migration and transition experiences as revealed in the stories of the FENs,
2. identify challenges and stressors discussed by FENs in their stories of living and working in the US, and
3. Describe strategies the FENs reveal they used to adapt and cope with challenges.

To achieve the aims of this study, a phenomenology of practice research approach was used to elicit and understand the subjective perceptions and reflections of a sample of FENs as first order truths viewed through their own *gazes* (Merleau-Ponty, 1967). The conduct of this study was guided by the following research question:

> What are the lived experiences of foreign educated nurses working in United States of America?

BACKGROUND AND SIGNIFICANCE

The lived experiences of new immigrant nurses, including events that characterize acculturative stressors and responses, are understudied phenomena that impose a change in research priorities due to the ever-increasing volume of international recruitment efforts by health care institutions in the US. While literature suggests that core values of

professional nursing are the same universally, how nursing care is delivered is dependent upon contextual and cultural factors that vary among societies, groups, cultures and subcultures. (Bola et al., 2003; Obemeyer, 2005; Xu, 2007). An immigrant nurse is not only faced with the challenges of understanding and adapting to the American way of living but he or she must also understand what nursing care is and how it is delivered in the US. The American way of nursing is a culture of its own and it presents challenges to the FEN each day. The following section presents definitions of culture and acculturation that inform the context for this phenomenological investigation.

There are many definitions of culture. Simply stated, culture is the way we do things around here. The HarperCollins Dictionary of Sociology (2001) defined culture as "the way of life for an entire society" (p.101). More recently, the United Nations Educational, Scientific and Cultural Organization stated that "... culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO, 2002, Universal Declaration on Cultural Diversity, p. 8). Thus it is clear that different societies possess different cultures and due to the centrality of it to the ways of living and doing, a person coming from a foreign culture may find it difficult to understand and to interact with the dominant and minority cultures in a diversely populated society.

Acculturation is the modification of the culture of a group or individual as a result of contact with one or more different cultures. Every new migrant coming to the US is faced with the challenges of acculturation and acculturative stress (Born, 1970; Mena et al, 1987; Padilla et al., 1986; Thompson et al.,2000). Different from general forms of stress, stress stemming from the difficulties of acculturation is referred to as acculturative stress (Berry, 2005; Padilla, 1980). Given the numbers of different cultures residing in the US and the large numbers of FENs who come to work here, acculturative stress is an important construct for researchers in the discipline of nursing to study.

Cultural competence of FENs caring for patients of many different cultural backgrounds is difficult to assess. FENs themselves are at varying stages of learning

about customs, traditions, and ways of living of people of western cultures and all minority cultures residing in the US. Acculturative stress potentials of the FENs are further complicated by the multilingual and multicultural nature of their client population. Furthermore, even though the core values of professional nursing are the same universally, how nursing care is delivered is dependent upon contextual and cultural factors that vary across societies and cultures. Therefore, FENs are not only faced with the challenges of understanding and adapting to the 'American way of living' but also are faced with trying to understand and deliver the 'American way of nursing' (Bola, et al, 2003). The acculturative stressors experienced by FENs are understudied phenomena in nursing. Given the ever-looming nursing shortage in the US and the continuing recruitment of FENs, increasing the numbers of research studies in this area must be an immediate priority. According to United States Department of Labor (USDL) statistics, a 30 percent growth in numbers of RNs is needed in the workplace by the year 2014 to meet population demands for quality health care (Trossman, 2002; U.S. Bureau of Labor Statistics, 2006). However, based on current enrollments in schools of nursing across the US and predictions that there will be a 17 percent shortfall in the needed numbers, the nursing shortage in the US is real and it is here to stay for the coming decade (Buerhaus, Donelan, Ulrich, Norman and Dittus, 2006). At the present time, nearly 12 percent of RNs working in the US are foreign-born and foreign educated. Given the regular practices of recruiting FENs that started during World War II, it is predicted that recruitment efforts will not only continue but will also increase rapidly in order to address the projected shortage of nearly one million nurses in the US by the year 2020 (Davis & Nichols, 2002). Current statistics also reveal that the majority of FENs working in the US were recruited from the Philippines, India, Nigeria, Canada, Korea, the United Kingdom and the Commonwealth of States (formerly the U.S.S.R.) (Friess, 2002; Obermeyer, 2005; Trossman, 2002).

At the international level, a few studies have addressed the phenomenon of acculturation of FENs. Magnusdottir (2005) conducted a phenomenological study that explored the lived experiences of foreign nurses working at hospitals in Iceland and the

findings were presented as five sub-themes that describe the essence of the main theme, *growing through experiencing strangeness and communication barriers*. The first sub-theme portrays how the nurses met and tackled the multiple initial challenges. The second sub-theme described the challenge of becoming outsiders and needing to be let in. The third sub-theme expressed the language barrier the nurses encountered and the fourth sub-theme described the different work culture the FENs faced. The fifth sub-theme illuminated how the nurses finally overcame these challenges and won through.

Another phenomenological study, conducted by Omeri and Atkins (2002), used a sample of immigrant nurses in Australia and aimed to understand their lived experiences. The major findings were three themes that emerged from stories of immigrant nurses who described experiencing *professional negation*, *otherness*, and *silencing* in the context of a lack of support, strangeness, and language and communication difficulties. Around the same time that Omeri and Atkins conducted their study, a quantitative descriptive survey was conducted in the Netherlands by Nivel, Ouden and Francke (2004) to describe the experiences of nurses who migrated to the Netherlands from the European Union (EU) and their findings revealed that the EU nurses who migrated reportedly faced major difficulties such as lack of familiarity with Dutch laws, Dutch fiscal and social security systems, and a lack of recognition of their professional nursing qualifications.

However at the national level, such studies addressing the experiences of FENs from different countries were not done in the US. Studies conducted in US regarding acculturation of FENs were limited to FENs from a single source country. For Example, Yi and Jezewski (2000) conducted a study among Korean nurses in the US and Kinderman (2006) conducted a study among Filipino nurses in the US. Other than such isolated attempts using FENs from single source country, studies using a diverse sample of FENs from different source countries were not found in the literature. This pointed the investigator to the need of exploratory studies in the field of acculturation experience of FENs in the US. During a national level study of RNs working in the US, Yu and Chanyong (2005) performed a secondary analysis of comparisons between demographic, educational, and employment characteristics of internationally educated nurses (IENs)

and U.S.-trained nurses (USNs). Data used in their study were from the National Sample Survey of Registered Nurses (NSSRN, 2000). Profiles they formulated suggested that the FEN prototypes were young, unmarried females from the Philippines, Canada, India, and the United Kingdom, in their 40s and 30s, and living or working in urban areas of the US. As several authors cited in the previous paragraphs of this section of the study suggest, FENs are strangers in a strange land and it is likely that many of them will experience culture shock and acculturative stress that must be addressed.

Kinderman (2006) interviewed Filipino FENs working in the US and concluded that a major problem faced by Filipino nurses was disrespect from their US counterparts. Similar findings were revealed by Yi and Jezewski (2000) during their grounded theory research with 15 Korean nurses. Findings from their study suggest that the acculturative process of an FEN spans five to ten years with an initial stage of adjustment in the first two to three years, which is a period of enormous psychological stress characterized by confusion, anger, fear, depression, and communication barriers. Findings from the above mentioned studies were used by this investigator to propose eligibility requirements for participants in this dissertation research.

In the context that international migration is a neutral phenomenon that balances the supply and demand of health care professionals, more research is needed to guide the development of programs that support the acculturation of migrant professionals working to provide health care services in a new country. Humphreys and Han (2005) conducted a phenomenological study to understand the phenomenon of community integration of foreign trained doctors in Australia and report that two broad issues appear to influence the settlement of migrants to a new place. First, meeting the daily requirements like securing adequate jobs, locating a suitable residence, and developing necessary skills are the initial focus. Second, integration issues associated with cultivating relationships with locals assist in anchoring migrants in the new community and forming their identity as part of that community. The authors further pointed out that, while local community support facilitated the integration of the physicians into the community, discrimination

and other barriers hastened their return to their native countries as soon as it could be arranged.

A similar study was conducted by Chen (2004) using ethnographic methods to examine the cultural adaptation of non-Western culture (NWC) counseling professionals as they worked in their new western cultural settings. In this study, core issues also appeared to be two-fold. First, the NWCs had to deal with the new values in their host country. Second, they had to adapt to the new ways of doing things that were consistent with the values of the profession as practiced in the western countries. Social and racial discrimination were not reported as relevant factors by the participants in this study. A quantitative descriptive study conducted by Yeh & Inose (2003) employed a sample of international students studying in the US and found that lack of English language proficiency, social connectedness and social support satisfaction were significant predictors of acculturative stress.

Other researchers (Levin & Stephen, 1999) have pointed out that although foreign professionals face acculturation issues, especially during initial stage, they often become successful in their disciplines. Interestingly, the comparison descriptive study conducted by Levin and Stephen found that scientists in the US who make exceptional contributions to their disciplines are more often from a foreign-born rather than US-born cohort. Conclusions suggest that the US has benefited to some degree from the influx of foreign-born talent.

Migration issues are hot beds of ethical and human rights concerns given the vulnerability of a new immigrant for exploitation. Many nurses recruited away from foreign countries come to the US via either as a non immigrant foreign worker through the H-1B visa program or as an immigrant through E-3 visa program for skilled workers and are sponsored by the US hospitals and health care organizations where they will be employed. Employers who hire H-1B visa nurses must pay the prevailing fair wage, not use FENs to undermine domestic labor conditions, show they have recruited and attempted to employ American workers to fill vacant positions, and notify American workers that they are hiring H-IB workers (AFT, 2006; Glassel-Brown, 1998; USCIS,

2007). However, once recruited and employed, FENs are solely dependent on their employers for survival and unfortunately there are no mechanisms in place to monitor how any foreign recruited or FEN employee is treated by an employer, possibly because such employees enter the US legally to take up a job that has been offered to them. Kingma (2007) pointed out that FENs often becomes victims of poorly enforced equal opportunity employment standards.

Ethical concerns regarding foreign recruitment and 'brain drain' have even spurred discussions at the global platforms such as the world health Organization (WHO). The trend in recruiting and employing all types of foreign educated professionals from developing countries has increased dramatically in recent years due to human resource shortages in many developed countries as a result of the ageing workforce and an overall increase in the globalization of economies. The ease of international travel also influences these trends. These trends are believed to contribute to an escalation of debates about ethical issues of the recruitment of foreign health care professionals. (Kingma, 2007; Loefler, 2001; Martineau et al., 2004; Ross et al, 2005; Smith & Mackintosh., 2006; Xu & Zhang, 2005).Many developing countries have voiced concerns about the strains on their health care delivery system due to the loss and shortage of healthcare professionals (Bundred & Lewitt,2000; Chikanda, 2005; Davlo, 2007; Perrin et al., 2007).

Internationally, there have been many discussions about the trends and policy implications of international recruitment and some of the studies looked at the issue comprehensively from the interest of all the involved stakeholders (Adams & Stilwell, 2004; Buchan et al., 2003; Buchan & Sochalsky., 2004; Diallo, 2004; Miranda & Saravia, 2004). Xu and Zhang (2005) argued that the nurses' self-determination and their rights to move about freely must be honored and protected, especially when worsening socioeconomic and working conditions threaten their safety, livelihood, and survival. The authors further concluded that "a 'one size fits all' approach to the ethics of international nurse recruitment remains too simplistic and is merely an illusion in this complicated and imperfect world" (p. 9). Similar ethical concerns are raised by several organizations

including the American Nurses Association (ANA) (ANA, 2002), American Organization of Nurse Executives (AONE) (AONE, 2003) and the International Council of Nurses (ICN) (ICN, 2005). In May 2005, CGFNS and the ICN jointly established the International Center on Nurse Migration (ICNM) with the fundamental goals of ethical recruitment and equitable treatment of migrating nurses.

Foreign recruitment of nurses in US is an organized effort between different agencies like CGFNS, International council of Healthcare Professions(ICHP), Immigration and naturalization services (INS), National Council of State Boards of Nursing (NCSBN) and the recruiting employer in order to ensure the quality of nursing practice in the US. Once recruited into the US workforce, however there is no mechanism in place to ensure the successful integration of FENs into the US workforce. There are no guidelines in place from regulatory bodies of nursing regarding the structuring of orientation programs.

Upon examining the limited literature related to foreign-education professionals and FENs working in the US, including limited reports of their acculturation experiences, it is the conclusion of this investigator that more descriptive studies are needed in this area. Basic knowledge development will promote more advanced research about these phenomena and will support acculturation programs that improve overall quality of life and well-being of FENs and others. Although a limited number of nursing studies have dealt with aspects of acculturative experiences among FENs working in US, naturalistic studies using phenomenological approaches to investigate the lived experiences of the FENs are even fewer in number. Since culture and its extensions are elusive phenomenon to capture with empirical measures, it is appropriate to employ phenomenological methods to understand the lived experiences of FENs, which may include variations of meanings of acculturative stress. It is appropriate and timely to undertake such a study to address the lived experiences of FENs who come to work in the US where the population is already multicultural and multiethnic. Although only a few studies on the perceived training needs of FENs by nursing management were available for review, they lacked empirical evidence thereby leaving the tasks of formulating interventions to facilitate the

acculturation of FENs to guesswork. It is essential to undertake research in this area to understand the lived experiences and possible acculturative stress issues of FENs so that solid interventions can be planned to facilitate their cultural transition, their well-being, and the quality contributions they can make to nursing practice in the US.

PHILOSOPHICAL FOUNDATIONS AND METHODS OF THIS STUDY

Introduction: Phenomenology as Philosophy and Method

Phenomenology is referred to both as a philosophy and as a research method (Munhall, 2001). Phenomenology, as philosophy, refers to an individual's perception of what an event in this/her lives means to them. Perception is understood as original awareness of an experience and it provides access to truth, which is regarded as the foundation of all knowledge (Merleu-Ponty, 1962). Phenomenology, as a method, aims to describe a phenomenon according to the perceptions of people who experience it rather than attempt to explain or analyze it. Merleau Ponty (1962) states that phenomenology is the study of first order perceptions and reflections that are truths and understandings based on subjective experiences rather than scientific theories. Leedy and Ormrod (2001) agree that the meaning of any event is found in a person's experiences with the event rather than in anything found outside of the person. As pointed out by Merleau-Ponty, understanding phenomena through the use of perception and reflection provides a better approximation of truth than does science, which can only explain the empirical existence of the world and not how a person experiences it. In his work on the primacy of perception, Merleau- Ponty explains the authenticity of experience over empirical science. He says:

> There is an empirical or second order of perception, the one we exercise at every moment, and which conceals from us the former basic phenomenon, because it is loaded with earlier acquisitions and plays….. The whole universe of science is built upon the world as directly experienced and if we want to subject science to rigorous scrutiny and arrive at a precise assessment of its meaning and scope, we must begin by reawakening the basic experience of the world of which science is the second – order of expression (p. viii).

Merleau Ponty was a student of Edmund Husserl, the founding father of phenomenology. Since the times of Edmund Husserl, there had been many movements and variations in the field of phenomenology. The one pertinent to this study is the phenomenology of practice.

Phenomenology of Practice as Method

This study to explore the lived experiences of FENs working in US was conducted using the contemporary research approach of the phenomenology of practice. According to Van Manen (2002), for human science scholars who are primarily interested in applying phenomenological methods to study their disciplines and professional practices or aspects of their life world, it is quite appropriate to take an eclectic approach to the tradition of phenomenology. The foundations and methods associated with the phenomenology of practice are congruent with the general beliefs about phenomenology as outlined by Center for Advanced Research in Phenomenology (CARP, 2005). According to CARP, seven widely accepted features of the phenomenological approach are listed below. Among them are both positive and negative features:

1. Phenomenologist's tend to oppose the acceptance of unobservable matters and grand systems erected in speculative thinking;
2. Phenomenologist's tend to oppose naturalism (also called objectivism and positivism), which is the worldview growing from modern natural science and technology that has been spreading from Northern Europe since the Renaissance;
3. Phenomenologist's tend to justify cognition (and some also evaluation and action) with reference to what Edmund Husserl called *Evidenz*, which is awareness of a matter itself as disclosed in the most clear, distinct, and adequate way for something of its kind;
4. Phenomenologists tend to believe that not only objects in the natural and cultural worlds, but also ideal objects, such as numbers, and even conscious life itself can be made evident and thus known;

5. Phenomenologists tend to hold that inquiry ought to focus upon what might be called "encountering" as it is directed at objects and, correlatively, upon "objects as they are encountered";
6. Phenomenologists tend to recognize the role of description in universal, a priori, or "eidetic" terms as prior to explanation by means of causes, purposes, or grounds; and,
7. Phenomenologists tend to debate whether or not what Husserl calls the transcendental phenomenological epochê and reduction is useful or even possible.

Overview of Methods and Sampling

This qualitative practice phenomenology study was conducted using a purposive sample of foreign educated nurses working in Houston and Galveston area hospitals in the southeastern US. Despite the multiple countries and cultures that US FENs represent, this study recruited a sample of participants that represent the most populace groups practicing in the target region. Eligibility criteria included that the FENs came to the US to work during the past five years, had basic nursing preparation in their homelands that was equivalent to a baccalaureate degree, and were from The Philippines, India, and Nigeria.

A purposive sample of 20 full-time employed nurses who migrated to US within the last five years was needed to reach data redundancy and saturation, both of which signaled the cessation of data collection (Lincoln & Guba,1985). Recruitment materials that described the study and delivered information about how to contact the investigator for more information were disseminated through e-mail blasts and networking and oral presentations at the meetings of the Filipino nurses association. Once the data collection was underway snow ball sampling also was employed to recruit the sample.

Written, informed consent was required of all those who volunteered to participate. Data collection was done through interviews conducted by the researcher using a semi structured interview guide. After agreeing on the setting and time for the interviews, the researcher made arrangements for a private location where the interviews

took place. Each interview lasted between 30 and 60 minutes. Samples of questions from the Interview Guide (Appendix C) used in this study follow:

- Tell me about your experiences working as a nurse in the USA.
- Tell me about the experiences you had that you hope no one else ever has to experience.
- Tell me about the experiences you had that you wish everyone who comes to the USA to work can have.
- Tell me about anything else you want me to know about your experiences.

Data analysis procedures used in this study followed Giorgi's (1985) phenomenological psychological method of narrative analysis. This is a method appropriate for use with research conducted as a phenomenology of practice (Van Manen, 2002). Interview data were recorded and transcribed. Transcripts were subjected to open coding using a line by line method which served as the first step in identifying the main concepts, themes and events discussed by the participants. Coded data were compared to categorize the variables, psychological meanings, conceptual categories and the emergent themes. Identified categories of variables, themes and events were later used to explain the phenomena revealed.

Several methods were used to establish rigor and trustworthiness in this study. Identifiable audit trails were made using coded data, researcher's journals and memos. Member checks and constant comparison methods will be used to establish confirm ability. Transferability of the study to similar samples was assessed (Burns &Grove, 2003; Lincoln & Guba, 1985). Details of the methods and procedures involved in this study are provided in Chapter Three.

ASSUMPTIONS IN THIS STUDY

Every immigrant faces many challenges that include language barriers, lack of familiarity with ways of doing things in the new country, and finding safe and affordable places to live. While these are only a few of the many challenges immigrants face, the underlying source of anxieties, concerns, and fears that many of them report experiencing involves the clash of cultures between those of their native countries and their new

homeland. The Harper Collins Dictionary of Sociology (2001) defines *culture* as "the way of life for an entire society" (p. 101). As such, it includes codes of manners, dress, language, religion, rituals, norms of behavior and systems of belief. Given that different societies possess and express different cultures that are central to the ways of living and doing, a person who moves to a new country with one or more different cultures may find it difficult to understand and be understood within the new country's dominant society.

Understanding the influence culture has upon one's everyday life is important to consider when conducting research. According to Paradise (2002), culture must be considered as part of the context that influences subjects rather than studying it as a variable that can be defined and measured in manageable ways. We need to better appreciate the open ended, dynamic and diffuse natures of culture and cultural phenomena and acknowledge their capacities for shaping adaptation and re-signification that assist individuals with overcoming obstacles and barriers.

It has been reported by several researchers that acculturative stress (Krishnan & Berry, 2001) is one type of phenomenon experienced by immigrants and it may have a role in determining whether an individual adapts to mainstream cultures in the new country or returns to his or her native land. It is assumed, for purposes of this study, that acculturative stress is part of the lived experiences of foreign nurses working in the US. This researcher bracketed (Ashworth, 1999) this assumption and her experiences as an FEN, during data collection and analysis so as not to impose upon or contaminate the real lived experiences presented in the stories of the study's participants.

LIMITATIONS OF THIS STUDY

The purposes of this study also comprise its limitations. Given a small sample size and a phenomenological approach to the study problem, findings cannot be generalized to all nurses of all cultures who come to the US to practice professional nursing. More studies are needed to learn the stories of the lived experiences of these nurses. However, data presented here in themes can be used to inform recruiters and employers in the USA about the types of supportive programs and services immigrant nurses can benefit from in order to ensure their smooth transition into US workplace.

SUMMARY

The overall aim of this phenomenology of practice study is to understand the meaning and experiences of acculturation of FENs working in the US. A dearth of literature relative to the acculturative experiences of foreign educated professionals, especially nurses, is the motivation to conduct this study. This study's findings are expected to contribute to the body of knowledge that supports acculturation of FENs and add emphasis to the need for US employers to provide cultural and practice-focused education to FENs after they arrive here. In addition, suggestions FENs made about how to help those who plan to come to the US in the future will influence recruitment programs.

CHAPTER II

Literature Review and Theoretical Perspectives

The purpose of this Chapter is to present a brief review and critique of published works that are representative of research studies that have explored the realities of the nursing shortage in the USA, rights of immigrant nurses, challenges facing immigrant workers and nurses in the USA, and how business, industry, and health care delivery systems interpret and address the challenges and needs of immigrants workers. The last section presents the theoretical perspective that motivates this investigator to explore the problem and analyzes the goodness of fit between this study's aims and those of professional nursing as a growing discipline.

REALITIES OF THE US NURSING SHORTAGE

According to United States Department of Labor (USDL) statistics, a 30 percent growth in numbers of RNs is needed in the workplace by the year 2014 to meet population demands for quality health care (Trossman, 2002; U.S. Bureau of Labor Statistics, 2006). However, based on current enrollments in schools of nursing across the US and predictions that there will be a 17 percent shortfall in the needed numbers, the nursing shortage in the US is real and it is here to stay (Buerhaus, Donelan, Ulrich, Norman , Dittus, 2006). At the present time, nearly 12 percent of RNs working in the US are foreign-born and foreign educated. Given the regular practices of recruiting FENs that started during World War II, it is predicted that recruitment efforts will not only continue but also will increase rapidly in order to address the projected shortage of nearly one million nurses in the US by the year 2020 (Davis & Nichols, 2002).

Current statistics also reveal that the majority of FENs working in the US were recruited from the Philippines, India, Nigeria, Canada, Korea, the United Kingdom and the Commonwealth of States (formerly the U.S.S.R.) (Friess, 2002; Obermeyer, 2005; Trossman, 2002). Despite the multiple countries and cultures that US FENs represent, this proposed study aimed to recruit a sample of participants that represents the most

represented groups. That is, participants who migrated to the US during the last five years from The Philippines, India, and Nigeria were recruited for participation.

RIGHTS OF IMMIGRANT NURSES

Many nurses recruited away from foreign countries come to the US via the H-1B visa program or the E-3 visa program and are sponsored by the US hospitals and health care organizations where they will be employed. The number of nurses permitted to enter the US through this program is negotiated under the General Agreement on Trade in Services (GATS), an international agreement signed by the U.S. in 1995 (AFT,2004; Diallo, 2004; Kingma, 2007). Employers who hire H-1B visa nurses must pay the prevailing fair wage, not use FENs to undermine domestic labor conditions, show they have recruited and attempted to employ American workers to fill vacant positions, and notify American workers that they are hiring H-IB workers (Glassel-Brown, 1998; USCIS, 2007). However, once recruited and employed, FENs are solely dependent on their employers for survival because under the terms of visa issuance an H-1B visa holder cannot work for any other employer and their dependents, including their spouses, are not eligible to work in US.

Although the E- 3 visa is an immigrant visa that allows the employee and his or her dependents to live and work in the US immediately, the FEN in this condition is still bound to the recruiting employer for the contract period decided by the employer (Glassel-Brown, 1998). According to Kingma (2007) immigrant nurses are frequent victims of poorly enforced equal opportunity policies and pervasive double standards. Unfortunately there are no mechanisms in place to monitor how any foreign recruited or FEN employee is treated by an employer, possibly because such employees enter the US legally to take up a job that has been offered to them.

CULTURE AND POTENTIAL CULTURAL CLASHES FACING IMMIGRANT WORKERS

There are many definitions of culture. Simply stated, culture is the way we do things around here. The Harper Collins Dictionary of Sociology (2001) defined culture as "the way of life for an entire society" (p.101). More recently, the United Nations

Educational, Scientific and Cultural Organization stated that "... culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO, 2002, Universal Declaration on Cultural Diversity, Para. 8). Thus it is clear that different societies possess different cultures and due to the centrality of it to the ways of living and doing, a person coming from a foreign culture may find it difficult to understand and to interact with the dominant and minority cultures in a diversely populated society.

Acculturation is the modification of the culture of a group or individual as a result of contact with one or more different cultures (Nivel, Ouden, & Francke, 2004; Yeh & Inose, 2003). Every new migrant coming to the US is faced with the challenges of acculturation and acculturative stress (Born, 1970; Mena et al., 1987; Padilla, et al., 1986; Thompson, 2000). Different from general forms of stress, stress stemming from the difficulties of acculturation is referred to as acculturative stress (Berry, 2005; Padilla, 1980). Given the numbers of different cultures residing in the US and the large numbers of FENs who come to work here, acculturative stress is an important construct for researchers in the discipline of nursing to study.

Cultural competence of FENs caring for patients from many different cultural backgrounds is difficult to assess. FENs themselves are at varying stages of learning about customs, traditions, and ways of living of people of western cultures and all minority cultures residing in the US. Acculturative stress potentials of the FENs are further complicated by the multilingual and multicultural nature of their client population described above. Furthermore, even though the core values of professional nursing are the same universally, how nursing care is delivered is dependent upon contextual and cultural factors that vary across societies and cultures. Therefore, FENs are not only faced with the challenges of understanding and adapting to the 'American way of living' but also are faced with trying to understand and deliver the 'American way of nursing' (Bola et al., 2003).

Berry and Kim (1988) postulated that any migrant entering in a foreign country experiences various acculturative stressors and goes through different phases of acculturation from pre contact through cultural adaptation, resulting in varying outcomes. The acculturative stressors experienced by FENs are understudied phenomena in nursing and the outcomes of their acculturation process are not well understood. Given the ever-looming nursing shortage in the US and the continuing recruitment of FENs, increasing the numbers of research studies in this area must be an immediate priority.

CULTURAL CHALLENGES RELEVANT TO THE FEN POPULATION

A close examination of available literature reveals that FENs coming to work in any country face major barriers mainly in the form of language, culture and practice issues. It is also revealed that many issues of stress and adaptation of FENs are not handled in culturally sensitive ways. When FENs from many countries and American-born nurses work together, cultural clashes are bound to occur because of biases, difficult communications, a lack of education about other cultures, and practice differences. It is important to identify these barriers and biases to ensure the smooth transition of foreign nurses to the mainstream of American nursing culture. However, little research has been done to discover and describe phenomena particular to the nursing workforce in the USA.

At the international level, a few studies have addressed the phenomenon of acculturation of FENs. Magnusdottir (2005) conducted a phenomenological study that explored the lived experiences of foreign nurses working at hospitals in Iceland and the findings were presented as five sub-themes that describe the essence of the main theme, *growing through experiencing strangeness and communication barriers*. The first sub-theme portrays how the nurses met and tackled the multiple initial challenges. The second sub-theme described the challenge of becoming outsiders and needing to be let in. The third sub-theme expressed the language barrier the nurses encountered and the fourth sub-theme described the different work culture the FENs faced. The fifth sub-theme illuminated how the nurses finally overcame these challenges and won through.

Another phenomenological study, conducted by Omeri and Atkins (2002) used a sample of immigrant nurses in Australia and aimed to understand their lived experiences.

The major findings were three themes that emerged from stories of immigrant nurses who described experiencing *professional negation*, *otherness*, and *silencing* in the context of a lack of support, strangeness, and language and communication difficulties. Around the same time that Omeri and Atkins conducted their study, a quantitative descriptive survey was conducted in the Netherlands by Nivel, Ouden and Francke (2004) to describe the experiences of nurses who immigrated to the Netherlands from the European Union (EU). This survey research employed a sample of 1768 EU nurses. Findings revealed that the numbers of EU nurses migrating to Netherlands was declining at the same time as shortages of nurses in the Dutch health care systems prevailed. The EU nurses who immigrated reportedly faced major difficulties such as lack of familiarity with Dutch laws, Dutch fiscal and social security systems, and a lack of recognition of their professional nursing qualifications. Nivel, Ouden and Francke concluded that the Dutch government should take several measures to make the Netherlands more attractive for foreign nurses if they were going to meet demands for nurses in the workplace.

Sochan and Singh (2007) conducted a qualitative study among FENs in Ontario that reported three major themes: *hope*, *disillusionment and navigating disillusionment*. Major shock for FENs in Ontario was the realization that their domestic qualifications did not meet the entry to practice requirements in Ontario and that they must take a bridge program to meet Canadian standards. But there are no studies done to evaluate the objectives, content and the effectiveness of those bridge programs. The United Kingdom (UK) is another country which offers formal adaptation programs to FENs before their licensure in the UK (Gerrish & Griffith, 2004). However no organized efforts from the nursing practice regulatory bodies are in place to require adaptation programs for FENs coming to US.

During a national level study of RNs working in the US, Yu and Chanyong (2005) performed a secondary analysis of comparisons between demographic, educational, and employment characteristics of internationally educated nurses (IENs) and US-trained nurses (USNs). Data used in their study were from the National Sample Survey of Registered Nurses (NSSRN, 2000). Profiles they formulated suggested that the

IEN prototypes were young, unmarried females from the Philippines, Canada, India, and the United Kingdom, in their 40s and 30s, and living or working in urban areas of the US. In addition, the researchers found that IENs in the database had more years of experience working as RNs, were more likely to have completed diploma or baccalaureate nursing programs as their basic nursing preparation, were working full time in direct patient care, and worked more hours and earned more money when they were compared to their US counterparts. These findings suggest that IENs (FENs) may experience more stress in their lives and may over-work because they are likely to be the sole breadwinners in their families.

As several authors cited in the previous paragraphs of this Chapter suggest, FENs are strangers in a strange land and it is likely that many of them will experience culture shock and acculturative stress that must be addressed. In yet another study, Kinderman (2006) interviewed Filipino FENs working in the US and concluded that a major problem faced by Filipino nurses was disrespect from their US counterparts. Subjects stated that the disrespect stemmed from assumptions that Filipino nurses were less knowledgeable and the reality that their US counterparts failed to understand differences in their cultures. Similar findings were revealed by Yi and Jezewski (2000) during their grounded theory study with 15 Korean nurses. Findings from their study suggest that the acculturative process of a FEN spans five to ten years with an initial stage of adjustment in the first two to three years, which is a period of enormous psychological stress characterized by confusion, anger, fear, depression, and communication barriers. These findings guided the eligibility requirements for this study in that FENs recruited for participation had to have arrived in the US within the past five years.

Xu (2007) conducted a metasynthesis of studies related to immigrant nurses and summarized the problems faced by new immigrant nurses into four major themes; *communication as a daunting challenge, differences in nursing practice, marginalization, discrimination and exploitation, and cultural differences.* Findings from this and similar studies were used by this investigator to propose additional eligibility requirements for participants.

ACCULTURATION OF OTHER HEALTH CARE PROFESSIONALS

In the context that international migration is a neutral phenomenon that balances the supply and demand of health care professionals, more research is needed to guide the development of programs that support the acculturation of migrant professionals working to provide health care services in a foreign country. Humphreys and Han (2005) conducted a phenomenological study to understand the phenomenon of community integration of foreign trained doctors in Australia and report that two broad issues appear to influence the settlement of migrants to a new place. First, meeting the daily requirements like securing adequate jobs, locating a suitable residence, and developing necessary skills are the initial focus. Second, integration issues associated with cultivating relationships with locals assist in anchoring migrants in the new community and forming their identity as part of that community. The authors further pointed out that, while local community support facilitated the integration of the physicians into the community, discrimination and other barriers hastened their return to their native countries as soon as it could be arranged.

A similar study was conducted by Chen (2004) using ethnographic methods to examine the cultural adaptation of non-Western culture (NWC) counseling professionals as they worked in their new western cultural settings. In this study, core issues also appeared to be two-fold. First, the NWCs had to deal with the new values in their host country. Second, they had to adapt to the new ways of doing things that were consistent with the values of the profession as practiced in the western countries. Social and racial discrimination were not reported as relevant factors by the participants in this study. Zubin (2007) examined the geographical migration, psychological adjustment and professional identity of international pharmacy graduates in Ontario and the findings of that study point out that these professionals experience severe cultural shock in the new workplace. As more studies across professional groups of foreign-educated workers reach the literature, more evidence accrues to suggest that education and support programs are vital to their survivals.

A quantitative descriptive study conducted by Yeh & Inose (2003) employed a sample of international students studying in the US and found that English language proficiency, social connectedness and social support satisfaction were significant predictors of acculturative stress. Other researchers (Levin & Stephen, 1999) have pointed out that although foreign professionals face acculturation issues, especially during initial stages of adaptation, they often become successful in their disciplines. Interestingly, the comparison descriptive study conducted by Levin and Stephen found that scientists in the US who make exceptional contributions to their disciplines are more often from a foreign-born rather than US-born cohort. Conclusions of that study suggest that the US has benefited to some degree from the influx of foreign-born talent.

ETHICAL ISSUES OF FOREIGN RECRUITMENT AND EMPLOYMENT

Perhaps, the most debated aspect of foreign recruitment recently is the ethical and human rights issues of recruiting the most qualified professionals from developing countries by the employers in the developed countries, commonly known as the 'brain drain' issue. The trend in recruiting and employing all types of foreign educated professionals from developing countries has increased dramatically in recent years due to human resource shortages in many developed countries, the aging workforce, and an overall increase in the globalization of economies. The ease of international travel also influences these trends. These trends are believed to contribute to an escalation of debates about ethics of the recruitment of foreign health care professionals (Kingma, 2007; Loefler, 2001; Martineau et al, 2004; Ross et al, 2005; Smith & Mackintosh, 2006; Xu & Zhang, 2005). Many developing countries have voiced concerns about the strains on their health care delivery system created by the losses and shortages of healthcare professionals (Bundred & Lewitt, 2000; Chikanda, 2005; Davlo, 2007; Perrin et al, 2007). Brunded and Lewitt (2000), concerned with the migration of physicians, argued that the ethics of national polices that allow developed countries to recruit en-masse the most qualified physicians at no cost or penalty to themselves should be challenged. The authors appealed to the World Health Organization (WHO) to convene an international

meeting for the purpose of establishing an international code of ethics for recruiting physicians from less developed countries to more developed ones.

Loefler (2001) argued that the motivating factors for medical migration are not always financial gain but there are three reasons for doctors to migrate: one is to learn, the other to seek professional satisfaction combined with the opportunity to make a decent living, and the third one is to escape political oppression and professional stagnation. Several theorists tried to analyze factors involved in international migration and had put forth the typology of 'push and pull' factors involved in international migration (Iredale, 2001; Kingma, 2001; Kline, 2003). Internationally there have been many discussions about the trends and policy implications of international recruitment and some of the studies looked at the issue comprehensively from the interest of all the involved stakeholders (Adams & Stilwell, 2004; Buchan, 2003; Buchan& Sochalsky, 2004; Diallo, 2004; Miranda & Saravia, 2004).

Xu and Zhang (2005) analyzed the ethics of international nurse recruitment from the conceptual framework of stakeholder interests and they pointed out that some developing countries such as the Philippines and China greatly benefit from the international migration of nurses and so it is in their best national interests to have migration continue. Another ethical issue highlighted by Xu and Zhang is that nurses' self-determination and their rights to move about freely must be honored and protected, especially when worsening socioeconomic and working conditions threaten their safety, livelihood, and survival. The authors further concluded that a 'one size fits all' approach to the ethics of international nurse recruitment remains too simplistic and is merely an illusion in this complicated and imperfect world (p. 9)

Similar ethical concerns have been raised by the American Nurses Association (ANA) in its *Position Statement on Recruitment of Foreign Nurses* (ANA, 2002). A similar position was later adopted by the American Organization of Nurse Executives (AONE) in their *policy statement on foreign nurse recruitment* (AONE, 2003). The International Council of Nurses (ICN) echoed similar concerns, but at the same time upheld the freedom of movement of international nurses and their rights to fair and

equitable treatment. In May 2005, CGFNS and the ICN jointly established the International Center on Nurse Migration (ICNM) with the fundamental goals of ethical recruitment and equitable treatment of migrating nurses.

ISSUES OF QUALITY AND RETENTION

Foreign nurses recruited into the US are screened and tested at various stages of their immigration process to ensure quality of the professionals who are allowed to migrate to the country. Major steps include evaluation of their education and verification of their license by CGFNS, tests of spoken and written English language proficiency and passing the NCLEX-RN examination (CGFNS, 2007). Bola et al (2003) describe the steps of a foreign nurse's immigration and how CGFNS and the government ensure quality of foreign nurses recruited. The authors identified key areas in which work related problems are encountered by FENs. The authors point out that FENs have filled nursing positions in the U.S. since World War II and although recruiting foreign nurses may reduce short-term staffing woes, it demands a solid commitment. Authors suggest that to successfully assimilate foreign-educated nurses into a hospital system, competency, communication, culture, and compassion are important to all processes and programs. Available data suggests that a foreign nurse coming to the US is entering a new, confusing place and is easily lost in communication barriers which can contribute to culture shock. Bola et al (2003) also recommended that Leininger's Sunrise Theoretical/Conceptual Model of Cultural Care Diversity and Universality (2001) may be a useful tool to use when planning orientation programs for FENs.

Davis and Nichols (2002) conducted a Commission on Graduates of Foreign Nursing Schools (CGFNS) validity study to evaluate the performance of CGFNS measures as mechanisms for ensuring quality of the FENs immigrating to the United States. One of the major findings in the CGFNS validity study was that FENs holding a CGFNS certificate had an 86% pass rate on the NCLEX-RN examinations, whereas those FENs without a CGFNS certificate had only a 43% pass rate. The significant difference between these two groups in NCLEX –RN pass rates supports the validity of the CGFNS Certification Program. The second part of this same Davis and Nichols' article revealed

the transitional experiences of the FENs procuring employment in the US. The CGFNS conducted focus groups in eight major cities and data revealed that many foreign nurses had difficult, often painful experiences while adjusting to the “American way” of living and nursing. Major difficulties were identified in the areas of language, knowledge of traditions and customs, and nursing practice. The major impact of this study is found in the following excerpt of the CGFNS report:

> Due to limited exposure to American conversational English, these nurses often were not able to engage in dialogue with other health care professionals or with patients and their families. This placed them at a severe disadvantage in the workplace. Many participants expressed the desire to understand the traditions and customs practiced in the United States. Pharmacology and medical terminology were the most addressed topics within the area of nursing practice. Names of medication varied from country to country. Several participants emphasized that foreign nurses were at a disadvantage in the workplace because they often do not understand the procedures and are too embarrassed to ask. Advice from international nurses to future international nurse colleagues was: "Have a support system and stay positive, Make sure that there are friends, family, or anyone that can provide that Support and be flexible and open to change (p.50).

Among the several countries with high rates of nurses migrating to the US, The Philippines ranks the highest (NCSBN, 2005). Kinderman (2006) suggested some retention strategies that healthcare institutions might use with newly hired Filipino nurses to reduce turnover and yield a return on their investment in recruiting efforts. The author identified certain dilemmas of newly hired Filipino nurses and suggested some culturally sensitive strategies to use to better integrate them into the US workforce. Main strategies included: appreciate education similarities, provide practice for specific skills, encourage team participation, discuss patient and family expectations, teach daily organization skills, point out patient diversity, provide personal life-skill classes, adapt the orientation program, and promote strong collegial relationships.

Nu and Davidhizar (2004) examined the conflict management styles of Asian and Asian-American nurses from different theoretical perspectives and the findings reveal that both of these groups have contradictory methods of conflict management. Asian

cultures work from a collective strategy and their "face" is relational to the group. They, at any cost, try to avoid a direct confrontation if a conflict situation arises. On the contrary, in Asian-American culture, individualism and protecting self face are important, and conflicts are addressed directly. It is a perplexing situation for the nurse manager who has to manage conflicts in the work place. It is important for diversity to be valued and embraced to strengthen the team. As increasing numbers of the health care providers include persons from minority cultures, it is essential that the manager plan strategies that will enhance respect and appreciation of each team member as a cultural being. Haddad (2002) suggested that in order to enable foreign nurses to be integrated into patient care safely and respectfully in an institution, every effort must be made to help overcome cultural barriers, and that can cut both ways. Understanding how personal biases, including prejudice, influence our attitudes and conduct is important to ethical decision making. The author stated, "Should a conflict arise, all nurses should be judged by their ethics, performance, and standard of care, rather than where they came from" (p. 27). Ryan (2003) suggested the use of a buddy program as a viable strategy to make the international nurses feel welcomed into a culturally diverse work culture and to provide needed support to enhance retention.

Several of the findings of the studies presented in this review of literature are similar to those found in this study. Chapter V places the findings of this study in context of what is already known and disseminated. Findings also expand the body of knowledge by delivering exemplars from the study group that offer a context for interpreting and understanding their lived experiences as FENs.

SUMMARY OF LITERATURE REVIEW

Upon examining the literature related to the acculturative experiences of FEN, few studies have been conducted in the US and more are needed to develop this body of knowledge. This is an issue of national and international significance and evidence based strategies are required to null the social, political and professional concerns of foreign recruitment. Exploratory studies on all aspects of this issue are the first logical steps to take to gain understandings of this phenomenon. During this study, lived experiences of

FENs were elicited to reveal their stories and discover the specific strategies they used to recognize and mediate acculturative and other stressors in their daily, personal and work lives.

CHAPTER III

Methodology

This chapter addresses the research design and methods employed to achieve the aims and questions posed by this investigator. Included in the discussion of design and methods are the ethical considerations of this research and a discussion of its trustworthiness and rigor. Findings of this study will be presented in Chapter Four. Discussion, conclusions, and recommendations related to the findings of this research will be presented in Chapter 5.

RESEARCH APPROACH

This study explored the lived experiences of US-employed foreign educated nurses (FENs). Methods and procedures employed in this *phenomenology of practice* (van Manen, 1990) study were designed to capture, describe, and interpret the meanings of the lived experiences of the FENs in the study group. According to van Manen, "the aim of phenomenology is to transform the lived experience into a textual expression of its essence" (p.36) so that those who listen to and read the reflexive account can relive the experience as if it was his or her own.

While the conduct of a *phenomenology of practice* employs eclectic methods and procedures in the process of discovery, it remains true to the accepted philosophical foundations and features of phenomenology as a research tradition (Munhall, 2001; Van Manen, 1997, 2002). As a research tradition, phenomenology aims to describe a phenomenon according to the perceptions of people who experience it rather than attempt to explain or analyze it from an objective outsider's or theoretical view (Merleau-Ponty, 1962). That is, phenomenology is recognized as the study of first order perceptions and reflections that are truths and understandings based on subjective experiences.

As pointed out by Merleau-Ponty (1962), a student of Edmund Husserl, the founding father of phenomenology, understanding phenomena through the use of perception and reflection provides a better approximation of truth than does science, which can only explain the empirical existence of the world and not how a person experiences it. Leedy and Ormrod (2001) agree that the meaning of any event is found in

a person's experiences with the event rather than anything found outside of the person, including theory.

Whether the goal of any phenomenological investigation is to describe (Husserl, 1920; Benner, 1994; Leonard, 1994) or interpret (Heidegger, 1927; Collins & Selina, 1998; Leonard, 1994) subjective meanings and essences found in the reflections of the study participants, there are seven features of phenomenological approaches that are widely accepted across various philosophical foundations of phenomenology (CARP, 2005). Most agree that phenomenology: (1) recognizes observable matter; (2) opposes objectivism; (3) searches for cognitive evidence; (4) strives to make all of life evident; (5) focuses on objects as they are encountered; (6) can be known through description; and (7) produces useful knowledge.

Even in the context of agreement about the features of phenomenological approaches to discovery, many movements and variations in the field of phenomenology have emerged since the times of it founding fathers, Husserl and Heidegger. The one movement pertinent to this study is the emergence of the *phenomenology of practice*, or applied phenomenology, as a research approach. Van Manen (2002), in his descriptions of the historical precedents of the *phenomenology of practice*, has suggested that its beginnings were seeded in the 1940s by the Swiss psychiatrist, Binswanger. Binswanger, like many contemporary practitioners of life, applied, and health care sciences, was more interested in the practice and application of phenomenology to everyday lives than its philosophical understandings.

Following the trend started by Binswanger, professional practitioners in the Netherlands, Belgium and Germany spread the use of this research approach over several decades as they conducted investigations related to their respective professional practice concerns. The *phenomenology of practice* became popular in North America during the 1960s, under the leadership of Duquesne University scholars like Amadeo Giorgi (Thomas, 2005; Van Manen, 1997, 1998). Since the 1970s, the *phenomenology of practice* has inspired psychologists such as Moustakas (Van Manen, 2002), nurse researchers such as Benner (1994), and educators such as van Manen (van Manen, 2002).

The *phenomenology of practice* continues to gain popularity as a research method that provides insights into the lived experiences of practitioners as well as their clients and the systems they interact within.

In this study, which aimed to capture the lived experiences of FENs working in the US, a *phenomenology of practice* approach was used to elicit subjective perceptions and interpret descriptive reflections of the study group as first order truths *viewed* through their own 'gazes'(Merleau-Ponty, 1967). Reflections of their lived experiences were elicited during interview-based data collection when participants were asked to recall their experiences and tell their stories Analysis and interpretation of participant's reflections were guided by Giorgi's Phenomenological psychological method (1985). Findings of this study are reported in detail in Chapter Four.

SETTING FOR THE RESEARCH

This research was conducted using a purposeful sample of FENs residing in the greater metropolitan areas of two major cities in the southwest United States (US). Both cities report population demographics that qualify them as ethnically diverse cities and both have large numbers of acute care hospitals that have recruited and employed FENs in large numbers over the past decade. The ethnic diversity of FENs working in the hospitals in both cities facilitated the recruitment of a maximally varied sample whereby every attempt was made by the investigator to enroll all eligible participants until data saturation and redundancy were met.

STUDY POPULATION AND SAMPLING PROCEDURES

The sample recruitment strategies used in this study were guided by nurse employment data from the two target cities and literature that suggest that the majority of FENs currently working in the US were recruited from The Philippines, India, Nigeria, Canada, Korea, the United Kingdom and the Commonwealth of States (formerly the U.S.S.R.) (Friess, 2002; Obermeyer, 2005; Trossman, 2002). Despite the multiple countries and cultures that US FENs represent, this investigator recruited a sample of participants that best represented the most number of FENs immigrating to US. That is, participants were those who immigrated to the US during the last five years from India,

the Philippines, and Nigeria (NCSBN, 2006). The sample was delimited by the required five-year period of stay in the US because, according to the existing literature, initial stages of acculturation occur between two to three years average length of stay and are completed within five years (Yi & Jezwski, 2000).

RECRUITMENT OF THE SAMPLE

A purposive sample of 20 full-time employed FENs nurses who migrated to US within the last five years from the countries of The Philippines, India and Nigeria were recruited for the study. Recruitment materials that described the study and delivered information about how to contact the investigator for more information were disseminated in hospitals, throughout organized networks of FENs, and in the communities surrounding the target hospitals. The study was also introduced by an oral presentation at one Filipino Nurses Association meeting. Once the study was underway, snowball sampling was employed to recruit the prospective participants.

Informed consent was obtained from all those who volunteered to participate using the IRB approved consent forms. IRB approved guidelines for protection of human subjects were followed throughout the study. Enrollment continued until data saturation and redundancy were observed in each of the Filipino, Indian, and Nigerian groups of participants. Recruitment and enrolled ceased when overall, data saturation and redundancy (Lincoln & Guba, 1985) emerged across all three study groups. The final sample consisted of eight nurses from Philippines, seven nurses from India, and five nurses from Nigeria. A complete description of the study sample is presented in table and narrative formats in Chapter Four.

ETHICS AND PROTECTION OF HUMAN SUBJECTS

The FENs are a vulnerable group considering their place in the mainstream of American nursing. The major factors contributing to their vulnerability are that they are new immigrants and ethnic minorities, they are completely dependent on their employers for the immigration status, and the majority of them are women coming from eastern cultures that view women as nonassertive and submissive to men. FENs, as new immigrants, are largely unaware of the tenets of mainstream American culture including

American history and government, language values and customs of the mainstream culture. In addition to gaining knowledge of American nursing practice, FENs are also struggling to get a grasp of the culture of the new country. The lack of knowledge regarding the American culture also affects the FENs' abilities to provide culturally competent care. Cultural and ethnic diversities of their client populations further complicate this dilemma.

A second factor that makes FENs vulnerable group is their complete economic and social dependence on their employers. While FENs are knowledgeable of nursing concepts, they need time to adjust to their new institutional environment and get a grasp of the technology, equipment and materials used in the workplace. Extreme dependence on the employer makes it difficult for the FEN to be assertive and ask for help because of the fear of being classified as incompetent and possibly losing their jobs. Socially, these nurses are of ethnic minority status in the US and lack the support of a wider, more well-known and accepted social network.

A third vulnerability is the FENs' communication gap. Specifically, they were perceived by co-workers to have a language barrier that caused them to be labeled as different, classified as incompetent, and isolated from others in the US workplace. While most of the FENs in this study group learned to speak English at a very young age and went through English-speaking nursing education programs, they were not skilled with American English, colloquialisms, and slang used here.

Additional factors that contributed to their vulnerability in the US workplace were their culturally ascribed nonassertive and submissive roles they had in their respective homelands. For some, their workplace activities were intimidating when it came to talking with doctors, asking questions about where supplies were located, and taking on roles that they did not traditionally incorporate into the professional practice of nursing in their countries of origin. They were unaccustomed to asking physicians for orders and they encountered patients who complained that they could not understand them.

All of the above-mentioned factors also contributed to making study participants uncomfortable about the prospects of participating in this study until they read through all

of the informed consent documents and had the researcher answer all of their questions. Diligent care was taken to approach the prospective participants sensitively and by explaining to them the neutrality of the researcher, in that she was not associated with immigration or any of the hospitals where they worked.

When prospective participants contacted the researcher to learn more about the study, the IRB approved informed consent was presented and all questions were answered before any individual was asked to sign the consent and enroll in the study. Participants were informed of their rights to privacy, anonymity, confidentiality, fair treatment, protection from discomfort, and to withdraw from the study at any time without harm. After the informed consent was signed, data collection commenced. A copy of the IRB Letter of Approval to conduct this study and a sample of the Subject Consent Form are found in Appendix A.

DATA COLLECTION

Data collection was done by in-depth individual interviews with the participants. After obtaining informed consent and agreeing on the setting and time for the interviews, the researcher made arrangements for a private location where privacy of the participants could be ensured. Data collection began when demographic data were gathered by the researcher to later describe the sample and determine recruitment needs so that maximum variation could be achieved. Demographics collected were: age, gender, marital status, country of origin, nationality of the spouse, nursing practice specialty, and number of years of nursing practicing in both their homelands and the US. The demographic data collection sheet used in this study can be found in Appendix B.

In-depth interviews lasted between 30 minutes to one hour each and no participants were asked to be interviewed more than three times. Samples of questions that were asked are listed below. They are also found in Appendix C. as components of the Interview Guide. Participants were asked to:

- Tell me about your experiences working as a nurse in the USA.
- Tell me about the experiences you had that you wish everyone who comes to the USA to work can have.

- Tell me about the experiences you had that you hope no one else ever has to experience.
- Tell me about anything else you want me to know about your experiences?

All the questions were supplemented with specific probes to focus on the phenomenon of interest and were asked as open ended questions to allow for the free flow of ideas and reflections.

Supplemental data that were part of this study but are not presented in the findings include the investigator's personal journal and field and methodological notes. The personal journal contains the investigator's reactions to procedures and events in the study. Field and methodological notes recorded procedural and observational situations, events, recommendations for changes, and actions of the researcher in response to recommended changes. While these data are not considered part of the findings of this study, they have influenced the discussion, conclusions and recommendations presented in Chapter Five.

All interviews were audio taped and transcribed verbatim. Transcripts were reviewed by the investigator while listening to the tapes in order to check for accuracy. To protect the identities of the participants, tapes and transcripts and all other study materials were coded with an identification number known only to the investigator. No participant's name was ever written on any study document. The signed consent forms were locked in a file cabinet inside the investigator's office, separate from any other study materials that might otherwise link data to a participant. Biodemographic data collected for purposes of describing the study group of participants was also used to verify that the investigator achieved maximum variation sampling.

To prepare the transcripts for coding during data analysis, the investigator read and re-read them to capture the essence of the stories told by the participants. Coding procedures commenced with the first interview as is recommended in most qualitative studies. This strategy provides guidance to and feedback for the investigator when planning the next interview with a newly recruited participant or follow-up interviews with those already enrolled.

DATA ANALYSIS

Data were analyzed according to a phenomenological psychological method developed by Giorgi (1985) and deemed appropriate for use with studies conducted as a *phenomenology of practice* (Van Manen, 2002). The four essential steps of the Giorgi method, used in the analysis of this study's data, are described in the following paragraph. As was introduced earlier, the first step of data analysis involved the reading and re-reading of each transcript by the investigator in order to get a general sense of the whole story or reflection presented by each participant. Next, the researcher read through the data a third time and marked those places in the narratives where a transition in meaning occurred, from a psychological perspective, and identified these as the 'meaning units'.

All similar meaning units identified throughout the data from the entire study group were then gathered together and labeled with terms that represented the various clusters of psychological insights being expressed at each level of abstraction. Also during this third step of Giorgi's process, inductive logic was used to order the meanings and insights into themes and conceptual categories that best represented the subjective reflections described by the participants. Finally, in the fourth step, the researcher synthesized all of the transformed meaning units (themes and conceptual categories) into consistent statements that communicated the shared insights about the meaningful experiences the study group revealed.

In Chapter Four, a summary table (Table 4.1) of the typology of themes and conceptual categories that emerged from this study is presented prior to a description of the sample. Following the description of the sample, detailed findings from the analysis of study data are presented. In the remainder of this Chapter's discussion of data analysis, examples of how this researcher moved through data analysis procedures are provided in the following paragraphs.

While reading the transcripts, identified transitions in meanings were marked as meaning units. Specifically, when one of the male participants reflected upon his expectations of coming to the US, he revealed that he thought it might be hard. However,

when he actually arrived here to live and work, he became aware of the reality that what he anticipated was indeed real and the reality was actually harder than his pre-arrival expectations. He said, “I knew that it would be hard. But nobody really told me personally that it is this hard!”(5.46-47). His transition from his perceptions to his reality was identified and marked as a meaning unit by the investigator. All similar meaning units revealed by many study group participants about life and work in the US being ‘hard” or “harder than they thought” were similarly marked in each transcript, aggregated and transferred into a separate document, and labeled using direct expressions or words of the participants in order to stay close to the data.

The tracking of data aggregates, descriptions, instances of data, and abstractions resulting from inductive thinking were accomplished using code books. Code books provide the audit trail for this study and validate the investigator’s movements through the data. They are found in Appendix F. Examples of how they were used throughout levels of abstraction are provided below. In the previous example, the meaning unit “it was hard” was identified as a transition, labeled using the direct expression, “it was hard”, and entered into Codebook I as a meaning unit. Expressions of similar meanings throughout the entire study group were identified, labeled, and added to the ‘it was hard’ meaning unit. After intensive examination of all similar expressions clustered into the ‘it was hard’ meaning unit, and a comparison of them with other direct psychological expressions of difficulties the FENs met with, inductive reasoning yielded a larger, more complex and parsimonious awareness of many things that FENs described as being “hard”. This re-organization or recoding of previously isolated meaning units of “hard” things into larger, more abstract clusters is recorded in Codebook II. For example, the more abstract cluster into which many types of “hard” experiences the FENs described and expressed were organized was labeled “reality was harder than the dream”, which gave a unified context to the internal psychological meanings expressed by each participant. This process continued until all psychological expressions of what the FENs

found “hard” in their experiences were exhausted: that is, until all were identified, aggregated, and labeled with the most appropriate terms.

In the next step, the groupings of “hard” things revealed in the reflections of the FENs and labeled accordingly as conceptual categories of psychological meanings were organized and displayed in Codebook III. At this point, specific verbatim descriptions taken from the transcripts were permanently affixed to the conceptual categories that emerged when individual and collective meanings collapsed to form these units of meanings. Movement of the researcher back and forth between the data and the conceptual categories that were emerging from them continued throughout all coding operations. Specifically, the researcher systematically went back and forth between each conceptual category and the raw data to test for goodness of fit. Descriptions of data that no longer fit the emerging context were moved or recoded to conceptual categories that were more compatible in terms of consistency in meanings. This inductive exercise is closely related to the constant comparison strategy used in grounded theory methods. Determining the best-fit conceptual category for any expression of meaning often requires help from the investigator’s free imaginative variation.

Following along with the previous example, direct psychological expressions of FENs revealing that their realities were harder than their dreams fit well within the conceptual category labeled ‘*Everything is harder than expected’* This category label emerged from the collapsing of all descriptions the FENs offered about finding life and work in the US more difficult than expected. At the beginning of the data analysis process, it might seem that separate categories are easy to identify. However, as inductive logic is applied to the organization of similar meanings so that abstraction permits theoretical efficiency, attention must be paid to the avoidance of jumping to conclusions too early. As data analysis and reduction continued, the investigator paid close attention to whether or not new conceptual categories were emerging. In fact, expressions of meanings overlapped more often than expected among the stories of the study group even though participants represented three different ethnic identities and came from three

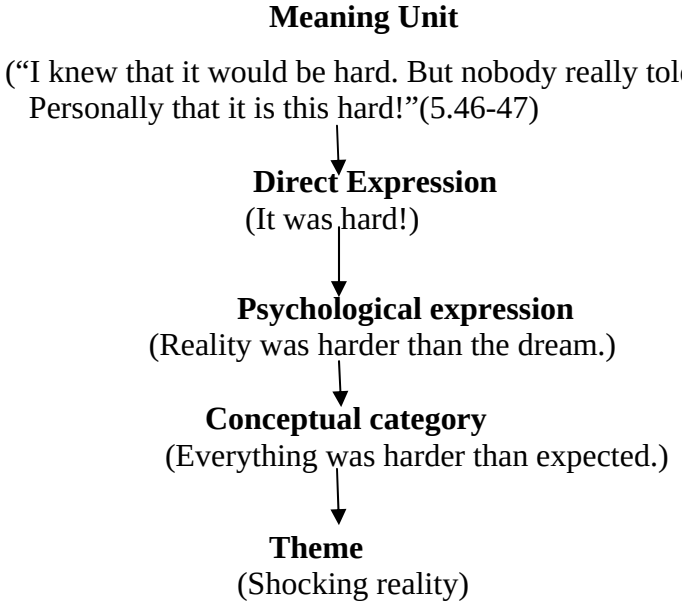
different homelands. Their experiences as FENs were amazingly similar and parallel, making it possible for all data to be analyzed together rather than in separate aggregates.

In the Final Codebook, conceptual categories in which meanings were grouped were examined for logical interrelationships. In the process of satisfying the existence of logical consistency, theme labels discerned through phenomenological intuition emerged for the clusters as described in the following example. The example conceptual category of ‘Everything is harder than expected’, along with the conceptual categories clustered with it because of similar psychological meanings, was subjected to a final analysis of theoretical consistency during which the emergent theme “A shocking reality” came to the fore as the label that unified collective meanings organized there. Thus, a thematic label is not the result of a "listing" of meanings expressed as conceptual categories, but is a representative "structure” which supports certain interrelationships among the concepts naively expressed by the subjects.

The determination of the essential categories and themes and their ultimate expressions remain subject to constant scrutiny and revision until the whole process of analysis is completed when data saturation and redundancy are achieved (Lincoln & Guba, 1985). In all these cases, the categories were tested against the descriptions or instances of data and vice versa. The following diagram (figure 3.1) displays the flow of inductive reasoning used throughout data analysis in this study as exemplified in the above mentioned example.

Figure 3.1

Flow chart of data analysis



At the conclusion of data analysis, 17 conceptual categories and six themes had emerged. They are discussed in detail in Chapter Four. The following section discusses how this investigator selected and evaluated criteria used to establish scientific rigor and trustworthiness of the study

ESTABLISHING RIGOR AND TRUSTWORTHINESS OF THE STUDY

Burns and Grove (2003) proposed that five standards should be used to evaluate the rigor of qualitative research studies: (1) descriptive vividness, (2) methodological congruence, (3) analytical preciseness, (4) theoretical correctness, and (5) heuristic relevance. Descriptive vividness refers to the clarity and accuracy of the researcher's account of the study. This criterion was met for this study by the researcher's attention to detail in the account of the study's procedures and a written presentation that brings the reader close to the data and its participants. The examples provided throughout data analysis and findings attempt to keep the reader connected to the authenticity and

originality of this study. Minute to minute proceedings are recorded in the researcher's personal journal and in methodological and field notes. Due to space limitations, they are not included in the Appendices, but are available upon request.

Methodological congruence, according to Burns and Grove (2003) is evaluated by how well the investigator meets (1) rigor in documentation, (2) procedural rigor, (3) ethical rigor, and (4) audit ability. To meet these criteria, this investigator accurately collected and recorded data and used member checks with participants to verify that the recorded data actually represented their stories. At least one Filipino, Indian, and Nigerian FEN in the study group participated in member checks. Data analyzed to the point of emerging conceptual categories were presented to the members for verification. No one identified misinterpretations or advised that changes needed to be made. Potential biases of the researcher, herself an FEN, were bracketed. The bracketing was determined sufficiently rigorous when member checks resulted in no requests for changes due to misrepresentation. Ethical rigor was achieved by requiring written informed consent from each volunteer participant. Vulnerabilities of the immigrant nurses made it especially important to protect them from harm and so extra precautions were taken to ensure confidentiality and privacy. Audit ability of this study is met at a high level given the detailed examples that were provided when data coding and analysis were discussed. The audit trail for this study consists of this written dissertation, all of its texts, codebooks, and appendices. Raw data found in the tapes and transcripts of the narrative also constitute auditable records. Dr. Terry Throckmorton who examined codebooks and findings in the forms of conceptual categories and themes determined audit ability to be satisfactory. She attested that she could follow the decision trail of this investigator and arrive at the same conclusions.

Analytical preciseness was determined by Dr. Drew's examination of the data coding procedures, the emergence of theoretical efficiency and congruency, and the records that suggest the goodness of fit between data, the conceptual categories, and themes. Dr. Drew has also determined that many of the findings have a theoretical

connectedness to extant knowledge and others contribute new perspectives that can be translated to nursing practice, in particular, with FENs.

The last of Burns and Grove's (2003) standards for establishing the rigor of qualitative studies is heuristic relevance. For a qualitative research study to meet this standard, the reader of the study's proceedings must have the capacity to recognize the phenomena described in the study, the theoretical significance of the findings, the applicability of findings to nursing practice and their influences upon future research.

In addition to evaluating the rigor of qualitative studies, trustworthiness or truth value is also an important determinant of the authenticity and usability of the findings. Basically, Lincoln and Guba (1985) established criteria for trustworthiness that are appropriate for all forms of qualitative research, including phenomenology. The goals of subjecting qualitative studies to examinations of their trustworthiness are related to determining whether or not the data reflect the truth of the phenomena of the lived experiences revealed by the study participants. The four criteria associated with evaluating the truth value of this study are: credibility, dependability, confirmability, and transferability.

Credibility

Credibility in qualitative research is concerned with the confidence in the truth of the data and the interpretation of the data (Lincoln & Guba, 1985). In this study, credibility of the study findings rests on the use of the techniques of prolonged engagement, persistent observation, triangulation and external checks. The prolonged engagement that took place during this study is related to the investment of time in the respective workplace communities where FENs are employed. Prolonged engagement created name and face recognition for the researcher and developed a degree of trust that she was not associated with immigration and meant no harm. This prolonged engagement also provided opportunities for the investigator to understand some of the cultural and language use issues the study group revealed during interviews. Consistencies between what the investigator heard and saw were established through prolonged engagement and persistent observation.

Triangulation is another technique that was used to establish credibility in this investigation. Triangulation uses multiple referents to draw conclusions about what constitutes the truth. Its purposes are to overcome intrinsic biases that come from single-method, single-observer, and single-theory studies (Denzin, 1989). While multiple methods were not appropriate to employ in this phenomenology, biases were held in check by having members of the dissertation supervisory committee and other dissertation students participate in peer debriefing. Peer debriefing in this study involved meeting with objective peers to review and explore various aspects of the research study and meeting regularly with mentors. Member checks, already described above in the section on Burns and Grove's criteria for evaluating rigor, involved having members of the study group critique the accuracy of concepts and themes in terms of how closely they represent what they revealed during the interviews with the investigator.

Dependability

Dependability is the next criterion that is evaluated to establish the trustworthiness of a qualitative research study. Like the reliability-validity relationship in quantitative research, there can be no credibility in the absence of dependability. There are two suggested techniques associated with establishing dependability in qualitative research: (1) the stepwise replication, and (2) the inquiry audit. In order to establish stepwise replication, the qualitative study should involve several researchers so that the results found by each can be compared and tested for reliability and validity. In the case of this dissertation, the requirement that it be independent research precludes the use of multiple investigators. Therefore, stepwise replication cannot be addressed or evaluated. However, establishing dependability through an inquiry audit was possible and was done. The inquiry audit involved the use of an external reviewer to scrutinize the data and all relevant supporting documents. Three individual researchers participated and determined that the criterion of dependability was met. They arrived at this determination following an audit using the trail of the researcher's movements through the data and the study procedures recorded in the researcher's journal and in field and methodological notes.

Confirmability

Confirmability is associated to the objectivity and neutrality of the data in a study. In this study, confirmability was evaluated by two peers and two dissertation committee members when they determined the study's accuracy, relevance, and meaning. Confirming the closeness between the data and the emergent categories and themes contributed to positive conclusions that bracketing was successful (Ashworth, 1999). The detailed presentation of this study's methods, procedures, and findings the auditable trail required by the evaluators. Two independent auditors confirmed that conclusions drawn by this investigator are true and rest on the thick and rich data provided in the interviews. Member checks and peer debriefing, described earlier, were also used to verify the researcher's findings and conclusions.

Transferability

Transferability occurs when the findings from the data can be 'transferred' to other settings or groups and is similar to the concept of generalizability. The transferability of these study findings is yet to be determined. However, this researcher has left a detailed and auditable trail that directs replication in other or similar populations. A thick description of the research setting as well as the transactions and processes observed during the research project has been delineated. However, given the exploratory nature of this phenomenology of practice and the small sample size, generalizability of study findings is limited. In conclusion, this study has met minimum criteria to establish its scientific rigor and truth value. While there are many authors with lists of evaluation criteria, Burns and Grove (2003) and Lincoln and Guba (1985) were determined to be the most respected and appropriate experts to use in this study.

The findings of this study are presented in Chapter Four, including a description of the study sample. Discussion, conclusions, and recommendations will be found in Chapter Five. A summary of this Chapter follows.

SUMMARY

This qualitative Phenomenology of practice study to understand the meaning and experiences of acculturation of FENs was conducted using a sample of 20 foreign educated nurses from Philippines, India and Nigeria who were migrated to US within the

last five years and are residing in the Houston and Galveston communities. Data was collected through detailed interview of the participants and the transcribed data were coded and analyzed according to the Giorgi Method (1985). Findings constituted 6 themes and were representative of the Phenomenon under study. Rigor of the study was evaluated against the Burns & Grove (2003) criteria of descriptive vividness, methodological congruence, Analytical Preciseness and Heuristic relevance. Also trustworthiness was evaluated against Lincon and Guba (1985) criteria of credibility, confirmability, dependability and transferability.

CHAPTER IV

Findings

The purpose of this phenomenology of practice investigation was to explore and describe the lived experiences of twenty foreign educated nurses (FENs) who immigrated to the United States of America (US) to work as registered professional nurses. Participants in this study completed their baccalaureate nursing education (BSN) in their countries of origin; respectively, The Philippines, India and Nigeria. All came to the US within the five years prior to their participation in this study in response to recruitment efforts conducted in their homelands by US healthcare corporations.

As described in Chapter 3, demographic data and narrative data were collected during interviews with the investigator. Each interview lasted between 30 and 60 minutes, was audio taped, transcribed, and coded to protect the identities of each participant. Data analysis proceeded according to Giorgi's Phenomenological Psychological Method (Giorgi, 1985), also described in Chapter 3.

OVERVIEW OF THE FINDINGS

Codebooks found in Appendix F of this dissertation reveal the inductive logic and units of meaning that emerged throughout the data analysis process. Empirical instances of data found in the transcripts were unitized, collapsed, and abstracted to form 17conceptual categories of meaning that represent the study group's lived experiences. Further analysis of the17 meaning units yielded six main themes that communicate the realities that the FENs experienced between the time they arrived in the US and their participation in this study. Table 4.1 below displays the conceptual categories and themes. A detailed discussion of these findings follows Table 4.1.

Table 4.1 Conceptual Categories and Themes

Conceptual Categories	**Themes**
Desire for money Live the good life	*Dreams of a better life*
Navigating immigration Leaving friends and family behind Feeling lost	*Difficulties of the journey*
Everything is harder than expected Nothing is familiar Overwhelmed by cultural diversity Needing help and getting little Being viewed as incompetent	*A shocking reality*
Building on individual strengths Willing to learn new ways Creating networks Finding support	*Rising above the challenges*
Mastering systems at work and in daily life Building new dreams	*Feeling and doing better*
What others need to know and do	*Ready to help others*

Theme one, *Dreams of a Better Life*, establishes the context of the FEN's aspiration to move to the US. The narratives reveal the promises given by the recruiting agencies and the images of American life communicated to the participants through television programs, movies, and other media. The dreams talked about by the study

participants were in place prior to the start of their journeys to the US. As will be discussed in detail later in the explanation of conceptual categories and themes found in this study, most participants admitted that the promises of earning lots of money and living the good life in the US were what enticed them to respond to recruitment efforts. The conceptual categories reflected in the data were desire for money and live the good life.

Theme two, *Difficulties of the Journey*, depicts the unanticipated hardships the FEN study participants faced once they made the decision to go to work in the US. The conceptual categories that collapsed to form this theme were navigating immigration, leaving friends and family behind, and feeling lost. Again, the details of each meaning unit and the emergence of categories and themes will be provided later in this chapter.

Theme three, *A Shocking Reality*, emanated from the conceptual categories of everything is harder than expected, nothing is familiar, overwhelmed by cultural diversity, needing help and getting little, and being viewed as incompetent. In work life and everyday life, the FEN participants found meaning in what it was like to face a failed dream, feel like a stranger, be lost in a foreign land, and have little support to face obstacles and overcome barriers. Details and instances of data to support the categories and themes are presented later.

Theme four, *Rising Above the Challenges*, emerged from conceptual categories of meaning that reveal the FEN participants' responses to lost dreams and a shocking reality that forced them to view the unfamiliar as things that needed to be overcome. As realities replaced what was promised by recruiters and presented in the media's portrayal of the American way of life, the FENs mobilized their personal strengths and abilities to rally towards seeing their dreams come true. The conceptual categories that collapsed to form this theme were building on individual strengths, willing to learn new ways, creating networks, and finding support.

As time evolved and dreams were modified, the FEN participants found themselves *Feeling and Doing Better*. This fifth theme reveals meanings found in the collapsing of the conceptual categories of mastering systems at work and in daily life and

building new dreams. Theme six, the final theme, reveals the FENs' readiness to share their lived experiences for purposes of helping others. *Ready to Help Others* suggests that the meanings of the lived experiences of FENs are believed to be significant and important to pass along to ease the adjustment of FENs to come. The primary conceptual category that contributes to the emergence of this theme is what others needed to know and do. This category and theme express the various needs FENS experienced having and what can be put in place to help future FENs. Primarily, the FENs' suggestions may guide future planning by recruiting agencies and inform the networks of FENS both in their countries of origin and as newcomers to the US.

DESCRIPTION OF THE STUDY SAMPLE

The demographic data pertinent to this study include age, gender, nationality, marital status, number of children, nationality of the spouse, educational status, type of nursing specialty and years practiced in their home countries and in the US. The study group was comprised of 20 baccalaureate-prepared nurses; eight from The Philippines, seven from India, and five from Nigeria. Three had earned masters degrees in their homelands before moving to the US.

Overall, the age range of the participants was from 23 years to 44 years. Eighty percent of the Filipino nurses were unmarried, whereas all the nurses from India and Nigeria were married. Only two spouses were of American nationality. The others were the same nationalities as their nurse spouses. On average, the Nigerian nurses had more children than Filipino and Indian nurses.

Years of nursing practice experience while in their home countries ranged from one year to 23 years, mostly in acute care specialties. Years of nursing experience in the US ranged from three months to four years and nine months, again, mostly in acute care specialties. Table 4.2 presents a summary of the description of the sample of participants.

Table 4.2 Demographic Data

Country of Origin (n=20)	Gender (M=male) F=female)	Age Range in Years	Marital Status (M=married S=single)	Mean Number of Children (M/S)	Mean Years Nursing Experience in the homeland.	Mean Years Nursing Experience in US
The Philippines n=8	M=2	30-32	1M 1S	0 0	6.5 years	1.9 years
	F=6	23-42	2M 4S	1.5 0		
India n=7	M=1	30	1M	0	8.4 years	1.6 years
	F=6	26-43	6M	1.16		
Nigeria n=5	M=0	n/a	n/a	n/a	8 years	2.7 years
	F=5	28-44	5M	2.3		

DETAILED PRESENTATION OF FINDINGS

Theme 1: *Dreams of a Better Life*

While aspirations for high paying jobs and opportunities to have a better life prevailed in the motivations that all study group members had for coming to America, they knew little about the struggles and challenges they would soon face as their journeys unfolded. No matter which home country they were from, each participant expressed a desire for money and a wish to live the good life as primary reasons for responding to the recruitment efforts of several US healthcare corporations. As these primary reasons emerged from each of the narratives, they were clustered and coded to form the conceptual categories that dominated the voices participants shared as they discussed their personal choices and how they came to determine what life in American would mean to them. Their family and friends already in America encouraged them to come to the US and painted them a picture of the American dream which, as they soon discovered, was brighter than the reality that was waiting for them.

Many of the participants told stories of how life in the US was depicted as rich, easy, and glamorous in television programs, movies, and other popular media broadcast worldwide. As their stories unfolded, the true realities disappointed them, shocked them, and presented challenges that they did not expect. In the words of a young female participant from the Philippines who was influenced by her family to make the journey to the US, disappointment can be heard as she tells of her discovery that life here is not easy. She said, “But my god they didn’t tell me like that it is this hard! All they told me is positive, positive!”(4.125-126).

Another participant from Philippines found a great contrast between the happy lives she saw in American movies and the realities of human experiences in everyday life. She said:

> And then the way they put it in the television, you know, well, that one is like in New York or California! It has always been a happy place, lots of people! Then

> when I came over, it was like oh my God, you are going to see lot of sick people out there! (8.147-152).

Expectation of an easy life in US was echoed by Indian and Nigerian nurses too. In the words of one Nigerian study participant:

> You know… [It was] very easy, the idea was once you come here, you can make it! We never had any negative aspect [about] coming to America. I never expected anything, any hindrances or difficulties, until I started looking for a job (16.1-9).

Throughout the analysis of narrative data in this study, no differences were verbalized about the expectations of coming to the US between participants from The Philippines, India and Nigeria.

Theme 2: *Difficulties of the Journey*

The FENs in the study sample faced multiple challenges and experienced many hardships while trying to realize their dreams of going to the US to live and work. Most that made the journey were sponsored by an employer and on their behalves the employers presented formal job offers and contracts to the US Immigration and Naturalization Services (INS). To complete their eligibility to enter the US and work as professional nurse, each FEN had to demonstrate English language competency in three examinations and safe nursing practices by passing both the CGFNS and NCLEX- RN examinations.

In addition to competency and nursing practice exams, there were hundreds of papers to complete and file pertinent to immigration and travel. For most, immigration processing took an average of two years. FENs invest a considerable amount of time in waiting and a substantial amount of money in terms of fees and expenses in order to complete the requirements. Once FENs reach the US, they are usually bound by contract to work for the employing hospital or agency for a fixed number of years.

Navigating immigration was not an easy task for any one of the FENs in this study. Discussion of such troubles was found repeatedly in the stories of the study group members which formed a major conceptual category that contributed to the emergence of the theme, *Difficulties of the Journey*. According to one of the participants who had a hard

time navigating immigration, the time needed to complete all that was required to obtain a work visa was long and frustrating. One male Filipino nurse said, “Regarding the visa, it is really a problem because it took me almost four or five years before I actually had it” (5.224-226).

Other dominant conceptual categories in the *Difficulties of the Journey* theme were leaving friends and family behind and feeling lost. Most of the participants admitted that they missed family and friends back home and their familiar patterns of living and working in their home countries. According to a young unmarried male participant, being in the US without people close to you presents a serious challenge. He said, “You just come here with nobody. Come here all by yourself with no experience, or own blood, it could really break you” (5.318-322).

The loneliness the study participants experienced was profound, as was explained by a Filipino participant who said, “It is hard adjusting to the system, like, if you have to live by yourself, you don’t have family with you and you do everything by yourself” (3.83-86). Many told a story of initially feeling overwhelmed by the demands of adapting to a new country, many new cultures, and a different work system. According to one male who experienced all of this, “culturally you know we had a hard time adapting with the language, with the culture, lifestyle, and way of living” (2.41-43).Upon arrival to the US, strangeness about this new living place contributed to their feelings of being lost in a strange land. A female nurse from India said, “It is hard because we are new here, the place and the way, the roads, you have to leave your children alone [you have to drive] in the night … I had that problem” (13. 83-87).

Theme 3: *A Shocking Reality*

Theme three, *A Shocking Reality*, reveals the awakenings and challenges the FENS experienced after arriving in the US; none of which were anticipated prior to their arrival. The realities were hardships for many as they tried to familiarize themselves with strange ways and adapt to a new environment, new culture, and new expectations. The conceptual categories of the challenges the FEN study group revealed in narratives of

their experiences define the strange and helpless feelings they were ill-prepared to face and deal with. Each will be discussed in the following paragraphs.

Everything is harder than expected captures the overwhelming realities expressed by the study group pertinent to what it was like to be a stranger in a strange land and not knowing the rules or ways to get around. For example, participants conveyed that transportation was their biggest challenge initially. It was extremely difficult for them to move around due to the lack of a car and driver's license. Lack of adequate public transportation to get around town further increased their difficulties because commuting to work necessitated having a car rather than using public transportation, which was the norm in their home countries. One distressed Filipino participant said, "But over in The Philippines you could go to work just commuting you know? There will be buses or taxis or anything…by using any means of public transportation. And here you are expected to drive" (3.79-83). Indian and Nigerian nurses also expressed the difficulties related to transportation. A well experienced and well traveled Nigerian nurse said:

> The only thing I found kind of like a set back was transportation, you know here in Texas! I guess it's not like that in other states or maybe in downtown you know? But coming to live down the road here you doesn't even have a car to come to work! (17. 27-32).

Many FENs were leery about highway driving. According to an Indian nurse who did not drive at all in her homeland but found it absolutely necessary to drive in the US, "Here this is a Highway; I drive and my husband sits. [Even after some time], I am still afraid of the crowds". (13.94-96). It was clear from the narratives that getting to and from work was harder than expected for all. Another source of stress among the study sample was related to work life being harder than expected. Rules at work often caused them worry. As one young nurse said about absences from work when feeling ill:

> Here the life is more stressful than there [homeland]. Here you have to work even if you are sick or something. You cannot be that way for a long time because it does affect everything, your insurance and everything if you are not working. (15.74-78).

Nothing is familiar is the next conceptual category that organized the study group's reactions to how strange they found everything to be as they tried to find ways to

get to and from work, find a place to live, locate everyday life necessities such as a house of prayer, a grocery store, schools for the children, and learn new systems of health care delivery and nursing practice. They were faced with the challenges of learning the American way of living and becoming familiar with multiple different nursing and social systems.

As the label for this conceptual category suggests, stories of the participants included their fears and anxieties associated with feeling like a stranger in almost every daily living and work encounter they experienced. In the work setting, some things American nurses take for granted were difficult for the FENs to learn about and cope with. For example, trade names of medications were different in the US than they were in their homelands and the FENs received little help from co-workers in understanding medication administration systems in the US. For example, Tylenol is not used or available for use in some countries. Learning about it prior to using it as ordered for patients was something the FENs had to do on their own. No orientations given by employing agencies included specific information about drugs used and not used in other countries. One Indian nurse with many years of experience in her home country said, "You know sometimes [it is] just difficult to catch the name for the medications and the way they give you the order, their [the doctors'] accents …. [Are difficult to understand]" (13.128-131).

In their new US practice settings, the FENs experienced additional unfamiliar expectations such as high patient acuity and patients with many demands. In their homelands, they experienced more family involvement in the care of patients and related the family's involvement to showing love and influencing the speed with which a patient recovers. One Nigerian nurse said:

> I see that around, it doesn't take anything from me going to give them water, but I feel if the families are there, that is your time, they show love, they show that they are really concerned and that would make the patient feel happy, feeling ready to go home(16. 111-116).

All FENs in the study group, no matter which country they came from, talked about how different US patients are compared to their own country patients. Among their

US patients, they saw that the demands they made of the nurses were based in their being better informed about their illnesses and health problems. As one Indian nurse explained, "The patients here are more knowledgeable and they have lot of questions to ask and that helps us also to make ….to brush up our knowledge and keep updated with our knowledge and all those things" (14.30-34).

Throughout their struggles in a new country and challenges of learning new ways of doing things, most of the participants admitted that they were overwhelmed by cultural diversity found in the US population; specifically in communities and among their patients and co-workers. Homelands of most all of the participants were filled with people of the same culture. While it is true that many different sects and religious orders co-existed in their home countries, there were far fewer ethnic and cultural groups to learn to live with than they found were here in the US. Many expressed that while the culture of nursing is universal; the cultures of the general population, co-workers and patients served by nurses in the US are not.

FENs in the study group continuously faced situations in which they had to adapt to different cultural expectations and values presented to them in their daily work and life. One Nigerian nurse emphasized that US employers and recruiters need to take into consideration the need to educate FENs about different cultures they will encounter in the US and that culture shock might be a reality that complicates their adjustment to daily life and work. She said, "This [culture shock] comes to you in a place where the culture is so different. People are bound to have culture shock which is one thing some [recruiters and employers] don't even [take] into consideration." (17.211-214).

Since most of the FENs recruited for participation in this study were from homelands in eastern countries where cultures are described as being more conservative and closed than the prevailing western cultures in the US, study group members strongly suggested that education about other cultures be formalized and presented to them to ease culture shock. More about their recommendations for recruiters and orientation programs are discussed in detail later in the report of the findings when the theme *Ready to Help Others* is presented.

Primary concerns about being overwhelmed by cultural diversity were in the context of understanding and meeting their patients' needs and being accepted and trusted by co-workers. The education about cultural diversity that the study group felt was important to include was that which addressed tolerance and how to set realistic expectations of each other. For example, one participant described benefits that can come from education on cultural diversity. One Filipino nurse said, "Like [it] helps you to understand . . . not to judge people . . . for us who are coming from a conservative culture, it helps [us] to be open to their [other] culture[s] (3.335-339)".

Participants with previous exposure to people of different cultures suffered less overwhelming feelings when they faced the cultural diversity of the US upon arriving and starting work. This previous exposure seemed to lessen the impact of culture shock. Another experience the FEN study group found that eased any pressures they felt in the midst of diversity was living and working in cosmopolitan settings versus the more homogeneous rural communities. Those living and working in large cities found their after-shock adaptation experiences to be more positive than those who first lived and worked in more rural settings where fewer foreigners were living and working. An Indian nurse who first worked in a rural US hospital shared her experiences and said, "I first came to Louisiana. The hospital where I worked had no Indians, so we [were] new for them. Sometimes we felt that we were kind of treated. . . [Not quite like] discrimination" (13.19-23).

A Nigerian nurse who first landed in a city in California said about her experience, "You have more foreigners in California, more Nigerians, you know, Indians [too], and you try to blend in, and you know knowing that you also are a foreigner" (16.64-67).

Prevailing complications of feeling overwhelmed by cultural diversity included difficulties with communications, especially in the work setting and with co-workers as well as patients. In the initial period after arriving in the US, many study participants admitted they were baffled by the different accents of the English spoken by different cultural groups. The FENs were able to understand Standard English but did not know

the meanings of most slang words. Some of them felt isolated and disconnected due to an imposed language barrier they had not anticipated. They tried to adapt by consciously making efforts to modify their own accents so they could be understood. In addressing her concerns about understanding others and being understood, one Filipino nurse said, "Because normally, in the normal conversation that we have we could understand each other. But when they speak their native slangs, that is where the difficulty comes in" (5.367-371). An Indian nurse also identified tuning into different accents as a major problem for people who use English as a second language. She said, "Because we were not speaking English as usual in India, the pronunciation is different" (9. 8-9). A Nigerian nurse who had a hard time understanding American English said "When they talk I don't hear. Maybe the person makes 10 sentences; I will be able to hear one" (18.100-101). A second Nigerian nurse described how most members of the study group were feeling about the language problems when she talked about how impatient others became waiting for other person to express themselves. She said: "Some of them say 'Oh, you have an accent. I don't understand you, I don't understand you', but they don't take time to listen! Because if they listen …..[They will understand]" (16. 217-219).

The study group as a whole discussed the difficulties they had with a strong sense of determination to adjust and succeed, no matter how little help was offered to them. The things they wished they had help for collapsed during data analysis to form the fourth conceptual category within the theme, *A Shocking Reality*. This conceptual category labeled, <u>needing help and getting little,</u> represents the study group's disappointments about having no one who really wanted to help them or make a special effort to ask how they could help them. Part of what made the realities the FENs faced in life and at work so shocking was the recognition that they needed help with many things and that there were few people to rely on for help. This unmet need echoed throughout their daily lives and most emphatically in their work lives. While all of the FENs in the study group were well-educated and articulate in the English language and the basic skills and practices of the nursing profession, unfamiliar healthcare delivery systems and

expectations peers set for them left them feeling alone and feeling as if they had to make it on their own.

Two of the most challenging work situations the study group members wished they had help to understand were the different goals the US health care delivery system had in comparison to the systems in their homelands and the consumer attitudes of the US population of patients. Most of the FENs expressed that recruiters had not prepared them to see and deal with a different system and face different patients. All wanted help to understand these differences so they could more quickly adapt and function efficiently at work. One participant expressed the overall perspectives of the study group members when she described how unprepared she was to deal with patient behaviors here in the US that vastly differ from what she was used to in her homeland. She said:

> Initially when I came I found that the patients here are more demanding. In our country [they consider nurses]; we are doing a service or something like that. Here there is more of a [consumer attitude]. . . That type of thing. . . and so the patients, they just cannot wait! (15. 29-34).

The complexities of the business-oriented US health care delivery system also presented challenges for many FENs in the study group. One said, “Insurance, case management . . . like in the hospital you have to know a lot of stuff. They have lots of institutions...like nursing homes… we don’t have nursing homes there [back home]” (4.84-88). Not only did the FENs express wishes to get help to learn about the new systems they were working in, but several also discussed how they had to re-learn many nursing skills and procedures that they were proficient in when they worked in hospitals and other healthcare systems in their native homelands. Specifically, modern, high-tech equipment and monitoring devices used in US health care delivery systems required the FENs to apply their nursing knowledge in new ways and adapt their skills away from the more primitive health care delivery styles they used in their homelands to those that were necessary to support the high-tech approaches to care used in the US. One Nigerian nurse said: “You have to learn the culture, have to learn the equipment, everything. I had to learn how to use the pumps and everything [else]” (19.62-64). One of the Indian nurses

voiced the same concern and said: “The equipment we were using in India was entirely different from here. Here, everything is well advanced” (9.15-17). The Filipino nurses also discussed differences in technology and expressed excitement about how relatively easy she found her work to be in the US. She said, “Everything here is like one punch! Like you know, you don’t have to calculate” (1.43-45).

While most FENs in the study group were pleased with the technologies that were making their jobs exciting and different, many told stories of needing more time, education and support to master those newer technologies. However, their stories also told of disappointing failures when criticism rather than support came from co-workers. Other experiences the FENs had related to needing help and getting little were in learning to use the computerized documentation system. In order to learn and become proficient in the use of such systems, FENs needed more practice time, but not enough was provided.

Still another area of practice that the FENs felt they needed help with was understanding the perceptions of pain among US patients and the types of treatments for pain commonly prescribed here. Cultural differences in pain perception and treatment were difficult for the FENs to understand. The FENs expressed that they were not prepared for this different pain and pain management culture and they found no help to support their adjustment to this difference. The Fens’ first exposures to patients’ perceptions and complaints of pain where overwhelming and the reality that no one was there to help them gain information and manage both their own shock and the patients’ pains were unpleasant experiences. One Filipino nurse who was surprised to find this challenging situation in her practice said: “So especially the pain, pain, pain. It is like a major thing for them (3.142-143). An Indian nurse who more gradually realized the differences in reactions to pain among patients said:

> Gradually I realize that the perception of pain here and in our country is a little different. Here maybe the tolerance it low or there maybe they think they will have some pain so it is expected, it’s ok. They won’t demand, but now I know I give more importance to pain, that was a new learning (15.40-46).

No recruitment or orientation materials did anything to prepare the FENs to face the reality that US patients seem to have very low pain tolerance when compared to

patients in the homelands of the FENs. One young Filipino nurse clearly captured the perceptions of the study group on this topic when she said, “Here [when patients have] just a little stress, [The physician responds like] ‘Okay you need Seroquel, You need Alprazolam, You need to talk to the Psychiatry’ ” (1.804-806). Another Filipino nurse remarked that there are deep differences in philosophies about pain management between her native culture and those found throughout the US healthcare system. She said, “I don’t understand this. Morphine every 4 hours. We don’t see people like that back home. They don’t need medications like that, but here it’s like chocolate” (6.222-225).

Telephone orders were other issues where FENs needed help adjusting to because it presented major differences in practices between their homelands and US nursing practice. Primarily, telephone orders presented major deviations in professional practices. In their respective homelands, the FENs were used to receiving only written orders from doctors who come and see the patients and then write the orders at the bedside. After coming to the US, they found they needed help to resolve uncomfortable feelings related to reporting patient’s condition to the doctors by telephone and receiving telephone orders because of doubt about the scope of practice and difficulties they had with language; understanding and being understood. As one Nigerian nurse noted:

> The first time I had [a telephone order], I was like what if the doctor said I wasn’t the person [s/he] spoke to you know and I had to talk to the doctor about this one and getting orders, what if [s/he] comes and denies [says] oh no that’s not what I said? (17. 107-112).

This issue was compounded for the FENs by the potential misunderstanding of what the physician ordered verbally because of the problems they were having with accents. Additionally, many found that attitudes of some doctors during the communication of verbal orders were offensive and made them feel like they were stupid. One Filipino participant noted, “when we ask them, the doctor, the way they [pronounce] the drugs [they are ordering]...like sometimes I can’t [understand] them and I [have to ask] ….doctor can you please spell it for me?” (1.261-264). One of the Indian nurses recounted that the nurses who worked night shifts had even greater difficulties obtaining telephone orders from unhappy physicians who were awakened by the nurse’s call. She

said, “Here we don’t have doctors in the ICUs. If in the [middle of the night] we need to inform or if we need to tell anything, we call the doctors and at that time they are rude” (10.122-125).

Some of the FENs found that their co-workers viewed difficulties the FENs experienced with language, doctors’ orders, patients’ demands, and new technologies as signs that they were incompetent. This perception and harsh treatment from co-workers made the FENs feel that they were disliked and not trusted. A Filipino nurse who felt no support from her coworkers said, “You know, the way they don’t welcome you, you don’t get that support and you don’t grow” (3.306-308).

The FENs’ stories about these experiences provided data that when analyzed collapsed to form the fifth and final conceptual category comprising the theme, *A Shocking Reality*. The lack of a supportive environment not only shocked the FENs, but it seriously affected morale. One participant reacted to being mistrusted on the job and made to feel like she was incompetent. She said, “It’s like a shock to me, very degrading; it’s very like my morale is down. It’s like rejecting you totally. But I cannot understand them. They are always thinking I’m new and I don’t know what I’m doing” (6.71-76)

Having come to the US with several years of nursing experience and confidence that each was a “good” nurse, feelings of mistrust and incompetence imposed by peers in the US workplace were hurtful and shocking to most members of the study group. However, feelings that they were not getting the help they needed and wanted, combined with being made to feel inadequate, actually moved the FENs to try even harder to overcome the challenges they faced rather than retreat. Their stories reveal that they pulled themselves together, supported each other, and moved forward. It was not comfortable for any of them to feel inadequate and be perceived by peers as not measuring up to expectations.

Despite the many unanticipated realities that shocked the FEN study group members, as time passed and they adjusted to the new systems, technologies, and diverse characteristics of the US patient and peer populations, they found themselves enjoying their professional practice. As the FENs renewed their confidences and enjoyed their new

tools and skills, they found new bonds with each other and created new support systems to sustain the positive changes they were experiencing.

Theme IV: *Rising above the Challenges*.

The new and combined sets of energies and confidences that the FENs experienced contributed to the emergence of the fourth theme, *Rising above the Challenges*. *Rising above the Challenges* represents the collapsing of four conceptual categories of meaning that tell the stories of the FENs' new beginnings. The four conceptual categories are: building on individual strengths, willing to learn new ways, creating networks, and finding support.

Changes in the ways the FENs handled criticism was driven by resurgence in self-confidence. Their growing knowledge about the cultures they were encountering and positive changes they made in their own responses to what others tried to do to put them down were signs that they were building on their own strengths. As one FEN suggested:

> So now I am learning so when they ask 'do you know what you are doing?' I am not hurt anymore. I'm like; yes, of course I know what I am doing. I've been practicing this for how many years? I know what I am doing. (6.93-97)

Another story about how the FENs rose above the challenges came from a Nigerian nurse who talked about how important it was to show they were willing to learn new ways. In the context of explaining how much harder she had to work to gain acceptance from peers in the workplace, she said, "You actually have to work so hard to make them know that you exist on the unit." (16. 23-24). New learning was also demonstrated in the many ways the FENs overcame the initial language barriers that tended to isolate and disconnect them from peers and patients and had fostered their insecurities. A Nigerian nurse explained the new way she learned to manage what people in the workplace perceived to be a language barrier. She said, "So it was, I would say I have a communication problem sometimes. Your client they wouldn't understand you because of your accent, [but I learned to say] things in a way they will understand" (19. 32-36). In addition to learning new ways themselves, the FENs found that if they rallied

together and supported the needs they had as individuals and as a group, they were much better able to cope.

Creating networks and finding support in each other were two dominant conceptual categories of meaning that emerged from instances of data revealing how banning together to join strengths helped the FENs rise above the challenges. Even though the following instance of data delivers some negative messages, the context of this participant's story holds suggestions for what not to do and how to correct current practices by dealing openly and directly with peers, so positive changes could be made and supported. The FENs regarded support from co-workers as vital for adaptation to the work place. One participant captured the study group's growth in interpreting and responding to communication styles that they all agreed were in need of change. She said:

> Instead of telling you 'oh this is what you're doing wrong, [say] 'let's do it this way' [so] we can correct the person, talk to the person. . . [So the] person . . . can change. [When we don't], everybody else hears about it except the one who is involved. You know and that's not good, so by the time you know it, your image has been damaged (16. 187-194).

This lesson in communication shared a place with the growing understanding of cultural differences that helped the FENs rise above the challenges and begin to feel better about how their peers in the workplace viewed and treated them.

Originally, when FENs met with what they felt were harsh, direct, and hurtful communications of their peers in the US workplace, they retreated according to most of their cultural teachings. They handled conflict with avoidance. However, after time and after learning new ways, different communication styles and coping strategies emerged and they used them with confidence, making sure to support each other. Breaking down language barriers and becoming more fluent also enabled the FENs to realize they were

Theme V: *Feeling and Doing Better*.

Feeling and Doing Better is the next to the last theme that emerged from the data in this study. It represents the collapsing of two conceptual categories of meaning that capture the stories the FENs' told of their experiences with mastering systems at work

and in daily life and building new dreams. Moving forward from creating networks and finding support as they rose above many challenges, the FENs experienced an increase in confidence and more positive feelings about the work they were doing, how they managed and enjoyed their progress in learning and adapting to new ways, and how their achievements gave rise to new dreams after the dreams they came to the US with were all but destroyed.

There was overwhelming agreement among the FEN study group that adaptation to living and working in the US was a lot easier if they concentrated on building on inherent strengths. The inherent strengths they knew they had but had to keep reminding themselves of were their excellent educational backgrounds gained in their homeland schools of nursing and their willingness to re-learn what they had to in order to succeed in their work in the US. These strengths, combined with support, were what propelled them forward into mastering systems at work and in daily life. One of the male participants said that, "We are coming in with, well equipped with. . . you know . . .knowledge and skills and. . . the right attitude. . ." (2.183-186).

Building new dreams became part of the lives of the FENs when mastery of systems at work and skills for everyday living took less time and energy away from their enjoyment of their new country. After the initial struggle, many FENs expressed happiness about knowing the American culture better and making a contribution to their new chosen country. They also expressed being happy about the fact that nursing is recognized as a respectable profession in the US. They enjoyed better working conditions than those in their native homelands. As one participant noted, "Everything you need to work [here] is all laid out for you." (2.143-144).

Some members of the study group reported that once work skills were mastered, working in the US was actually easier than expected. Once there was mastery at work and peers in the workplace no longer viewed them as incompetent, they enjoyed an atmosphere of mutual respect, something they only dreamed of having before. According to one Indian nurse participant's own words:

> I mean, in that sense, it's really good working over here because you get the respect and you are, I mean you feel like you are doing something, and you feel like you are someone, and that's really a good experience (12. 18-22).

Most participants also found that they enjoy better career prospects in the US than would otherwise be available to them in their homelands. Dreams of having more opportunities to advance in nursing education and practice were expressed. As one Nigerian FEN said, "I love the profession. I think America is a good place for me to do it, to do a better job and to expand in my education." (19.189-191).

Theme VI: *Ready to help others*

As dreams were verbalized by all, and actualized by some, there were strong feelings revealed in the stories the FENs told that portrayed them as being confident and *Ready to Help Others* who were farther behind in their journeys to live and work in the US. *Ready to Help Others* is the final theme that emerged from the stories the FENs told of their experiences living and working in the US. This theme holds one conceptual category of meaning, <u>what others need to know and do</u>. This conceptual category offers an understanding of helping others using what they learned from their own journeys. Many helping gestures were in the form of information gained through each of the FENs own lived experiences in relationship to how those experiences enhanced or minimized their adaptation to US life and work. For example, one participant thought that her exposure to American culture before actually moving to the US helped her adjust and overcome challenges. She said, "In Nigeria, I was working for an American company and so I didn't have any problem adapting [when I got] here [the US]" (17. 3-5).

The FENs suggested that others need to know and do included gaining an understanding of US cultural diversity by identifying and connecting with some commonalities in language and patterns of daily living. The study group admitted that this would be easier for some than others. For example, some discussed that Eastern and African countries had been influenced by European and American culture through colonization over centuries of time. FENs planning to come to the US but do not have this exposure or commensurate personal experiences may wish to study histories that

describe the various cultures they will find in the US. These exercises serve both the purposes of presenting realities outside of television and movies and avoiding great disappointments and emotional hurting when what is found in the US is far different from the images portrayed in movies and television series.

Emphasizing the advantages of knowing something about the diversity of US cultures before going to the US was also important to one of the Filipino nurses and she said, “American culture, it is not really like you are learning it because it [my country] has been under the American rule for so long. [It is familiar] (5.327-330). The introduction of the English language early on in The Philippines, India, and Nigeria helped the FENs in the study group have one less language barrier to face and surmount. Another FEN said, “Well, the culture wasn’t much difference [in culture or language] for me because I came [to the US] through England” (17. 18-19).

Even though the FENs complained about not being able to understand the numerous accents spoken among English-speaking individuals, words with common meanings did help them rise above some challenges such as language barriers. FENs made the point that making a conscious effort to modify their own accents helped with their acceptance by others, demonstrated their willingness to learn new ways, and eventually contributed to getting support from others to adapt to American language. The FENs in the study group also stated that showing strong determination to adapt, succeed, and learn quickly helps others recognize your value and feel good about supporting you with opportunities for education and advancement. One Nigerian nurse spoke about her personal attitude and said: “But you see, I was determined, so whatever they said I said that was fine. Say whatever you want to say, but show [what you can do]” (18.16-21). A Filipino nurse pointed out that her major strength was her adaptability. She said, “That is one thing I can be proud of. Given the training you can adapt” (3. 230-232).

The FEN study group believes that others need to know that the cultural style of communications at work in the US is direct and assertive. It is not always meant to be hurtful or disrespectful. Knowing this may help some FENs move more quickly in the adaptation process and reach acceptance by peers earlier than otherwise possible. Advice

given by one participant suggests that communication styles and what is said during a communication be accepted simply as the American way. He said:

> When you think of it with American culture in mind it would really make sense to you that it is just normal to them. So you just shrug it off. Don't think about it. So I think that would be one problem [that] the foreign nurses coming in [can avoid] (5. 611-615).

Other important advice that the FEN study group wants others to know is that they need physical, psychological, emotional and spiritual preparation before beginning a journey to another country. According to a young male Filipino nurse:

> When you plan to come to another country like America, I think you really need to be prepared psychologically, physically, emotionally and spiritually because that would be the only thing that would look after you, because I was not really that prepared. I think [if you are] it would be [very] healing (5.291-298).

FENs also suggest that newcomers to the US need to plan for the time necessary to re-learn everything from procedures to the use of technology and modern equipment. Previous nursing experience in the homeland might not directly transfer to US nursing practices due to different delivery systems of care and differences in the scope of and regulations for nursing practice. More hands-on practical training and coaching may also be needed. As one of many participants said, "One thing of course, everything is new, from the procedures, to the instruments, to the equipment, you have to learn everything" (6.37-39). Some of the FENs stressed the importance of having a primary preceptor throughout their orientation to work in the US. A young Filipino nurse discussed this issue and said, "Because like… I had different preceptors and this other person is like going to teach me another thing …and this other person is going to teach me another thing…[you ask yourself], which [one] is which?" (1.569-575).

Given all that was new and needing to be re-learned, many FENs suggested longer orientation periods than those routinely offered by the US hospitals. Only a few in the study group were fortunate to receive more orientation time and they felt more confident than those who did not. One participant who found everything was new to her when she came to the US from India said, "I just came back from India and everything was new to me, so I took like three months [for orientation]" (12-183-185).

The study group suggested that part of what others need to know and do includes taking time to familiarize themselves with the new ways of working and living and requesting longer orientation periods. They experienced the need to be oriented to US social systems, ways of living, and customs. As one said about what others need to know and do regarding new FENs in US workplaces:

> It's just that it's hard on her to just come in within 2 months and pick up the language, the culture, it's gonna be hard on her. So you've gotta go slow with her. She's gonna be a good nurse you know. She has the potential, but it's just that everything's overwhelming for her right now (17. 228-231)

So many of the lived experiences of the FENs in the study group lend themselves to becoming tools that US hospitals and health care systems can use to ease FENs transitions to US healthcare system and help them become part of a productive nursing staff sooner and with less stress. The FENs, now *Ready to Help Others,* provide a beginning blueprint for successful adaptation that employs lived experiences that led them to suggest approaches to practical training that include education on culture and language, time to advance the learning of skills and procedures, and adequate support from each other, administrators and peers in the workplace.

SUMMARY

The findings of this phenomenological study capture and describe the lived experiences of the FEN study group. Most can be considered to be in early stages of acculturation into American ways of living and working. Data analysis of study narratives, according to Giorgi's (1985) method, revealed six major themes comprised of 17 conceptual categories. The findings reveal the experiences of the FENs' journeys to a better life and the internal and external struggles they faced as they realized that what they expected was quite different from what they found. As their *Dreams of a Better Life* met with the *Difficulties of the Journey,* they found A Shocking Reality that they dwelled in until they arrived at basic understandings of what they needed to learn and do differently to "fit in". As confidences grew and they were able to put the reactions of their peers into perspective, they found that their individual and collective strengths

helped them with *Rising above the Challenges*. As their mastery of living and working in the US grew, they were Feeling and Doing Better. Their journeys and their successes helped them see that they could potentially make the journeys and lived experiences of future FENs better than they had. They were ready to Help Others with their new optimism and support they felt for each other and others from their native homelands who dream as they dream.

CHAPTER V

Discussion, Conclusions and Recommendations

INTRODUCTION

The purposes of this chapter are to discuss the findings of this study in the context of the contributions they make to the knowledge base that supports professional nursing and to evaluate the place the findings have in the larger body of knowledge about adaptation and acculturation of foreign educated nurses (FENs). The stories of the FENs in this study reveal what it was like for them to leave their homelands with dreams of a better life, only to find a difficult journey filled with shocking realities they were ill-prepared to deal with. Even though their confidences were shaken and they suffered personal and professional setbacks, they eventually called upon the strengths they had as individuals, created networks of support for each other, and rose above the challenges. They mastered new ways of living and new skills at their jobs, and set future goals of advanced education and practice, which they knew they had limited opportunities to achieve back home.

Many of the experiences and transitions found in the analysis of this study group's narratives can be explained by acculturation and adjustment theories (Berry, 2005; Berry et al, 1999). However, some of the FENs' experiences are unique and are yet to be explained. While the study group was comprised of representatives from three different homelands (The Philippines, India and Nigeria), there were no differences among them in the ways they discussed their dreams, realities, challenges, and successes. For example, using the word "shocking" to describe their interpretations of what they found different in the US, compared to what they anticipated daily life and work life to be, occurred consistently across the three cultural groups of FENs. The six main themes, reported as findings in Chapter IV and elaborated in this Chapter V, emerged from similarities in the narratives of all study participants, regardless of the homelands they came from.

Extant knowledge of similar phenomena experienced by other individuals and groups who have come to the US to live and work is found in the literature. While

relatively few studies of FENs were found, the interest in this line of research is growing to keep pace with nurse migration patterns and trends. The findings of this dissertation study begin to make a contribution to raising awareness about acculturation, adaptation, and adjustment issues our migrant nurses must deal with. In this way, findings of this study may be useful to many hospitals and health care organizations that recruit and employ FENs, from the perspective that there are suggestions made by the study group that they hope will be used to reduce the difficulties and minimize the shock among future migrant nurses. The potential benefits this raised awareness has for employing agencies and organizations are the abilities to stimulate higher FEN productivity, reduce staff conflicts and turnovers, and increase patient satisfaction.

SIGNIFICANCE OF THE STUDY SAMPLE

Given the current nursing shortage that is predicted to continue unresolved for decades to come (Brush & Burger, 2002; Castle, 2000; HRSA, 2000; Ross et al, 2005), it is likely that health care organizations in the US will increase their recruitment efforts to attract more and more FENs to fill the gaps. For recruitment to be successful in the numbers it needs to be, good and positive feelings about US experiences are important for future recruits to hear from FENs already working here. Of significance to the transferability and applicability of the findings of this study is the composition of the study sample. Specifically, this sample of participants was purposefully recruited, as described in Chapter III, to provide a realistic representation of the larger population of FENs living and working in the US. Published reports of the 2000 National Sample Survey of Registered Nurses (NSSRN) (Xu & Chanyeong, 2005) were consulted to determine the groups from which this study sample should be drawn. At the same time, the maximum variation in ages, nursing practice experiences, marital status and family composition were sought in order to avoid biases in any of one of the FEN population sectors.

Based on the NSSRN reports and rationale presented by Xu and Chanyeong (2005) and Xu and Kwak (2007), the sample of participants in this study is demographically similar to the real cultural distribution of FENs working in the US. That

is, according to Xu and Chanyeong's (2005) secondary analysis of the NSSRN, a typical profile of FENs in the US is that they tend to be younger unmarried females in their 30s and 40s living and working in urban areas. Xu and Chanyeong also reported that FENs had a significant numbers of years of nursing experience in their homelands before coming to the US, had diplomas or baccalaureate degrees as minimum educational preparation, and had prior work experiences in acute care rather than in community, long-term care, or education settings.

The following summary of the sample in this study is presented to support that how closely the sample resembles the true population of FENs in the US. As was presented in detail in Chapter IV, this study's sample was comprised of 20 FENs; eight from The Philippines, seven from India and five from Nigeria. Their ages ranged from 23 to 44 years. All had earned baccalaureate degrees in nursing in their homeland schools and three had advanced degrees at the master's level. Years of nursing experience in their homelands ranged from one to 23 years. Years of experience in the US ranged from three months to four years and 9 months. Consistent with the report by Xu and Chanyeong (2005), the majority of the Filipino nurses (80%) were unmarried whereas the nurses from India and Nigeria were all married. Only two of the married FENs had spouses of American nationality. The rest of them were married to spouses from their homelands. Married Nigerian nurses had more children than Filipinos and Indians.

DISCUSSION OF THEMES AND CONCEPTUAL CATEGORIES

Dreams of a Better Life, that include having more money to spend on living 'the good life', are the most popular reasons health professionals give when asked about why they want to go to the US to live and work. For the FEN study group, dreams of earning a better salary and having a better life were influenced by images seen in American movies and television shows, and stories told by relatives already living in the US. According to the literature, promises of a better life are dominant motivators for health care professionals who want to migrate to other countries. As Adams and Stillwell (2004) have suggested, some health professionals choose the brighter promises of better

economic futures for their families over the psychological and social costs of leaving their homelands, extended families, and friends.

Several researchers and theorists have described decisions migrant nurses make about leaving their homelands for better lives as involving "push" and "pull" phenomena (Dovlo, 2004; Chasokela, 2001; Saravia & Miranda, 2004). In an extensive report about migration of nurses, the International Council of Nurses (ICN) cited low pay, poor working conditions, lack of resources to work effectively, and limited career and educational opportunities as major factors that "push" nurses away from home. "Pull" factors, associated with the countries that are attracting nurses to move there for work, were discussed in the same ICN report and were listed as higher pay, better working conditions, educational opportunities, and political stability (Buchan et al, 2003). While no members of this study's sample used the terms "push" and "pull" when telling stories of their *Dreams of a Better Life*, they did give some of the same reasons for migrating and leaving their homelands as were found in the ICN report and found in nurse migration data published by Stilwell et al (2004). Descriptions of experiences that might be called "push" and "pull" factors were found throughout the narratives of the FENs in this study and they permeate all the themes and conceptual categories presented as findings.

Dreams of a Better Life that involves the desire for money and the ability to live the good life are commonly held among health professionals throughout many countries in our increasingly global community (Kingma, 2006, 2007). For example, as revealed in a study done in Africa (Chikanda, 2005), the major reasons given by health care professionals as to why they wanted to leave Zimbabwe for work in more highly developed countries were primarily economic. In responding to a government study, 55 percent of those surveyed said they hoped for better pay in the intended country so they could buy a car or a home. Forty-seven percent of survey respondents stated that having a car and a home would prove that they achieved their goals for a better life.

Contrary to the opinion that economic reasons are exclusive motivators of health professionals who want to migrate to the US for a better life, Loefler (2001) found that

physicians leaving Kenya felt that professional fulfillment rather than money was their top priority. In his editorial, Loefler went on to say that any country that loses its doctors "should examine . . . whether the opportunities for deriving professional satisfaction from everyday work exist – or whether these have been thwarted by the hierarchy, conservatism, cronyism and the general lack of comprehension of what good medical care is about" (p. 504).

While the FENs in this study had many dreams of better everyday and work lives, most were not fully aware of the struggles that were ahead of them. In addition to the American lifestyles the FENs saw portrayed in the media, their narratives also revealed that relatives already living in the US painted a very positive picture of American life for them. Not one study participant said anything negative about what family members told them. Instead, they repeatedly stated that family members living in the US were telling them that life is good and everything would turn out to be okay.

The realization by the FENs that they might encounter *Difficulties of the Journey* did not come to the fore until immigration and travel arrangements were being processed. Even though US employers provided some assistance, obtaining visas took longer than expected and required much more work than was originally anticipated. In addition, the language and nursing proficiency exams that the FENs had to master before they were fully eligible for licensure in the US were also major hurdles they had to overcome.

In the American Organization of Nurse Executives' (AONE) (2003) policy statement about the recruitment of foreign nurses, it is acknowledged that many recruitment agencies use the U.S. nursing shortage as an opportunity to lower international regulations governing the profession of nursing and make false promises to recruits. While no FENs in this study talked about false promises made by the recruiting agencies or their representatives, they did discuss feeling deeply disappointed when they discovered how little help they received from those same agencies when relocation and adaptation really challenged them. These revelations in the narratives were major contributors to the emergence of the theme, *A Shocking Reality that* resonated throughout the study group and left them feeling lost and isolated.

Similar experiences of FENs being shocked and surprised by unanticipated difficulties in their new countries were reported by Sochan and Singh (2007) in findings of their qualitative work with 12 volunteer nurses representing The Philippines, Mainland China, Korea, The Ukraine, and India. The difficulties the nurses in the Sochan and Singh sample had were primarily related to problems associated with obtaining a legitimate Canadian RN license. Analysis of the stories provided by that study's sample revealed three stages in their personal journeys. The stages were hope, disillusionment, and navigating disillusionment. Hope revealed the true and positive desires everyone in Sochan and Singh's study group held about becoming a Canadian nurse. Their disillusionment came when they discovered that the nursing qualifications they earned in their homelands did not meet Canadian standards. Finally, navigating disillusionment emerged from stories the sample members told about the destruction of their original dreams and the acceptance of the fact that they needed to upgrade their educational preparations in order to earn a Canadian RN practice credential. In some ways, the findings of this dissertation study and those of the Sochan and Singh study both present important information that US recruiters and US health care organizations should consider using to more clearly and accurately prepare FENs to face difficulties. Time and time again, the FENs in this study stressed the importance of having information ahead of time so they would not be surprised or shocked by unanticipated difficulties of the journey.

During this study, FENs' discussions of shock and disappointment about the difficulties of the journey were related to transportation, language, finding places to live and worship, and finding support for the adjustments they needed to make. Of course those stressful factors were not restricted to everyday life. As has been revealed in the findings reported in Chapter IV, the strangeness of work life also came as a shock to the FENs. They found that nursing practice was not as universal as they thought it would be and the reactions of their peers that made them feel incompetent only stressed them more. Peers making them feel incompetent and language and communication problems were major sources of stress in the difficult journey. However, these sources of stress are not unique to this study group. FENs in Magnusdottir's (2005) phenomenological study reported feeling

like ‘outsiders’ in the workplace when nurses, native to Iceland, treated the migrant nurses as if they did not know anything at all. Magnusdottir’s (2005) nurses, like the FENs in this study group, wanted to be accepted by peers and have opportunities to show that they were good nurses. Other types of similar findings between this study and Magnusdottir’s were that FENs were willing to learn new ways, overcome language problems, and one day be viewed as equals to peers. As the findings reveal in Chapter IV, the most stressful language issues for the FENs also seriously complicated an important practice issue. For example, telephone orders were especially difficult for FENs to understand and verbally discussing patients with doctors made them doubt their competencies. Of course, looking incompetent to nursing peers was very distressing and finding little or no help for learning about nursing practice differences further raised their anxieties.

A nursing practice difference between the US and their homeland countries also complicated the work lives of the FENs and represented one more thing that was unfamiliar and overwhelming. The US scope of nursing practice holds expectations that RNs constantly assess and follow-up with patients. In most of their homeland countries, a very different scope of practice required the FENs to merely monitor patients and leave all else concerning assessment, treatment, and evaluation of outcomes to the physicians. What this difference meant to the FENs was that they had to change their scopes of nursing practice and develop different relationships and ways of communicating with doctors, other nurses, and patients. It was no wonder that the FENs were stressed by finding so few familiar things in practice, being overwhelmed by cultural diversity of patients and peers, and having to learn new communication patterns with physicians.

FENs working the night shifts struggled even more with language, practice, and communication issues than those on days and evenings because they were embarrassed to speak and hesitant to wake up doctors to get orders. Communication difficulties like these discussed by the FENs were described by Xu (2007) as types of racial experiences that precipitated a glass ceiling effect, low morale, and high turnover. Hadad (2002) further pointed out that low morale among FENs is often linked to prejudice and being viewed as ‘outsiders’. Hadad acknowledged that labeling FENs as difficult to communicate which

sets up the condition for misjudging them and not seeing the quality nurses they really are. Removing the psychological barriers at the workplace is very important to achieve faster and cost effective integration of FENs as significant team members in the healthcare and social environment.

Other unfamiliar nursing practice issues that presented themselves to the FENs made them feel that practice in the US was harder than expected. Specifically, higher patient acuities than the FENs were used to in their homelands, higher demands for attention and care from patients and families, and rules about patient privacy added to their shocks and slowed down their adjustments and adaptations. The Filipino nurses also felt that sometimes patients did not trust them; thinking that they were inexperienced, presumably due to their small stature and younger looks.

The stressors the FENs in this study group experienced motivated them to overcome and rise above challenges, no matter whether the challenges were presented by everyday life or at work. When the FEN study group members discussed experiences that led to the emergence of the theme, *Rising above the Challenges*, they spoke of the opportunities they felt were very important to them and served as reasons to persist in overcoming difficulties and barriers that faced them. For most, working in well-equipped hospitals and having opportunities for professional advancement in the US gave them staying power and provided them with foundations for building new dreams. Some of their feelings and beliefs about professional development opportunities were found to be consistent with what Saravia and Miranda (2004) pointed out when they reported that younger, well-educated individuals are most likely to migrate to more highly developed countries because of opportunities for higher education.

Despite the fact that the FENs had little help from employers and others to rise above their challenges, they remained dedicated to changing and adjusting. As they thought through the types of help they wished they had had, they began to reveal strong desires to help the FENs coming to the US after them. While their lists of things they hoped to help others with grew, the FENs realized that until they became comfortable with their own

adjustments, helping others would have to wait. As they began *Feeling and Doing Better*, their narratives revealed they were *Ready to Help Others*. As the FENs analyzed what the next migrant nurses would need to ease their stress and adapt more quickly, they also realized that their US peers could benefit from information about incoming FENs. It was hoped that reciprocal information would help to foster an environment of support and acceptance. It was clear to the FENs that improving the experiences of others required them to suggest helpful guidance for future FENs and US nursing peers as well. As Ward (1996) proposed in his early works about acculturation, peer acceptance and support in the workplace is necessary and possibly more important than personal support when trying to become an 'insider'. There is support for such reciprocal information sharing from the American Organization of Nurse Executives (AONE). In its position statement (AONE, 2003), cited earlier in this paper, the AONE states that it is incumbent upon the recruiting institutions to teach about and foster an environment that is culturally sensitive and supportive as foreign nurses are assimilated into the American health care system. As the FENs in this study have suggested, more education needs to be done to encourage recruiting and employing agencies to raise standards for making adjustment and assimilation of FENs more positive experiences.

According to the FENs in the study group, the waning of the *Shocking Reality* each one experienced came as a result of the fortitude and commitment they found deep inside and desire each one had to overcome obstacles. Data supporting the emergence of the theme, *Rising Above the Challenges,* revealed the FENs building on strengths, learning new ways, creating networks, and finding support to continue to make adjustments and to eventually 'fit-in' in their new country. In essence, during this phase of their adjustment, Participants began to show their flexibility and adaptability. The fear, anxiety, and feelings of incompetence and insecurity that dominated their lives during their first few months in the US, gradually rather than abruptly, diminished as they found strengths in themselves and in each other. They learned new ways of living, found places to live and worship, and obtained drivers' licenses. Having a license did not make easier to get around, but it instilled confidence in them that the fear they had of the busy

freeways would soon fade away with experience. Similar goals and progress were found among the nurses in Magnusdottir's (2005) study when they revealed how strong their desires and abilities to adjust and assimilate were. As their own confidences grew, they were noted to say that "quitters never win" (p. 265). That theme communicated the resilience that Magnusdottir's nurses possessed and their never-ending quests to secure a brighter future for themselves and their families.

It is interesting to note that the stressful and shocking experiences discussed by FENs in this study group were similar to those presented in the findings of the Commission on Graduates of Foreign Nursing Schools (CGFNS) validity study (Davis & Nichols, 2002). Specifically, the CGFNS validity study found that foreign nurses in their sample had difficult, often painful experiences while adjusting to the "American way" of living and practicing nursing. Several researchers and theorists have explained these phenomena in the context of acculturative stress (Berry, 2005; Berry et al, 1999). Theories about acculturative stress suggest that major contributors to this type of stress for new immigrants are issues with transportation, different values and cultural expections between groups, and language and communication barriers. Based on the data collected and analyzed in this study, the FENs certainly faced these major stressors and more.

Rising above the Challenges also captured the FENs learning new ways to master their work environments and gain respect from their peers. The FENs in this study group said that one of the first things they needed to learn, but had little support for doing so, was the unfamiliar structure of American health care delivery system. Accustomed to a service model of care in their native homelands, the business model upon which the US health care delivery system is based confused the FENs. They were perplexed by the diversity and complexities of our health care institutions and all the contemporary technologies and information management systems we use. Many of the FENs' struggles with the new health care system were also reported by Xu (2007) in her metasynthesis of studies about foreign nurses' experiences. Themes Xu found in the literature were *communication as a daunting challenge, differences in nursing practice, marginalization,*

‘*discrimination and exploitation*, and cultural differences. Xu’s findings revealed that FENs needed more time, education and support to be fully competent at the workplace. Xu’s findings are further supported by the findings of this study.

Another practice concern that FENs in this study had to overcome in order to *Rise Above the Challenges* pertain to the discomfort they felt about the abundant use of pain and psychotropic medications in patient care. The FENs believed that US patients had low pain tolerances compared to the patients they had cared for in their homelands. The FENs were unaccustomed to hearing so many complaints of pain from patients and were even less familiar with all of the pain medications used here. Some of this can be explained by cultural differences.

Culture shapes the values, beliefs, norms, and practices of individuals, including the ways persons react to pain. Also culture affects the assessment and management of pain (Davidhizar & Giger, 2004). To add to the distress of the FENs in this study group, names of medications used in the US differ greatly from those used in their native homelands. While the FENs were more than willing to learn and adjust to new types of patients and new medications, their information deficits slowed down their progress and perpetuated negative opinions of them held by peers. Peers suggested that the FENs were stupid and incompetent, when in reality they were in need of mentors and preceptors who would help them get the information they needed in a timely fashion. To rise above these challenges, the FENs found information on their own and in most cases, as time went on, their proficiencies rapidly increased and so did acceptance by their peers. The more things changed for the positive, the more confident the FENs became. The peer acceptance issues for this study group were classified by them as being due to the lack of understanding of each other’s cultures.

FENs *Feeling and Doing Better* became more apparent as they expressed an increasing degree of comfort with life and work in the US. Their narratives revealed that they adapted to meet the demands of their situations and find their comfort zones. Most expressed that they actually grew to enjoy working and living in USA. They also talked

in ways that revealed a sense of feeling triumphant; having prevailed over the adversities they faced and having adapted using their own inherent strengths.

The strengths the FENs believed helped them adapt and prevail were personal as well as those that they gained from having had excellent nursing education in their homeland schools. Their basic intelligences and what they described as sound transferable knowledge, combined with the willingness to learn and relearn, contributed in large part to their adjustment and adaptation in the new country. Even though many of the FENs expressed the benefits of being educated in the English language, the communication difficulties they had culturally cannot be underestimated. It was pointed out by several of the FENs that knowing the English language was not the biggest advantage given the cultural surprises that they encountered regarding accents, styles, and role complications. Those FENs with previous exposures to the American culture were the ones who said they had an easier time fitting in and adapting to what overwhelmed so many of the others. They had had previous reality checks and were already over the pretenses that television, movies, and other media deliver about life in America.

In the aspect of cultural adaptation, previous exposure and knowledge about the real American culture were beneficial. The Filipino and Nigerian nurses in this study group were most familiar with American culture and US health care systems because they had worked in US-controlled health care agencies before migrating to the US. The Indian nurses were not so fortunate. Still, members of all three cultural groups experienced the difficulties described throughout the findings of this study, although some in different levels of intensity and shock. Identifying and building on the familiar was a working strategy for the FENs with previous exposures to US workplaces. An exposure to another foreign culture, even if not the American culture, before migrating to the US was believed by the study participants to reduce the impact of cultural shock.

Feeling and Doing Better also revealed pride the FENs felt about mastering new systems and working in a profession that is highly recognized and rewarded in the US. As their competencies grew and with their peers they cultivated an atmosphere of mutual respect, the FENs found their work lives much improved and pleasant. Improved

opportunities to excel in their work and return to school for advanced degrees encouraged the FENs to focus less on the many challenges they faced and more on the positive experiences and their victories. They were building new dreams. The mastery and adaptation that the FENs celebrated are consistent with similar experiences that Magnusdottir (2005) found when that study group's narratives gave rise to the theme, "overcoming challenges to win through". In some ways, the pride of overcoming and desires to show mastery were driving forces behind being *Ready to Help Others*. Their readiness to help others came together when, after celebrating their successes, they realized that shock could be minimized, adjustments could be less traumatic, and adaptation could be easier. While they could not change a major health care system, immigration laws, or nursing practice regulations, the FENs knew they could recommend various ways of sharing knowledge to influence education and preparation of future FENs. The dreams they built on realities rather than fantasies helped them determine how best they could pass along what they learned to those preparing a journey similar to theirs.

While there are many ways in which the findings of this study can be interpreted, the lens used here in this phenomenology of practice was that of the FENs in the study sample. In discussing the findings of this study and their fit with extant knowledge, it is clear that nurse immigration needs further study from the perspectives of the country of origin, the receiving country, the systems the nurses work in, and the FENs themselves. Beyond the scope of this study is an exploration and description of the "brain drain" phenomenon often written about on behalf of countries that lose their best and brightest professionals who seek better living and working conditions in more developed countries.

The following section of this Chapter presents the conclusions related to the findings of this study. The investigator has drawn conclusions about the experiences the FENs discussed and placed those conclusions in a model that presents an emerging acculturation process (Berry, 2005). *Moving from being disappointed, overwhelmed, and shocked to rising above the challenges, doing better, and being ready to help others* have better experiences represent phases in a process that involved personal and professional

adjustments and adaptations. As the process model is explained in the following section, references to acculturation will be used to contextualize the lived experiences of the FEN study group.

CONCLUSIONS

For many years, increases in the immigration of people from all walks of life and for varied reasons have stimulated research about the psychology of acculturation for decades. John Berry (1989) has been instrumental in moving the science of acculturation forward with hundreds of research studies about human behavior in response to lived experiences in two or more cultures – either consecutively or concurrently. Previously isolated peoples, entrenched in their own cultures, are being exposed to and sometimes thrown into mixes of cultures about which they have no information or have misinformation. The FENs in this study group provided great details about their experiences as they planned to migrate to the US and make better lives for themselves and their families.

How individuals facing the challenges of living and working in a different culture or mix of cultures they have no familiarity with actually adjust, adapt, and survive in a "new" culture is something Berry calls an acculturation process (1989). While the FENs in this study shared knowledge about the culture of nursing, almost all other aspects of their lives were guided by different cultural traditions, mores, practices, religious beliefs, and rules for interactions, all of which had unique influences upon them. Then, they faced the shock of finding out that what they anticipated they would find in the US was not real. For most, adaptation was absolutely necessary because they were not going home. Here again, as Berry suggests, the course any individual takes to negotiate his or her way through the adjustments and adaptations they need to make is indeed called an acculturation process. In order to practice nursing in a culture different from one's native culture, cultural adaptation or acculturation is necessary. Employers often do not take this need into consideration and do not provide adequate support while recruiting and orienting FENs who come to work in the US. There are equal standards of performance expected for all nurses in the US workplace, irrespective of the cultural differences

among them. As was seen in the findings of this study, FENs that came from a conservative and restrictive cultural background were not always able to be assertive or handle conflicts directly. Initially, they were nonassertive and afraid to ask questions and make decisions. This difference in conflict management styles were identified by Yu and Davidhizar (2004) who studied the conflict management styles of Asian versus Asian American nurses. They found that Asian cultures work from a collective strategy and their "face" is relational to the group. They, at any cost, try to avoid a direct confrontation if a conflict situation arises. On the contrary, in the Asian-American culture, individualism and protecting self face are important, and conflicts are addressed directly. The effect of acculturation on the behavior styles of FENs was evident when they became more self-confident when dealing with doctors, other nurses, and their patients.

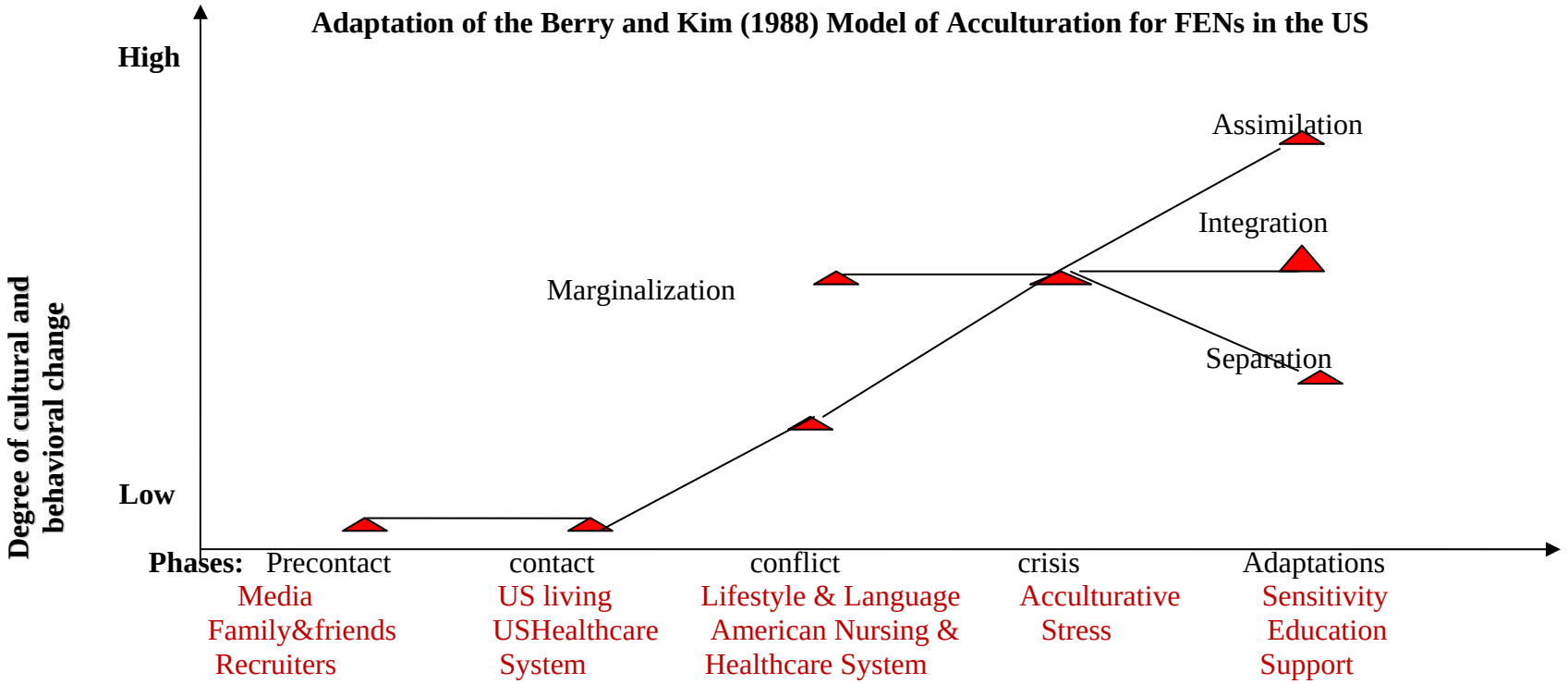
As the FENs conquered the language barriers that sometimes held them back, they began to feel more comfortable asking questions and speaking up. Feelings of isolation also diminished as they became more proficient and were more readily accepted as 'insiders' by their peers in the workplace. They also became better at confrontation and defense of their own abilities to deliver high quality patient care. They were proud to show what they could do to help patients and master the American nursing culture.

There are several models available to explain the phenomenon of acculturation. Berry (2005) conceptualized a multidimensional model of acculturation as assimilation - integration and separation - marginalization. An immigrant passes through different phases of the acculturative process, starting from making plans for the travel to the foreign land (pre-contact),dealing with and overcoming the unfamiliarity of the new land (contact, conflict, crisis), and at last learning to live in the new country and adopting a new lifestyle (adaptation). Adaptation to the new country can be multidimensional and the individual typically chooses one of four adaptive strategies; assimilation, integration, separation, or marginalization, depending on the positive and negative experiences he or she faces in the new country.

Assimilation occurs when members of the non-dominant group do not wish to keep their cultural identities, separation occurs when they hold on completely to their

cultural identities, integration occurs when individuals keep some of their original cultural integrity and at the same time seek to participate as an integral member of the larger social network and marginalization occurs when there is little interest in the cultural maintenance and at the same time little interest in having relationships with others of different cultural backgrounds. Marginalization may be in part due to discriminatory attitudes and practices of the dominant group. In all these ways, behavioral shifts precede psychological adaptation. In the following adaptation of Berry's model (Figure 5.1), acculturation processes occurring in the lives of the FENs are portrayed. Figure 5.1 is found on the next page.

Figure: 5.1


Adaptation of the Berry and Kim (1988) Model of Acculturation for FENs in the US
High
Low
Degree of cultural and behavioral change
Assimilation
Integration
Marginalization
Separation
Phases:
Precontact
contact
conflict
crisis
Adaptations
Media
Family&friends
Recruiters
US living
USHealthcare
System
Lifestyle & Language
American Nursing &
Healthcare System
Acculturative
Stress
Sensitivity
Education
Support

The FENs coming to the US need to be integrated into the mainstream of American society and American nursing so that they will productively contribute to and enjoy their lives here. Figure 5.1 depicts the phases of acculturation theorized in Berry's model that can help guide the acculturation and assimilation of FENs. According to the findings of this study, in the pre-contact phase of the acculturative process, FENs lacked information to prepare themselves adequately to face the demands and challenges in the new country as evidenced by the first theme *dreams of a better life* and the second theme the *difficulties of the journey* to a better life. The information they received from family, friends, media and recruiters was often misleading. When they landed in the US and started contact with the new country and its people, they experienced the *shocking reality* of their under preparedness for taking on the new culture and work environment.

According to Berry (2005), conflicts are inevitable in the acculturation process and behavioral changes occur before the psychological changes occur. Though FENs did draw upon their strengths to *rise above the challenges* as depicted in the third theme, most of the participants reported experiencing crisis situations and stress stemming from the initial lack of knowledge of the cultural expectations both in their daily lives and at their workplaces. As the FENs learned the culture and became confident, they started their phase of adaptation as portrayed by the fourth theme *feeling and doing better.* According to Berry, a person who is actively psychologically adapting to the new culture may actually be at different levels of acculturation such as separation, integration and assimilation. But when the new entrant to the culture is turned away by discriminatory attitudes and cultural confusion, he or she experiences acculturative stress that is characterized by uncertainty, anxiety and depression.

Adaptation should be psychological, producing a sense of well-being and self esteem as well as a sociocultural competence in the activities of daily intercultural living. The fifth theme evidenced in this study, *ready to help others* reports the essential elements of successful adaptation which the study participants wish to have in place to help the FENs coming to the US in the future. According to the participants, the

necessary ingredients for successful adaptation are cultural sensitivity from peers, educational support, and adequate time to build readiness.

RECOMMENDATIONS

While more studies of acculturation needs and processes experienced by FENs in the US need to be done, the findings of this study make important contributions to improving our profession's preparations of migrant nurses so their "outsider" status is shortened and they more positively and quickly adapt to being "insiders". The recommendations for such preparations described in this section come primarily from the FEN study group with support from the literature.

Ryan (2003) has said that socialization to professional nursing in the US is one of four important basic needs that must be addressed for FENs so they can successfully adjust to work in American health care organizations. Orientation programs that can help the FENs become part of the work community sooner than later can also help reduce the feelings of isolation such as those described in this study group as resulting from being viewed as incompetent by peers. Language use classes can be valuable tools for the FENs to speed up their abilities to learn the meanings of slang terms used in American English and in nursing practice in the US.

FENs suggested that understanding and using language as it is spoken here in the US will reduce the numbers of time they are told they cannot be understood and that they must be stupid or incompetent. Their recommendations about language orientation are similar to those published by Ryan and by Kingma (2001) who also found that slang used in American English both in everyday life and in the workplace contributed to a significant communications or language barrier.

In their quest to help future FENs avoid the pitfalls this study group experienced, they recommended that they and their US peers attend classes on cultures to help them learn about each other and learn how to work together more quickly and with more trust. Similar to strategies the FENs wanted to put into place to help others, Ryan (2003) promotes the use of cultural diversity enhancement groups (CDEG) as ways to orient both FENS and US nurses to their different cultures, common bonds, and models of

working together for the good of the patients. Ryan's suggestions include buddy programs which may be assumed to be synonymous with what this FEN study group recommended in terms of meeting their needs for mentors and regular preceptors who can help them gain information and knowledge about work systems more quickly. The FENs said that such strategies will reduce feelings of isolation, speed up their adjustment times, and help them assimilate sooner so they can work effectively.

Support from employers in the forms of pre-migration education pertaining to the US health care system, nursing scope of practice, and patient characteristics were also recommended by the FENs for use with future migrant nurses. The FEN study group faced situations in which they were shocked by what they experienced and other situations where they had to adapt immediately without the benefit of knowledge to support what to do and how to do it. Some participants revealed that their employers did not take into consideration the culture shock experienced and did not give them time to adjust. Instead, an equal and unforgiving standard of performance was expected of the FENs in the workplace, irrespective of the challenges and barriers they found there. Findings that address the challenges the FENs experienced regarding the multiple languages and cultural diversity they found in the US are prime examples of the information that study participants hope will be passed along to new migrant nurses so they will have fewer shocks when they begin working and living in the US. Similar findings and conclusions were in reports of a study conducted about Korean nurses working in the US (Yi & Jezewski, 2000). The authors reported that FENs underwent severe psychological distress due to cultural differences they encountered in their new environments and suggested that reducing FEN distress can be beneficial to the nurses themselves as well as to their employers and patients. Reducing shock and distress and supporting new learning, adaptation, and assimilation were what all the recommendations of the FENs were about. Making the acculturation process less traumatic and more positive and quick were goals the FENs highlighted once they knew they had succeeded themselves.

The challenges presented to the FEN study group by unfamiliar medicines, by name and by use, were findings unique to this study. That is, no reports of similar findings in studies of migrant nurses were found in the literature. Therefore, careful thought must be given to the significance of including such education in future orientation and support programs for FENs. Different cultural expectations and practices when it comes to pain recognition and management are important nursing practice issues that must be discussed and accepted (Lewis et al, 2004). Interpretations of pain that emerge from an individual's cultural knowledge must be shared so that nursing practice standards can incorporate individual preferences into plans of care for patients.

Another finding that deserves careful interpretation and use in nursing practice are the differences the FENs reported observing in ways family members address the needs of patients. That is, most of the study group talked about how, in their respective cultures, family members took care of the basic needs of any loved ones who were hospitalized. The FENs found that US family members of patients did little to attend to the patient's needs while in hospital and they did not understand why this was the case. For some FENs, there was a strong need to learn about US family customs and create new ways of communicating and understanding as means to reduce barriers and promote satisfying nurse, patient, and family relationships. Including education about these types of cultural differences in orientation programs for FENs prior to their migration and after they arrive will reduce distress and misunderstandings that have the potential to disrupt nurse-patient relationships.

Many studies that have compared how US families and foreign families care for their members with illnesses report that the lack of attention paid to the patient by family members is often interpreted by FENs as a form of abandonment. According to Josipovic (2000), such philosophical differences in practice can be put to best use to develop culturally sensitive nursing care, because culturally and linguistically diverse nurses are excellent sources of knowledge about culturally sensitive care. Josipovic's suggestions are seen in the strategies the FENs in this study used to share information, create networks, and find support. As a matter of fact, the FENs themselves said that peer education programs

that were informal parts of the networks they built with each other helped them learn cultural sensitivity and establish a more cohesive working environment. This turned out to be a very important strategy and effort in that it reduced expressions of ethnocentrism in the multicultural workplaces of the FENs. In addition to the comfort the FENs hoped specific information would bring to a smoother transition to US nursing practice, they openly recognized the need to have educational and support programs that address all dimensions of human wholeness - physical, psychological, emotional and spiritual.

Lastly, the FENs emphasized that there is a great need for learning time that they hope will be built into education and orientation programs for migrant nurses. It must be realized they say, that some are re-learning everything from procedures to the use of equipment. Some are learning things for the very first time, such as use of the computerized medical record. Time and support are vital. Previous experiences in the homelands of the FENs do not always translate fully to the US workplace due to differences in practice settings and scopes of practice. As was revealed in the findings, the scope of nursing practice in the US is broader and the acuity of patients is higher than in the countries from which this study group migrated. While they possess sound theoretical knowledge, differences in practice expectations need to be discussed and reinforced by mentors and preceptors. The FENs believe this collegial form of education and support is needed and will shorten assimilation time and smooth out the acculturation process. The few FENs that were fortunate to have some peer guidance were much more confident after an individually tailored orientation.

As Kinderman (2006) outlined as recommendations for retention strategies for newly hired Filipino nurses, education, opportunities to practice new skills, teamwork, family conferences, and educational diversity and life skills classes were most important and beneficial. All those strategies and more were recommended by the FENs in this study as able to positively influence social and workplace adaptation and acculturation of FENs.

SUMMARY

Findings from this study and those reported in extant literature indicate that recruiting agencies do not fully inform FENs of the many requirements that need to be met before migrating to the US, especially in the areas of education on cultures, lifestyles, and differences in practice standards. This lack of a realistic preparation predisposes the FEN to many *Difficulties of the Journey* and some of the *Shocking Reality*. The FENs experienced self-doubt about their abilities to cope with their new ways of life, new working environments and different practice standards. Recruiting agencies often overlooked the importance of warning FENs about the challenges they might face. Stilwell and her associates (2004) have suggested that more responsibility for assisting FENs in this area of concern must fall on the shoulders of the recruiting agencies.

FENs also need to be supported through the initial stages of acculturation through sensitivity education for peers and FENs so that workplace cohesiveness is enhanced through a better understanding of each other. Though acculturation is a lengthy process, Berry (2005) conceptualized different phases that can be facilitated or thwarted when successful or failed psychological and behavioral adjustments take place. In the face of discriminatory obstacles, resulting marginalization of new immigrants can be accompanied by high levels of acculturative stress. But, given adequate educational support and time to adapt, FENs might *rise above the challenges* and start enjoying their life in the US. In general, *feeling and doing better* is important for FEN's enhanced psychological and physical health and productivity. Acculturative stress and resultant feelings of marginalization can be avoided or proactively handled through cultural sensitivity, educational support, and time. According to Ryan (2003) successfully adapted FENs can be part of the cultural diversity enhancement groups (CDEG) as ways to orient new FENs and his view is supported through the fifth theme in this study, *ready to help others.* Essentially, cultural diversity should be preserved and enjoyed and nursing is no exception to this common theme in USA.

Appendix A

IRB-Approved Subject Consent Form

SUBJECT CONSENT FORM

You are being asked to participate as a research subject in the project titled, "A Phenomenological Study of the Lived Experiences of Foreign Educated Nurses Working in United States of America," conducted by Mini Jose, MSN, RN who is a student in the Doctoral Nursing Program at UTMB's Graduate School of Biomedical Sciences (GSBS). This project is supervised by Dr. Judith C. Drew, RN, PhD, Professor at the School of Nursing and full member of the GSBS faculty.

PURPOSE OF THE STUDY

The purpose of this study is to explore and describe the lived experiences of foreign educated nurses (FENs) as told by them in the form of their stories of everyday life and while working as registered professional nurses in the United States of America (US). This study fulfills the Ph.D. degree requirement that a dissertation research study be approved and conducted by Ms. Jose. Ms. Jose also teaches nursing students at a community college and is interested in learning from you more about your experiences as a foreign educated nurse. You are being asked to participate because you are a Registered Professional Nurse who has been educated in a foreign country and migrated to the US within the past 5 years.

PROCEDURES RELATED ONLY TO THIS RESEARCH

This is an interview study. There are no interventions or experiments. During this study, Ms. Jose will interview you at least once but no more than three times about your experiences with working and living in US. The interviews will be conducted at a time and place that is convenient for you. Each interview will last no more than one hour and will be conducted over a period of time that lasts no longer than two months, counting from when the first interview begins until the third interview is completed. The interviews will be audio-taped and transcribed verbatim so that data from the interview can be analyzed. The audio-tapes and transcripts will be coded. Your name will never appear on any study documents or recordings. Both the tapes and interview transcripts will be kept in a locked file cabinet in the researcher's office. Analysis of the transcripts involves searching for any commonalities among comments made by the total number of study participants.

Following the completion of the first interview, Ms. Jose will contact you to set up any additional interviews if needed. Need is determined on how much information was left to talk about when the first interview ended. The second interview meeting also provides time for you and Ms. Jose to clarify any questions she has and for you to add any additional information you wish to share.

In addition to participating in the interview(s), you will be asked to answer several questions about your age, gender, country of origin, where you completed your nursing education, the type of program you completed, years of experience you have worked both in your home country and the US, and your nursing practice specialty. This questionnaire will also be coded so that no identifying information can be associated with you. If, for any reason, you are unable to continue your participation in any of the interviews, they will be stopped without any penalty to you.

RISKS OF PARTICIPATION

The potential risks from participation in this study are few. You may become fatigued during the interview. There are no procedures or treatments associated with this research project; only conversation during the interview. Ms. Jose will take all possible steps to assure your confidentiality by coding study data and removing your name and other identifiers from study materials. However, there remains a minimal risk of the loss of confidentiality.

NUMBER OF SUBJECTS PARTICIPATING AND DURATION OF PARTICIPATION

The anticipated number of subjects participating in this study will be 30. All will be recruited from the greater Houston and Galveston communities. This is a community-based study and your employer will not be involved or ever learn of your participation unless you are the one who tells him or her or any co-workers. The length of time of your participation will vary according to how many interviews you agree to have with Ms. Jose. As explained above under “Procedures Related Only to this Research”, you will be asked to participate in at least one but not more than three interview sessions. No one interview session will last longer than one hour. The interviews will be conducted at a place and time that is convenient for you. Whether you will have one or more interviews will depend upon the progress that is made answering the questions Ms. Jose has. This study will begin in May 2007 and will be completed by May 2008. While this study will go on for approximately one year, your participation as an individual will last over approximately two months.

BENEFITS TO THE SUBJECT

There are no direct benefits to you for your participation in this research project. By answering the researcher’s interview questions, you may gain some insight into your experiences as a foreign educated nurse living and working in the US.

OTHER CHOICES (ALTERNATIVE TREATMENT)

There are no treatments in this study. You will meet with the investigator only to discuss the interview questions and answers you wish to provide. The alternative to participating in this study is to choose not to participate. Participation in this study is voluntary and not required.

REIMBURSEMENT FOR EXPENSES

There will be no reimbursement of expenses for your participation in this study. Depending upon where you choose to be interviewed, Ms. Jose will pay for your parking for the time you meet with her, if there is a charge.

COMPENSATION FOR RESEARCH RELATED INJURY

There are no treatments or substances given to you as part of this study's procedures. This is a study that only involves being interviewed by the researcher. The likelihood of you sustaining any type of physical injury because of your participation is extremely rare. However, if you are physically injured in any way because of your participation in this study, UTMB will provide you with the appropriate medical treatment not covered by your own insurance or health care program at no cost to you to the fullest extent permitted by Texas law. You will be responsible for paying any costs related to illnesses and medical events not associated with being in this study. No other forms of compensation are available. However, you are not waiving any of your legal rights by participating in this study.

COSTS OF PARTICIPATION

There will be no cost to you for your participation in this study.

REASONS FOR THE STUDY INVESTIGATOR TO STOP YOUR PARTICIPATION

You may be dropped from the study by the study investigator if the study is discontinued. If this is the case, Ms. Jose will contact you and explain the situation.

PROCEDURES FOR WITHDRAWAL

If at any time you wish to stop your participation in this study, simply contact the investigator at the numbers provided at the end of this consent form. Upon learning of your request, your participation will be ended.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Even though in this interview study no health information is accessed, collected, or used, you must know that all study records that identify you will be kept confidential as required by law. Federal privacy regulations provided under the Health Insurance Portability and Accountability Act (HIPPA) provides safeguards for privacy, security, and authorized access to your records. These regulations require UTMB to obtain authorization from you if it or anyone employed there attempts to use and disclose your health information. By signing this consent form, you are agreeing to participate in this

study. You are not authorizing the use and disclosure of your health information related to this research study.

Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in this study's records. However, you do need to know that study records will be coded without your name and be kept confidential as required by law. You will not be identified by name in study records. A code number will be assigned to you and only Ms. Jose will know that number. The key to the code will be kept in a locked file in Ms. Jose's office.

There are no sponsors for this research. Ms. Jose is acting alone, but under the supervision of his faculty, Dr. Drew, to complete her requirements for a doctoral degree. The study data, meaning the contents of your interview(s), will not be linked to you as an individual. Instead, the data you provide will be put together with data from all other participants and reported that way. You may see or receive a copy of any research reports of findings from this study at its conclusion. Please request those from Ms. Jose.

If you sign this form, you are giving Ms. Jose permission to collect, use and share the information you provide during the interviews. Your health information is not part of this study and you will not be asked about it nor will it be assessed. You do not need to sign this form. If you decide not to sign this form, you cannot be in the research study. Whether or not you agree to participate in the research project or give us permission to collect, use or share your interview information will not affect the care you will be given at UTMB.

Your interview information, without your name on it, may be reviewed by Dr. Judith Drew, for purposes of assisting Ms. Jose with learning to understand the data analysis process. If for any reason you want to stop your participation in this study, you can at any time. However, you need to inform Ms. Jose at the contact numbers listed in this consent form. You need to say that you have changed your mind and do not wish to continue participating in this study. At that time and thereafter, Ms. Jose may not collect any additional interview information from you. However, she may use the information that she has already collected. It is important to learn everyone's experiences, not just those of persons who complete the research study. The results of this study may be published in scientific journals and presented as posters without identifying you by name.

ADDITIONAL INFORMATION

1. An offer has been made to answer any questions that you may have about these procedures. If you have any questions before, during or after the study, or if you need to report a research related injury, you should immediately contact Ms. Jose, RN, MSN at (713) 471-0438 or, if after normal office hours, at Pager (713) 607-0215 or, Dr. Judith Drew at (409) 772-8227.

2. Your participation in this study is completely voluntary and you have been told that you may refuse to participate or stop your participation in this project at any time without penalty or loss of benefits and without jeopardizing your medical care at UTMB. If you decide to stop your participation in this project and revoke your authorization for the use and disclosure of your health information, UTMB may continue to use and disclose your health information in some instances. This would include any health information that was used or disclosed prior to your decision to stop participation and needed in order to maintain the integrity of the research study. If we get any information that might change your mind about participating, we will give you the information and allow you to reconsider whether or not to continue.

3. If you have any questions regarding your rights as a subject participating in this study, you may contact Dr. Wayne R. Patterson, Senior Assistant Vice President for Research, Institutional Review Board, at (409) 266-9475.

The purpose of this study, procedures to be followed, risks and benefits have been explained to you. You have been allowed to ask questions and your questions have been answered to your satisfaction. You have been told who to contact if you have additional questions. You have read this consent form and voluntarily agree to participate as a subject in this study. You are free to withdraw your consent, including your authorization for the use and disclosure of your health information, at any time. You may withdraw your consent by notifying Mini Jose, RN, MSN at (713) 471-0438 or, if after normal office hours, at Pager (713) 607-0215 or, Dr. Judith Drew at (409) 772-8227. You will be given a copy of the consent form you have signed.

Date	Signature of Subject
Signature of Witness	Signature of Authorized Representative *(if applicable)*

Description of Representative's Authority to Act for Subject *(if applicable)*

Using language that is understandable and appropriate, I have discussed this project and the items listed above with the subject and/or his/her authorized representatives.

Date	Signature of Person Obtaining Consent

Appendix B

Biodemographic Data Collection Sheet

BIODEMOGRAPHIC DATA

1. AGE: _____ years

2. GENDER: __ Female ___Male

3. MARITAL STATUS: ___Single ___Married ___Widowed

4. NATIONALITY OF SPOUSE _____

5. NUMBER OF CHILDREN _____

6. COUNTRY OF ORIGIN: ___Philippines ___Nigeria ___India

7. HIGHEST EDUCATIONAL PREPARATION IN NURSING: ___BSN ___MSN ___Ph.D. in Nursing or other discipline (Please specify) _____

8. AREA OF PROFESSIONAL NURSING PRACTICE IN HOME COUNTRY: ___Acute inpatient care ___Outpatient care ___Emergency care ___Long term care ___Other (Please specify) _____

9. AREA OF PROFESSIONAL NURSING PRACTICE IN THE USA: ___Acute inpatient care ___Outpatient care ___Emergency care ___Long term care ___Other (Please specify)

10. YEARS OF NURSING PRACTICE EXPERIENCE IN YOUR HOME COUNTRY: _____

11. YEARS OF RESIDENCE IN UNITED STATES: _____

12. YEARS OF NURSING PRACTICE EXPERIENCE IN UNITED STATES: _____

Appendix C

Semi-Structured Interview Guide

SEMI -STRUCTURED INTERVIEW GUIDE

1. Tell me about your experiences working as a nurse in the USA.

(Probe for the nurse's experiences as expectations of his or hers and the realities that they have encountered in actual practice that are different from or similar to their expectations.)

2. Tell me about the situations you faced and continue to face in which you feel you must adapt to different expectations, values, or cultural differences.

(Probe for types of challenges those emotions, work and daily life situations present to the participants.)

3. Tell me about any experiences that you have had that you hope no other nurse ever has to experience.

(Probe for sources of stress and distress that are on the minds of the participants.)

4. Tell me about the experiences you had that you wish everyone who comes to the US to work would have.

(Probe for the participant's introspection of the strengths and supports present in the social and healthcare environments that promote positive outcomes related to cultural integration.)

5. Talk about any special needs you think foreign educated nurses have.

(Probe for participant's suggestions for making transitions and cultural adaptations for future FENs better.)

6. Tell me about anything else you want me to know about your experiences since coming to the USA.

(Probe for the participant's views about the place of cultural differences in nursing practice and their relevance to nursing profession.)

Appendix D

Subject Recruitment Letter

Recruitment Letter Mailed to Individuals or Distributed to Groups

An invitation to participate in a research study: A Phenomenological Study of the Lived Experiences of Foreign Educated Nurses Working in United States of America

Dear Colleague,

If you think you might be interested in learning more about a research study that is being conducted to explore and describe the lived experiences of foreign educated nurses, please read on.

I am Mini Jose, MSN, RN, a nurse educator and a doctoral student in nursing at UTMB. I am conducting a dissertation research study under the supervision Dr. Judith Drew. She is a professor at the UTMB School of Nursing and is a full member of the graduate school faculty. Participation in the study is voluntary. All information about individuals is kept confidential and only aggregate findings commonly found in the collections of data from all participants are discussed in the report of the dissertation. I expect to present the findings to my research when I defend my dissertation during the spring of 2008.

The Institutional Review Board at UTMB has approved this study. Their guidelines for the protection of human subjects will be followed at all times.

If you want to learn more about this study and perhaps consider participating, please e-mail me at mmjose@utmb.edu and I will get back to you as soon as possible. If you would rather leave a telephone message, please call me at 713- 471-0438, tell me how to call you in return, and I will talk with you as soon as possible.

Sincerely,
Mini Jose, MSN, RN
UTMB Doctoral Student

Appendix E

Selected Sample of an Interview Transcript

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R---Transcript - 2

M. Actually...uh… actually...uh .before coming to US how was your expectations like coming to US. Whether it was like …what did you expect as there is in US?

Well, like any other foreign nurse that is coming to US you know come here, get to work and earn a better living than we had back at home. At that point you know...it... it was a reality.

M- How about your work environment? How... how did you expect your work environment to be and did your expectations match what you got?

R actually...uh... I expected more…I thought that... it will be so much harder and it will be so much …. It will need so much work and you know…. adapting in my part.

M. So you were expecting for the worst...uh?

R. Yah...actually…yah...I was expecting a lot worse than what I experienced.

M. Aah…So you have positive experiences.... more positive experiences than negative experiences. That is good! And...Uh…when you …..When you came to US, did you have enough help around to get you adapted to the American culture?

R- Well, getting adapted to the culture, not really. Because especially... we don't have any family here. So When we came here…It was just me and my wife and we have to... you know we... we…. we met some Philippine friends that helped us, but culturally you know we had a hard time adapting you know, with the language, with the culture , lifestyle, way of living..

M. So were you ...I mean uh …. All that is different from what you expected?

R. Aaah..?

M You had any idea how is the lifestyle here and... and did you...uh..?

R. I …Well you know by watching movies you...you...get an idea.

M (Laughing)

R. Yah...you can have pretty much an idea how they live here. But when you get here it was so much more different. You have to adapt to a lot of things and you have to learn and know what it is you have to start living …like…

M. through experience... you learn through experience. Aah...Did you have any... I mean like...aah...the patients; did you have any …. any constraints due to the difference in culture

R- Yah. Difficulty in the beginning Yes we do. The language barrier! Aah... American English is...is...is...different from…you know. ..from the Standard English. And the different patients have come from different cultures, different back ground and with them they carry different slang, and different pronunciations of different words. First I had hard time adapting to it. I even had an experience where …uh...one doctor told me something and .I did not fully understood what it was because it was actually a slang for something and It meant I have to take my patient to an ICU

M. Okay...

R. But it was said differently and I did not understand it. It was really … hard you know (laughing)

M Yah... (Laughing)...it was...aah... talking about the patients... aah...you know... you know what is the difference you see in the patients in here and in the Philippines?

R Well, here...uh...they are more….. They are more ...uh…participative of their care. ..They want to know everything about the care you that you give them… about. About what all the... their plan of care …., where as back home they just entrust you their health and you just do what you do and they are not really cared about knowing what is happening as long as they get better. Where here they are more questioning…. Inquisitive of what you are doing and what is happening. So have to have a better knowledge of how to care...caring proceedings …here than back home.

M Aah...And about... uh...you know...how you felt about American system. How did you handle like Social Security, Driving License etc all these... you know different…different ways of living that is special to America. How did you get adapt to all that… Was it very difficult or you were comfortable with it

R. If nursing wasn't a very ….if nursing wasn't a very...uh... important and demanded job here or nursing...or nurses were not earning ...you know… enough I probably said .you know too... Health care system here only favors those that. That has like good job and a stable job. But I was in America... and was not …. You know…in nursing … I probably would have had a hard time adjusting....or you know….probably would have a hard time with way of living and....

And about the environment, working environment. Like. What are the difficulties you experienced while adapting to the working environment? What are the special things you

wanted while adapting to the working environment?

R Actually…uh... I am not having any… I haven't had any major problems with my working environment. Actually working here in States is...is a lot better than the working environment back at home.

Okay….

R...Uh... everything you need is well provided for.

Okay...

R. Everything you need to work is all...laid out for you.

Aah... yah….

R. I …I don't have any...uh...I think it is one of the advantages they have …They have lot of resources to manage care for the sick people.

M- And did you get adequate orientation? How your adaptation to the working environment was facilitated? Did you get adequate help in adapting to the working environment?

R. yah…

M— what about the orientation and... I mean...when you came…when you were moving from Philippines to USA did you get as you promised by the employers and like pay and working environment and..

R Yah I didn't have problems with that. I think... They lived up to what they promised…and they were there at every step of the way like processing the papers to taking the test, placement in the hospitals. While in the hospital following up, you are doing okay or not... helping you relocate …

M And …and... What are the special needs we foreign nurses have?

I think…uh...because...we foreign nurses are... honestly speaking…we have more education than they have.

M. Okay.

R. They have just... they just have the mastery of language and the culture .We is coming in with….you know...well equipped with …you know….knowledge and skills and… right attitude. It is just that...uh…it is just not the culture that we know and we grew up with. You know. But our nursing skills are robust!

You mean …we may have to have more...uh…introduction to the culture…uh...before we start working? I mean …during orientation we should have more...?

R. Probably. Because. You know, when we...when we are educated back home. we are …we are .not just. You know ... we are not just educated to...You know...to focus on caring for Americans.

Oh...yah...

R. You know, we just get educated with the concept that we will be taking care of people and it is just people and don't specify any race or nationality. So it is … it is just that... uh...since we are here...we are…you know… we just have to adjust to it. But I think language …. If we had mastery of the language it would have helped.

M; Aah...So mastery of the language and the culture...I mean you know, the American culture is what really matters or..?

R If … if we went to Europe then it would have been another problem that…..same problem …. Same but just different culture….we have you know… went to London we would have the same type of problem but just a different setting. If we go to say.... Germany...it will be the same wherever we go.

But speaking about the culture in America you see there are different nationalities…different... like Hispanics, African Americans, Nigerians, Indians ,Filipinos, South Koreans, .There are more… multiplicities of nationalities and cultures and language. When you give...I mean... Did it... How did you adapt to and accepting different cultures

Here in Houston... uh... there is lot of Hispanics and there is lot of Hispanic communities. And we Filipinos will fit well in it. Because we have Spanish blood in us. It is used to be a colony of Spain for 300 something years.

M. Okay…

R. And some of our words and...and...cultures are based on Spanish cultures some what. So...you know...so …we even have …you know…some words that are similar with the people living in Mexico.

Aah…

R. So… that part...yah...we can work… we are not having a hard time with it. It is probably just here in Houston. There is a lot of...you know... Hispanic community.

M- Oh ...I am here for about five years and I still don't know more than 'kumo estha' in Spanish... you know...(laughing)..So it is an advantage....

M Did you have any experience which you think no one else should have? I mean...any bitter

experience as a foreign nurse? Anything that have particularly bothered you?

Well …uh….it is probably not just unique to me or it is probably just that it happened to me .You know I have experienced this couple of times. If you are like an outsider coming into America and they think that you know more than them, they get threatened. And ...and you know, in the face of threat they…they will try to put you down because they are threatened. But...you know, I don't think that is a...that is a very good experience for anybody here who is coming here just to work and you know share your knowledge and do what you are taught to do. But they look at it differently and they think that you are here to take over their job and coming in to tell them what they need to do. Because they think that you think you know more than them. And one way or another way they try to ...You know, put you down or...put your morale down… or...it is hard…

M. Yah….In such a situation how did you cope? How do you handle such a situation?

R. I…I didn't try to handle.... I did not try to do anything of…I did not...I did not try to do anything about it.

Amah...

R. I just …do what I do... and... You know, it is...I am only here to work and...I am not here to be...

…to confront..?
I
R. Yah... I am not here to be an American. I will be in America just to work. And , you know if there is something, if there is anything that they don't like or if there is anything that they do not feel that it will be total beneficial to them ,then it is their problem.

And what are the good experiences you had you know, you wish everyone who is coming to America should have? You know, count your blessings like the good experiences you had... you know, you wish everyone who is coming to America should have?

R. Well. On the professional side of it there are really a lot of things that that I have learned here that .you know. that is absent back home, that you can't learn back home .There are things that you can only read on a book back home actually I had a hands on experience here and.. That's. That's probably counts as one of the biggest or the most important experiences that I have had here. You know that learning part of nursing. Besides from that. You know, just happy and …just be happy to work and things like that... you know… earn a living and...

M And like with the employers you are happy and they gave you what they have promised…….Actually a lot have come out. I learned a lot from you. Do you think anything else you have to add to it?

R. Aah...Actually I don't. Like in what area or what..?

Aah...like...generally...you know to foreign nurses what the like are … you know … for example...what advice for the nurses who is going to come here...

R. If …you know...…you know if this is a book or...this interview whatever won't ever reach anybody back home...(laughing). Or it is...it is you know... It is not hard. It is not hard to work in America.

Oh...okay...

R. It is... It is not as unreachable and hard as many people think. It is probably harder to get here than to work here (laughing). So…

Thank you very much for sharing. Thank you very much.

Appendix F

Sample Auditable Trail of Coding Operations:

Code Book I Meaning Units Inducted to Code Book II Conscious and Unconscious Psychological Inferences

Code Book II

Code level II (Psychological Meanings)	**Code level I** (Clustered Meaning Units)	**Transcript reference** (Meaning Units: Descriptions as instances of data in the transcripts)
(N-1) No negative expectations	(N-1) Did not expect negative aspect of coming to America.	You know very easy, the idea was once you come here, you can make it! Kind of, we never had any negative aspect, to put it into a negative aspect of coming to America. I never expected anything, any hindrances or difficulties, until I started looking for a job.(16.1-9)
(N-2) Felt that working hard to gain acceptance	(N-2) had to work harder than others to prove self.	You actually have to work so hard to make them know that you exist on the unit. (16. 23-24).
(N-3) Disheartened by lack of compassion around	(N-3)Experiences less compassion among co workers	you are very compassionate, you put them in your shoes, like they are your family member the way you treat them, but when you come here, people, you've seen people do the job to earn money, so the Difference is that very clear, (16.36-40)
(***N-4) Cultural differences a barrier to develop unity***.	(N-4) Tried to blend in with other cultures.	You have more foreigners in California, more Nigerians, you Know, Indians, cultures and you try to blend in, and you know knowing that, You also are a foreigner. (16.64-67). Staff nurses they seem like they're friendlier and I would say they're from the same place. Unlike here, you hear you have different people from India, Africa, anywhere sometimes those they used to, they're not united (19. 130-135)
(N-5) Experiences a pervasive dissatisfaction at the work place.	(N-5) Experiences a tensed atmosphere at the work place.	They look all frustrated, you know there is no joy, and them some of the units, everybody is so tensed up, you're happy and they be looking at you like you are crazy. Why is she always happy? What is this? (16.76-80)
(N-6) Nursing is not for money but for career satisfaction.	(N-6) Experiences personal satisfaction in doing nursing	Personally I believe if you don't like your job, don't do it! And if you don't enjoy doing it, don't even bother going in to the profession.(16.83-86) I'm not the type I'm doing nursing because of money, it's my career. I took it as a little girl and

		my dad was the person that brought me into nursing because he believed when I was little there was just something in me. When someone was sick in our house, I kept checking on them every night, I don't know, it was just natural in me taking care of people, that's why I love it (19.181-189)
(N-7) Back home patients and families appreciate what nurses do for them.	(N-7) Back home patients and families appreciate what nurses do for them.	back home from Nigeria I'll say, patients, their families are very appreciative.(16.90-92) Nigeria something those people there, they may have a need, but they're so afraid to tell you. Like Oh she's the nurse, I don't want her to get mad at me or something like that. Unlike people here, they have laws (19.120-124).
(N-8) Surprised by lack of family members involvement in patient care.	(N-8) Back home family members help out with the patient care.	Patients, their families are very appreciative. You know, when you take care of them they're very happy, they bless you, they talk good about you, you know, they help you out! If they come in. They want to help as much as they can, to help their family members, not...(16. 93-97)
(N-10) Feels that family involvement will speed up the patient's recovery.	(N-10) Feels that family involvement will speed up the patient's recovery.	I see that around, it doesn't take anything from me going to give them water, but I feel if the families are there, that is your time, they show love, they show that they are really concerned and that would make the patient feel happy, feeling ready to go home.(16. 111-116).
(N-11) Experiences unfamiliarity with the equipments and materials used in the practice settings.	(N-11) Equipments used in home country are different.	Training back is different, they, you know the type of equipments that they have here is different from what we have. (16.124-126). Dressing change, I would say the nurse can put it, set up dressing ,Equipment, but here it's already made, made for them, like packed.(16.131-133) The equipment is totally different from what you had in Nigeria. (18.12-13). I'll tell you I've never seen a vital signs machine until I came to America. I've never seen it. I saw it here for the first time and I thought about this in telemetry. I don't know how, I was thinking it was a big machine, but when you came here you saw something electrodes and minimal, so it

		wasn't that bad (19.21-27).
(***N-12) Experiences the need to learn about language and culture during orientation***.	(N-12) Did not get adequate orientation	For one week in the classroom I got, about two weeks, no three weeks on the floor. (16.162-163) it's just that it's hard on her to just come in within 2 months and pick up the language, the culture, it's gonna be hard on her. So you've gotta go slow with her. She's gonna be a good nurse you know. She has the potential, but it's just that everything's overwhelming for her right now. (17. 228-231). But like the hospital you had orientation for about 5 weeks. (18.15-16).
(N-13) Experienced a non supportive atmosphere at the work place.	(N-13) Experienced a non supportive atmosphere at the work place.	They're not teaching you and even, they do a lot of criticism instead of telling you, they go back and you know they back stab you, you know. (16. 184-186). I was like 8 months pregnant and she comes and asks me to lift that patient. I said Huh! And the other nurse was saying no I don't want Frances she can't do it, and she was like No, you have to, if she can't lift then she has to stop Working. You meet people like that (19.163-168).
(N-14) Experienced the lack of open communication at the work place.	(N-14) Experienced the lack of open communication at the work place	Instead of telling you oh this is what you're doing wrong, let's do it this way, correct the person, talk to the person. That person needs to hear it so they can change. But they don't. They will go back and everybody else wills here it, except you that are being involved. You know and that's not good, so by the time you know it, your image has been damaged (16. 187-194). And also your colleagues ask for you know back home you're kind of closer to them I mean you come to work you all chat when it's necessary and all that. (17.235-238). Some of them get supportive some not. They were going back to tell my manager oh she doesn't do anything. Well the manager… I heard from someone else. She's doesn't know this computer, she's always asking me questions(18.

		37-40)
(***N-15) Excited about the prospects of career advancement in USA.***	(N-15) Feels that there are more learning opportunities here.	They are all opportunities to learn you know, if you want when you have the resources too,(16.206-207) I love the profession. I think America is a good place for me to do it, to do better job and to expand in my education (19.189-191)
(N-16) Hard time with the accents.	(N-16) Had difficulty about the accent.	Some of them say Oh, you have an accent. I don't understand you, I don't understand you, but you they don't take time listen because if they listen (16. 217-219). I wouldn't say they can't speak English but maybe the accent it's hard for them to really understand what people are saying which is kind of not,(17.197-200) When they talk I don't hear. Maybe the person makes 10 sentences; I will be able to hear one. (18.100-101).
(N-17) Made efforts to modify the accent to adapt to American English.	(N-17) Tried to modify the way of speaking to handle accent.	I've not really gone and taken an English class apart from I know before, it's just trying you trying to modify the way you speak, because it's still the same English you learn and uh, but the fact that some of them have not travelled out of Texas.(16.221-225). So it was I would say I have communication problem sometimes. Your client they wouldn't understand you because of your accent. You still try to know how to say, you say the things in a way they will understand. (19. 32-36).
N-18) Experienced cultural intolerance	(N-18) Experienced cultural intolerance	They don't, they cannot adapt to other people's culture. It's just they feel theirs is perfect, they feel their language, that if you look at it, you know (16.227-229)
(N-19) Have high quality education.	(N-19) Feels confident about the quality of the educational preparation from back home.	Like back home you go to school three whole years. Basic nursing and you do more clinical, you on the floor you have.(16.252-254) They tell us more in detail like you don't need to know those things, but I think you really do need to learn it to be able to defend your profession. I don't think it's for doctors'. I don't think it's

		regular in your stuff real good, so I think they teach us well for us to come here and take the board and pass. (19.79-85).
(N-20) Previous knowledge of the American culture was helpful for adaptation.	N-20) Previous exposure with the American culture helped with adaptation.	In Nigeria I was working for an American company and so I didn't have any problem adapting here. (17. 3-5)
(***N-20) had been to different countries and their cultures.***	(N-21) Had previous exposure to another country	Well the culture wasn't much difference for me because I came through England.(17. 18-19)
(***N-22) Was stuck without a car initially.***	(N-22) Transpiration was difficult in the beginning.	The only thing I found kind of like a set back was transportation you know here in Texas. I guess it's not like that in other states or maybe in Downtown you know, but coming to live down the road here you don't Even have a car to come to work you know and all that (17. 27-32)
(N-23) Must adapt to different practice settings.	(N-23) Previous experience was in a different specialty.	Well patient wise I mean there are different things you know of your city like when I was in England I worked in the OR. But here I'm on the floor. (17. 42-45) I did my nursing in Nigeria and came here. When I graduated from Nigeria I was they made me like a precept of students to instruct, that is what I was doing. Those things, like try to teach them, take them to hospital and instruct them, you don't see those. I know I wasn't working in a hospital. (19.37-43).
(N-24) Pain meds are used here in abundance.	(N-24) Pain management is different here.	Well back home really, people I wouldn't say they're in pain maybe because they have access to a lot of over the counter medications a lot of them I mean a lot of codeine you get it over the counter (17. 53-55). *But here somebody calls you for Pain medication* *I mean you have to respect what the patient* *says the pain is. (17.64-67)*

		You know these patients they check the time that I give the medicine to them. When it is exactly 4 hours, they call you. Can you imagine? We have somebody that takes pain medicine every 3 hours round the clock so when it was 20 after she called me Oh can I have my pain medicine. I feel sometimes they are not really in pain but because they know they have a schedule, they want to take it (18.76-84).
(N-25) Manageable work load.	(N-25) Work load is not hard here.	So you know the patient load is not really too bad yak it's not really too bad. Like on my floor its 5-6 patients to a nurse on night duty. (17.85-87)
(N-25) More job responsibilities than expected.	(N-26) Back home Patient assessment was the doctor's responsibility.	The doctors do the assessment you know all we do total nursing care. You don't do anything like patient assessment and oh no, we don't even have stethoscopes.(17. 97-100)
(***N-28) Do not trust in the process of telephone orders.***	(N-27) Have difficulty with telephone orders	Here I mean we get orders. The first time I had one, I was like what if the doctor said I wasn't the person you spoke to you know and I had to talk to the doctor about this one and getting orders what if he come and deny oh no that's not what I said?. (17. 107-112).
(***N-29) Was used to the system of Physicians visiting the patients and writing the orders but not the telephone orders***.	(N-28) Used to have the physician available anytime to write orders	Back home we had doctors in hospitals 24 hours a day, yah so whatever need or problem you want, go to them and you know they prescribe whatever the patient needs at the time (17.112-115)
(N-29) Feels that the patients in USA are well informed.	(N-29) In USA patients are more informed.	Ok, unlike England and Nigeria the patients are more informed in that care outside home.(17.130-131)
(***N-30) Coming from a closed culture were issues are not***	(N-30) Coming from a closed culture	I'm like Mom we have it back home but it's not a crime that's the fact you know, it's not a crime, kids are molested I mean and the families wanna keep it to themselves. (17. 159-163)

openly discussed.		
(N-31) Experienced lack of openness from the community.	(N-31) People are not open to each other here.	And another thing I see is the kids you know. They are freer back home. Leave them in the streets and go play with their neighbors or somebody. I mean, like here you can't do that I mean most people don't even know who their neighbors are When I came here my daughter was in school because in England where She was she was used to playing with other kids, hugging them, the Teacher kept sending a note oh don't hug kids in the class. I'm like what is all this you know. Children should be children, I mean let them play. Don't hug anybody in school you gotta stay on your own, but mommy why they're my friends. I said Look I got it here they don't like it, so don't do that. (17.180-189).
(N-32) Employers did not take into consideration of the culture shock that FENs experience.	(N-32) Feels that employers do not take into consideration of culture shock that FENS experience.	This comes when you place where the culture is so different. People are bound to have culture shock you know which is one thing some places don't even put into consideration. (17.211-214). I've seen a colleague of mine, you know She's new and as far as from my own assessment she knows what she's doing but it's just the culture and the language that is really putting her back you know.(17.214-218)
(N-33) Unfairly treated by disregarding the previous experience.	(N-33) Experience in the home country was not counted.	They asked me where are your right now? I tell them I am not working, I worked last in Nigeria. They say oh you are not working. So it took me a while before I got a job.(18.4-7)
(N-34) Supported by friends from the native country.	(N-34) Friends helped	At work, the very first place I worked had a lot of Nigerians so everything went well. I would ask questions. They would help you.(18.10-12)
(N-35) Left the job because of a non supportive environment.	(N-35) Left a non supportive environment.	So I have to leave that unit, and this is the unit I am working at now, so luckily I met someone they really give me good orientation so I now became familiar with the equipment and the work environment.(18.31-35)
(N-36)	(N-36) Patients in	Like here unlike my country Nigeria, the patients

Experienced stress from demanding patients.	USA are demanding	here are very demanding. (18.73-74).
(N-37) Felt that gradually getting adapted to the new environment.	(N-37) After a while gets used to it.	But after a while I got used to it and it became easier. I tell my husband I can't hear what they are saying he says just relax after a while you start hearing them. Right now no matter what someone says, I will hear it.(112-117)
(N-38) Appreciates kind supervisors.	(N-38) Supervisors were kind.	My first day I would say I had a good preceptor, the educator there (Name), she's a very nice lady. (19.11-13).
(***N-39) Possess sound transferable theoretical knowledge from the home country but practice was in different settings.***	(N-39) Learnt the same theoretical concepts but practice settings were different between the home country and USA.	My first day I would say I had a good preceptor, the educator there (Name), she's a very nice lady. In Nigeria, I wouldn't say they don't teach us a lot, but what they're teaching us you doesn't see those things. When you go to clinical it's totally different from what you read in the textbooks, because the textbooks are international textbooks, is because when you come here the Questions are not that different. But the only thing when you go to the hospital experience you don't see, they don't have it like, I'll tell you I've never seen a vital signs machine until I came to America (19.11-22)
(N-40) At first, everything is new and got to learn them!	(N-40) Everything was new for me and had to learn it.	Everything was new, everything in that unit as we come I had to learn everything. I'm lucky, but I try to learn it fast. Once you tell me once I remember it, (19. 29-31). You have to learn the culture; have to learn the equipment, everything there. I had to learn how to use the pumps and everything (19.62-64).
(***N-41) Must understand the psychological outlook of the people and their social customs***	(N-41) Way of living is different.	. The psychology is different. Like in Nigeria when I see a child that is not even my child, I have right to turn him around to stop him, but you can't do it here. You have to mind your business. So all these psychological facts of America, everything we have to learn it. How to talk to your patients, even when they're… (19.47-58).

(N-42) Experiences the need to get used to a different communication style.	(N-42) Communication style is different.	Interaction is different. Have to learn how to talk to your patient in a good manner. Have to learn all those things. (19.66-68).
(N-43) Feels that success depends on strong determination	(N-43) Have determination.	But you see I was determined, so whatever they said I said that was fine. Say whatever you want to say, but show I think we have determination came from somewhere else, not here. To come here and go through the stresses and changes and still get some meaning. (19.106-109).

NB: Codebook III and final coding operations are not included in this Appendix due to space limitations. They are available, as requested, from the investigator. They do constitute part of the auditable trail.

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VITA

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Mini Jose has been a nurse since 1992 and has served in various positions both in India and the USA. From March, 1993 to June, 1996, she was part of the cardiothoracic nursing team at Apollo Hospitals in Chennai, India. Her clinical experiences in the USA include staff nurse and charge nurse positions at a long-term sub-acute care facility in Massachusetts and the Memorial Hermann Healthcare System in Houston, Texas.

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