TRANSITION PROGRAM FOR INTERNATIONALLY EDUCATED FILIPINA NURSES

by

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ABSTRACT

This qualitative study was guided by standpoint theory and cultural competency theory for the purpose of exploring the lived experiences of internationally educated Filipina nurses (IEFNs) who migrated to Alabama to join the U.S. nursing workforce and to help alleviate the critical shortage of nurses. The goal of this research was to address the lack of transition programs for IEFNs in facilitating their transition related to socio-cultural differences, language barriers, and adaptation to their new living and working environment.

This study discussed the impact (or the lack thereof) of transition programs for IEFNs. The rate of internationally educated Filipino nurses entering the U.S. nursing workforce has been increasing faster than the rate of new nurses educated in the U.S. since 1998. Despite the increased utilization of IEFNs in the U.S., there is a lack of knowledge of how these nurses transition into the U.S. nursing workforce. Internationally educated Filipino nurses must adapt their practice and communication patterns to that of the new environment in order to successfully deliver safe, quality care to patients (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004).

This study therefore focused on the lived experiences of internationally educated Filipina nurses related to socio-cultural differences, language barriers, and adaptation to their new living and working environment. The experience of isolation, intimidation, discrimination and/or marginalization severely affected the transition and adaptation of the Filipina nurses. The development of transition programs based on these Filipina nurses lived experiences will hopefully help and assist in the transition of the newly hired internationally educated Filipino

nurses or future internationally educated foreign nurses migrating to Alabama to join the U.S. nursing workforce.

DEDICATION

This dissertation is dedicated to my deceased parents, Leopoldo T. Espino and Monica A. Espino. They raised eleven children and gave each of us our education. My father strongly believed that education is wealth and no one can take it away from you. He encouraged me to thirst for knowledge and to love learning that knows no boundaries. They both molded me into the person I am today. They instilled in me to work hard, to respect everyone I meet, to attain my goals, and to give back to my community.

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"There is a fountain of YOUTH: it is in your MIND, your TALENTS, the CREATIVITY you bring to your life and the lives of people you love. When you learn to tap this source, you will truly have defeated AGE." Sophia Loren

LIST OF ABBREVIATIONS AND SYMBOLS

AACN	American Association of Colleges of Nursing
AND	Associate Degree in Nursing
AHRQ	Agency of Healthcare Research and Quality
AIHW	Australia Institute of Health and Welfare
ANA	American Nurses Association
BSN	Bachelor of Science in Nursing
CGFNS	Commission on Graduates of Foreign Nursing Schools
CNS	Clinical Nurse Specialist
CNOR	Certified Nurse, Operating Room
CRNE	Canadian Registered Nurses Examination
DHHS	Department of Health and Human Services
ESOL	English Speakers of Other Languages
FNG	Foreign Graduate Nurse
GNA	Global Nurse Ambassador
GNP	Global Nurse Program
HRSA	Health Resources and Services Administration
HUP	Hospital of University of Pennsylvania
ICN	International Council of Nurses
IEFN	Internationally Educated Filipino or Foreign Nurses

IEN	Internationally Educated Nurses
ICNM	International Center on Nurse Migration
IEFN	International Educated Foreign Nurses
IOM	International Organization on Migration
IOM	Institute of Medicine
J-1	Working Visa
LPN	Licensed Practical Nurse
MD	Doctor of Medicine
NCLEX-RN	National Council Licensure Examination for Registered Nurses
NCEMNA	National Coalition of Ethnic Minority Nurses Association
NCSBN	National Council of State Boards of Nursing
NHS	National Health Service
NMC	Nursing and Midwifery Council
PJN	Philippine Journal of Nursing
PNAA	Philippine Nurses Association of America
RN	Registered Nurses
TIENS	Transitioning Internationally Educated Nurses
TOEFL	Test of English as a Foreign Language
UK	United Kingdom
UPNS	University of Pennsylvania Nursing School
USA	United States of America
US-EVP	United States Exchange Visitor Program
WHO	World Health Organization

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unselfish time and for your eagerness to change the living and working environment for all internationally educated foreign nurses.

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CHAPTER I:

INTRODUCTION TO THE STUDY

Background and Significance

Nurses educated in other countries represent a vital part of the U.S. nursing workforce (Gingrich, 2006). Nursing shortages impact not only the United States but also countries around the world like Australia, Canada, and the United Kingdom (Withers & Snowball, 2003). As a result, many healthcare agencies in the U.S. and around the world are recruiting and hiring nurses educated in other countries to fill the vacant positions. Schools of nursing in the United States currently are unable to educate a sufficient number of healthcare professionals to care for the U.S. public (Cooper & Aiken, 2006). The rate of internationally educated nurses (IEN) entering the U.S. workforce has been increasing faster than the rate of new nurses educated in the U.S. since 1998. According to HRSA, National Center for Health Workforce Analysis released in 2013, the U.S. nursing pipeline, measured by the annual number of individuals who pass national nurse licensing exams, grew substantially from 2001 to 2011, with RN test passers growing 108%. In 2011, more than 142,000 new graduate RNs passed the NCLEX-RN. This contrasted with the 68,561 new graduate RNs in 2001. The number of internationally educated RNs passing the NCLEX fluctuated significantly between 2001 and 2011. From 2001 to 2007, the annual passers increased steadily, from about 6,700 to nearly 23,000. Perhaps as a result of the growing number of U.S. graduates and the recession, the annual number of internationally educated NCLEX passers has dropped since 2007 and was only 6,100 in 2011.

According to the Philippine Overseas Employment Agency, a vast majority of Filipinos are seen to dominate the field of nursing in the United States with registered nurses (RNs) making the largest segment of the country's health care workforce. In the Philippines, an average RN commonly earns only around 5% of the salary that the U.S. can offer, with an average of P170,960 ($3,301) per year. From 2012 to 2017, 92,277 nurses left the Philippines in search of opportunities abroad (Robles, 2019).

Despite the increased utilization of foreign-educated nurses in the U.S., there is a lack of knowledge of how these nurses transition into the U.S. nursing workforce. Internationally educated nurses must adapt their practice and communication patterns to that of the new environment in order to successfully deliver safe, quality care to patients (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004). Nursing has become a more transferable career due to increased global communication and travel. Many IENs are drawn to the U.S. due to opportunities available for increased pay, better education, career advancement, and career development (Giegerich, 2006).

Throughout the 1980s, Filipino nurses represented about 75% of all foreign nurses in the U.S. workforce. Since then, the percentage of Filipino nurses has been dropping as the diversity of immigrant nurses has increased. In 2000, Filipino nurses made up 43% of the foreign nurse workforce (Brush, Sochlaski, & Berger, 2004), and are still the largest portion of nurses immigrating to the U.S. (National Council of State Boards of Nursing, 2005). The majority of foreign-educated nurses in the U.S. come from the Philippines, India, and Nigeria where the culture and the practice of professional nursing are very different from the practice of nursing in the United States (Davis & Nichols, 2002).

The U.S. Department of Health and Human Services (2005), using a large probability sample, reported that there were 2,909,467 nurses in the United States in March, 2004. Three and a half percent of registered nurses (RNs) received their education in another country, amounting to 100,800 nurses (U.S. Department of Health and Human Services [DHHS], 2005). There were an estimated 146,097 internationally educated RNs employed in the United States in 2008, 23.6% of whom were licensed between 2004 and 2008 (U.S. Bureau of Health Professions, 2010).

According to the Bureau of Labor Statistics' Employment Projections 2012-2022 released in December 2013, RNs are listed among the top occupations in terms of job growth through 2022. The RN workforce is expected to grow from 2.71 million in 2012 to 3.24 million in 2022, an increase of 526,800 or 19%. The Bureau also projects the need for 525,000 replacement nurses in the, bringing the total number of job openings for nurses due to growth and replacement to 1.05 million by 2022. The shortage of RNs is projected to spread across the country between 2009 and 2030. In this state-by-state analysis, there is a forecast of a nationwide RN shortage that will be most intense in the South and in the West (American Association of Colleges of Nursing, Nursing Shortage Fact Sheet, May 2015).

As the demand for nurses and the utilization of foreign-trained nurses' increases, it will become progressively more important to have a thorough understanding of these nurses. Greater understanding of these nurses will allow employers and U.S. nurses to better assist the migrating Filipina trained nurse to adapt easily to their new living and working environment, to socio-cultural differences, to new nursing practices and procedures, to new technology, and to learn the language barriers. The transition challenges of internationally educated Filipina nurses are not due to lack of knowledge or clinical skills, but rather linked to socio-cultural differences,

including the structure of the health care systems, language subtleties such as the use of idioms, acronyms, and abbreviations, unfamiliarity with their new surroundings, discrimination, and marginalization (Adeniran, Rich, Gonzales, Peterson, Josh & Gabriel, 2008).

The presence of perceived discrimination and marginalization by IENs can potentially affect IENs self-esteem, self-perception, and the role function if he or she cannot cope with stress which is related to discriminatory behaviors (Roy, 2009).

Statement of the Problem

This qualitative study discusses the impact (or the lack thereof) of transition programs for internationally educated Filipina nurses (IEFNs) migrating to the United States to join the U.S. nursing workforce to fill vacant nursing positions. This study therefore focuses on the lived experiences of internationally educated Filipina nurses related to socio-cultural differences, language barriers, and adaptation to their new living and working environment and will explore how these lived experiences of Filipina nurses in this study contribute to the development and/or enhancement of transition programs in the Southeastern United States.

Purpose and Significance of the Study

This study focuses on the lived experiences of internationally educated Filipina nurses related to socio-cultural differences, language barriers, and adaptation to new living and work environments. The purpose of this study is to explore how these lived experiences of the participants contribute to the development or enhancement of transition programs for internationally educated Filipino nurses who will join the nursing workforce in Alabama in the future.

In selecting a topic for my study I asked myself, “Why this study is important to me? Who will benefit and care about having an established transition program for internationally

educated Filipino nurses?" Clandinin (2013) proposed three ways to justify this study. The first has to do with how it matters to the researcher personally. I have personally experienced the difficulty of adjusting to the socio-cultural differences, and the language barriers especially here in Alabama with all the idioms, acronyms, abbreviations, slang, and accents I have experienced the difficulty of adjusting to work in a different environment marked by racism by many who obviously marginalized our level of education, derided how we communicated with them and with our patients, took advantage of our presence by giving us all the night shifts, increased patient load, and gave us the sickest patients in the nursing unit. A second justification has to do with the practicality of the study. My intent is to use the lived experiences of previous and present internationally educated Filipina nurses working in Alabama to provide a deeper insight into the necessity of having an established transition program for present and future IEFNs coming to work in Alabama where little or no studies have occurred. The final justification of this study is to bring awareness to healthcare organizations to adapt the established transition programs to support the transition of IEFNs to their new practice and living environments. At present, the U.S. healthcare agencies' transition programs differ across organizations and there has been minimal research to document whether the desired outcomes of these programs are being achieved. Initiating a national policy that would mandate healthcare organizations to have transitional programs requires an appreciation of the complexity of the problems and the answers needed to support the creation of such programs. Healthcare organizations need to sit at the table and discuss how they can work together to create positive environments for IEFNs. This is necessary to ensure the safety of those who receive nursing services from IEFNs (Lin, 2014; Smith & Ho, 2014; Wolcott, Llamado & Mace, 2013; Xu & He, 2012). I hope this study will add

to the existing professional literature regarding the migration of IEFNs and the lack of transition programs into the U.S. nursing workforce in Alabama.

Statement of Research Questions

The research questions that guided this inquiry are as follows:

1. How do internationally educated Filipina Nurses describe their lived experiences as they transition to the U.S. nursing workforce?

2. How can these lived experiences of Filipina nurses in this study contribute to the development and enhancement of transition programs in Alabama?

Theoretical/Conceptual Framework

Qualitative research often uses frameworks to provide guidance for a starting point in the field, as a lens or perspective from which to view the world, and at times to assist with the organization of data in a broad sense. Frameworks can be utilized in research in a number of ways in order to guide the study, to assist with the organization of thoughts and inquiry, and to help with data analysis (Creswell, 2009). Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to self (Denzin &Lincoln, 2011, p. 3). In this study, I used standpoint theory as the conceptual framework and I will use the power of storytelling as the method to access the experiences of my research participants. I will also use the theory of cultural competency to analyze the socio-political and cultural aspects of this study.

Standpoint theory analyzes inter-subjective discourses. This body of work concerns the way that authority is rooted in an individual's knowledge (a person's perspective), and the power

that such authority can exert. Standpoint theory supports what feminist theorist Sandra Harding calls strong objectivity, or the notion that the perspective of marginalized and/or oppressed individuals can help to create more objective accounts of the world. Through the outsider-within phenomenon, these individuals are placed in a unique position to point to patterns of behavior that those immersed in the dominant group culture are unable to recognize. The standpoint theory's most important concept is that an individual's own perspectives are shaped by his or her social political experiences. Standpoint theory gives voice to marginalized groups by allowing them to challenge the status quo as the outsider within. (Ryan, 2005; Harding, 1987). You have to be in my position to understand what Spivak (2012) wrote about the concept of being in the center or being outside of the circle. According to Spivak, deconstructionists do their work from within (from an intimacy with the structure); it is that within-ness that enables critique of the limits of the structure, or how it limits life. Structures themselves are not as stable as they appear, yet they do define and regulate people's way of living. So for Spivak, it is up to the deconstructionist to determine the contours of a structure and to take position that is "in the middle, but not on either side." As a new settler in this foreign country, I experienced trying so hard to be friend with my co-workers and to be accepted as one of their peers, better yet, to be one of their circle of friends. I worked very hard and I tried to do some of the tasks assigned to them just to be accepted. I even worked for them during their weekend schedules and during holidays. I was always outside of the circle looking within (Spivak, 2012). But when I am with my Filipino community I am considered to be their leader and organizer, I am in the center of the circle.

Asante and Davis' (1989) study of interracial encounters in the workplace found that because of different cultural perspectives, approaching organizational interactions with others

with different beliefs, assumptions, and meaning often leads to miscommunication. Brenda Allen (1996), stated that the organization's members' experiences, attitudes, and behaviors in the workplace are often influenced by race-ethnicity. The Filipino nurses found the adaptation process to their host country very difficult. It should be noted that the person who migrates encounters a new culture, a process called acculturation. This is a "process by which newcomers to a group, work to make sense of the surroundings and come to acquire the kind of knowledge that would enable them to produce conduct which allowed established members of the group to recognize them as competent" (Bond & Bond, 1994, citing Dingwall, 1977, pp. 12-13).This theory will aid in explaining the following phenomena of the lived experiences of Filipina nurses related to race, ethnicity, gender, inclusion, and class position.

Cultural competency theory results in four main themes: awareness of diversity among human beings, ability to care for individuals, non-judgmental openness for all individuals, and enhancing cultural competence as a long -term continuous process. Culture is defined as "the learned, shared, and transmitted values, beliefs, norms, and life practices of a particular group of people" (Leininger & McFarland, 2002). People's culture can be understood through their actions, that is, their behavioral patterns and through understanding why people act in the way they do; their functional patterns (Steir & Olsson, 2004). This framework will be used to explain the phenomena of socio-cultural difficulties experienced by internationally educated Filipino nurses.

Methodology

This study focuses upon the lived experiences of internationally educated Filipina nurses. This study will utilize the power of storytelling as a method. Stories is how we think. They are how we make meaning of life. Call them schemes, scripts, cognitive maps, mental models,

metaphors, or narratives. Stories are how we explain how things work, how we make decisions, how we justify our decisions, how we persuade others, how we understand our place in the world, create our identities, and define and teach social values. (Bennett, 2013, p. 43)

Storytelling was the first form of communication historically and it is the first form of communication that we encounter as children. As human beings we crave stories. We love to hear stories and we love to share stories. We learn and retain stories before we can read. Our minds intuitively understand structure and process the message, information and detail contained therein. But stories are more than that. Stories are our universal storehouse of knowledge, beliefs, values, attitudes, passion, dreams, imagination, and vision. Telling stories is a natural process and each of us does it all the time. Whenever we communicate we tell stories. We do so to make ourselves understood, but also to process our experiences, to digest them, and integrate them into a meaningful whole (Steixner & Heidegger, 2013). People who share their stories will feel the uniting effect that stories possess. When participants have listened to someone's story, they share this experience and connect to the storyteller. Storytelling activates our emotional memory. The effect might not be as strong as if they had gone through this experience together, but still, a story is the revival of a situation experienced in a different context. Not only the storyteller will revisit his or her experience, but also the listener will be stimulated to return to his/her experiences (Steixner & Heidegger, 2013).

People use stories to explain how things work, how we make decisions, how we justify our decisions, how we persuade others, how we understand our place in the world, how we create our identities, and how we define and teach social values. Through stories we share passions, sadness, hardships, and joys. We share meanings and purpose. Stories are the common ground that allows people to communicate and overcome their defenses and their differences.

Stories allow us to understand ourselves better and to find our commonality with others. (Rutledge, 2011).

By using standpoint theory and cultural competency as the theoretical framework for this qualitative study, the lived experiences of IEFNs and the researcher can be thoroughly explored through storytelling, through telling and re-telling, by sharing their experiences, their joys, their sadness, their passions, and their hardships. For the researcher the task is to write and share the stories that the participants tell.

Data Collection and Analysis

This study used individual stories of internationally educated Filipina nurses working in community hospitals located in urban, suburban, and rural Alabama. To explore the nature of the IEFNs transition to the U.S. nursing workforce, firsthand accounts were collected through the participant's stories. Because the IEFNs experience this phenomena, their accounts and perceptions are vital to exploration and understanding of their lived experiences. I asked each participant to share with me any written artifacts related to their lived experience such as diaries or notes discussing their journey.

I explained to each participant that they are invited to three informal meetings. Our meeting lasted at least one hour and it took place in a mutually agreed upon location like my home, my office, or a hospital conference room. I used guidelines in the form of an open-ended protocol for my inquiry. I wrote my observation field notes and used a research diary to allow me to track my thinking in an unstructured venue as I went through the research process. I asked permission to use a digital audio recorder during their storytelling session to facilitate the collection of information. After the storytelling meetings, I transcribed data for analysis to understand the participants' meaning. I shared the data with each participant to check it for

accuracy. Data were securely stored in an encrypted computer under the UA Box. And data could only be accessed by the researcher (see Appendix A for Interview Questions).

The method of analysis that was employed in this study was the constant comparative method, which is an analytic procedure of constant comparison with an explicit coding system designed to develop themes. As individual interviews are transcribed, I reviewed previous transcripts to continue to look for themes that emerged with additional data analyses. Data were triangulated through analysis, peer review, and audit trail. Data analyses are described in greater detail in Chapter III.

Assumptions

As the researcher, I had two assumptions for this study. First, my personal background and lived experiences led me to hold a philosophical paradigm as an advocate for my peers and colleagues. An advocacy paradigm is one in which I believe and act in ways to promote change in the area of concern (Creswell, 2007). Second, as the researcher, I assumed that all respondents expressed their views truthfully and freely based on their own experiences as internationally educated Filipina nurses practicing in Alabama or having practiced nursing in Alabama.

Limitations and Delimitations

The limitations are the lack of generalizability beyond the specific context of Alabama. The study is delimited to interviewing IEFN who are presently working or have retired in community hospitals located in urban, suburban, and rural Alabama.

Conclusion

Learning more about the lived experiences of internationally educated Filipina nurses who have retired or are still working in Alabama will give voice to this group. By interviewing Filipina nurses working in urban, suburban, and rural Alabama, the researcher intended to

explore and to focus on their lived experiences related to socio-cultural differences, language barriers, and difficulty adjusting to their new living and working environment. Open coding was used to assist the researcher in capturing interviewees' thoughts and perceptions concerning their lived experiences. Data were placed in categories and analytically examined to identify concepts and themes. The goal of this research was to use the lived experiences of the Filipina nurses in this study to assist in the development and enhancement of transition programs for future internationally educated nurses who will be working in Alabama as well as to begin to fill the gaps in the professional literature.

Operational Definitions

CGFNS International--Commission on Graduates of Foreign Nursing Schools is an immigration neutral nonprofit organization that helps foreign educated healthcare professionals live and work in their country of choice by assessing and validation of their academic and professional credentials. It provides foreign students and healthcare professionals with comprehensive assessment of their academic records to facilitate their successful admission to schools in the U.S. and other countries. It helps protect migrating professionals by advocating for ethical recruitment practices and continuously monitoring the global landscape trends in employment recruitment and workplace norms.

EVP--the U.S. Exchange Visitor Program was established in mid-1960 where Filipino nurses who participated in this program worked and stayed for maximum of two years in the United States, and then returned to their country of origin. This program was established to fill the critical shortage of nurses in the U.S.

Filipino--defined in this study as men and women from the Philippines and whose native language is Filipino.

Filipina--defined in the study as women from the Philippines and whose native language is Filipino.

ICNM--International Centre on Nurse Migration serves as a comprehensive knowledge resource created by the Commission on Graduates for Foreign Nursing Schools (CGFNS) International in partnership with the International Council of Nurses (ICN). ICNM emphasizes the development, promotion, and dissemination of research, policy, and information on global nurse migration. This resource center features news, resources, and publications widely available to policy makers, planners, and practitioners.

ICN--International Council of Nurses is a federation of more than 130 national nurses associations (NNAs), representing the more than 20 million nurses worldwide. Founded in 1899, ICN is the world's first and widest reaching international organization for health professionals. ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce.

IEFN/FGN--Internationally Educated Foreign Nurses/Foreign Graduate Nurse--nurses who obtained their nursing education outside of the United States of America.

NCLEX Exam--also known as the National Council Licensure Examination is a standardized exam that each state board of nursing uses to determine whether or not a candidate is prepared for entry-level nursing practice.

NCSBN--National Council of State Board of Nursing is the regulating body for state boards of nursing is the United States.

Pensionado--The Pensionado Act of 1903 refers to the law which allowed qualified Filipino students to study in the United States. These students were called Pensionados because

they were scholars studying at the expense of the colonial government in the Philippines. The students mainly earned degrees in government and administration because the idea of the program was to educate the students in the U.S. Government system, so upon their return to the Philippines, they would administer the government in the same fashion.

PNAA--Philippine Nurses Association of America was formed in 1979 by Filipino nurses in New Jersey in response to the growing need for concerted effort to address the issues and concerns of Filipino nurses in the USA. Retrieved from www.mypnaa.org

U.S. Colonialism in the Philippines--created an Americanized training hospital system that eventually prepared Filipina women to work as nurses in the United States as opposed to the Philippines.

U.S. Immigration Act of 1965--provided new visas to Filipino nurses with needed skills to migrate to the U.S. to meet the critical U.S. nursing shortage in post-World War II. This explains the phenomenon of the Filipino nurse mass migration to the U.S. The establishment of an Americanized training hospital system in the Philippines created the professional, social, and cultural foundations that enabled the Filipino nurse labor force to work in the United States. Filipina women in general and Filipino nurses specifically viewed work and study in the United States as a desirable experience, a prestigious path to professional mobility on their return to the Philippines. Some of the exchange visitor nurses claimed that they like living in the United States because their salary was higher than their earnings in the Philippines, enabling them to help their family financially. They also preferred the United States over the Philippines culturally. They have enough money to go to Broadway, Lincoln Center, and have the opportunities to travel because they have enough money (Choy, 2003, pp. 62-63).

CHAPTER II:

LITERATURE REVIEW

Introduction

The purpose of this chapter is to review research and literature that will provide background information and a deeper understanding of the lived experiences of internationally educated Filipino nurses transitioning into the U.S. nursing workforce to fill vacant nursing positions. As a severe nursing shortage grips the U.S. health care system, a whole new generation of Filipino nurses is coming to America to seek educational and career opportunities unavailable in their homeland. This newest wave of immigrating nurses faces a more complex health care system and stricter immigration rules compared to their counterparts of 30 or 40 years ago. Many of the challenges like adjusting to a new culture, language barriers, as well as the drive to seek a higher standard of living have hardly changed at all. Filipino nurses' desire to leave their homeland in pursuit of the American dream is then, as now, understandable and even inevitable. There are not enough jobs in the Philippines for all the nurses who graduate from universities, colleges, and schools of nursing (Lowery, 2013). Today's new arrivals encounter a much more complex work environment than that of a generation ago including new high-tech equipment, paperless medical records, increased regulation, utilization review guidelines, and new disease management concepts, to name a few. Filipino nurses are considered a racial minority group in the U.S. Most of them are females who face unique challenges not experienced by males. They are either immigrants, on working visas (J-1) or joining their families or

relatives who migrated to the United States ahead of them. They are new settlers who can speak English but have difficulty understanding idioms, acronyms, and deciphering accents. They face a new socio-cultural environment and have to adjust to their new living and working conditions. They come from average to middle class families in the Philippines with average socioeconomic backgrounds earning between 15,000-25,000 pesos per month, which is equivalent to $300.00 to $500.00 per month. They are highly educated, skilled, and prepared to leave their country for a better life and to support their families financially (Lowery, 2013). The literature review will provide an overview of their lived experiences while joining the U.S. nursing workforce.

Early History of Nursing in the Philippines

The introduction of nursing in the Philippines was part of a larger U.S. colonial and medical agenda that racialized Filipinos and Americans in the context of reform. Health care personnel contributed to the overall U.S. colonial project of preparing Filipinos for self-rule through the introduction of American medical practices. American medicine, they believed, would transform Filipinos into people capable of self-government. “Filipino health” became a forceful metaphor for the primary objectives of U.S. colonialism. As Victor Heiser, director of health in the Philippine Islands, claimed,

To summarize, it is to be understood that the health of these people is the vital question of the Islands. To transform them from the weak and feeble race we have formed them into the strong, healthy, and enduring people that they yet may become is to lay the foundations for the successful future of the country. Such concerns for the welfare of Filipinos complemented America’s “benevolent assimilation” of the Philippines, which as U.S. President William McKinley proclaimed in 1898, brought Americans to the Philippines “not as invaders or conquerors, but as friends” (Choy, 2003, pp. 20-21).

Although the introduction of professional nursing in the Philippines presented new opportunities for Filipina women, it needs to be understood as part of a larger U.S. colonial agenda that racialized Filipinos and Americans under the guise of benevolent reform. Furthermore, although Philippine nursing was shaped by both Filipinos and Americans, the study and practice of nursing took place in the context of unequal colonial relationships (Choy, 2003, p. 20).

Ceriza C. Choy (2003) documented a period of transnational mobility of nurses that has been marginalized in Filipino American history. In the early 20th century, American and Filipino nurses shaped nursing in the Philippines through travel as well as teaching, training, and practice. American nurses traveled to the Philippines to teach and practice nursing during the early part of the U.S. colonial period, and eventually returned to the United States. Filipino nurses also traveled to the United States to study and practice nursing and then returned to the Philippines. This multidirectional mobility has been ignored in Asian American histories that foreground Filipino migration eastward to the United States, but have focused on Filipino male migrants, many of whom worked as migrant agricultural laborers and settled permanently in the United States. Although these studies have importantly analyzed the racism and exploitation encountered by these Filipino men in America, more attention to other gendered forms of mobility during this period brings to light the transnational formation of new female labor regimes, such as nursing, during the U.S. colonial period. The formation of this gendered labor force would lay the foundation for the significant migration of Filipino nurses later in the 20th century.

The closely linked opportunities of study abroad and professional advancement in the Philippines increased nursing popularity. The first three graduates of St. Luke Hospital School of

Nursing in Manila completed their post-graduate coursework at Protestant Hospital in Philadelphia with financial assistance from the wife of a former U.S. ambassador to England. They returned to the Philippines and were appointed in faculty and supervisor positions. In 1922, the Rockefeller Foundation sponsored more Filipino nurses to complete their postgraduate coursework at Columbia University's Teacher's College and upon their return to the Philippines were awarded prestigious positions in hospitals and schools of nursing. Study abroad in the United States became a de facto prerequisite for occupational mobility in the nursing profession in the Philippines (Choy, 2003, p.33).

From 1943 to 1945, the U.S. colonial government established a new education abroad program called the *pensionado* program. Through this program the U.S. colonial government sponsored an elite group of male and female Filipino students called pensionados to study at U.S. colleges and universities. The colonial administrators expected the students to return to the Philippines and to assume positions in U.S. established institutions. Some Filipino nurses studying abroad stayed in the U.S. for periods of time longer than U.S. colonial officials expected, or desired. They settled permanently in the United States. Although U.S. colonial officials attempted to implement their agendas in the Philippines, colonial changes produced unintended consequences such as Filipina women's own strong desires to travel to the United States and to remain there indefinitely, and U.S. colonizer's inability to fully control Filipina women's mobility. Filipino nurses' idealization of American work and academic experience would only be one of several preconditions that would lay the foundation for the mass migration of Filipino nurses overseas in the second half of the 20th century. Americanized nursing education and work culture in the Philippines would inform and shape others (Choy, 2003, p. 33-34).

United States' professional nursing continued to be a dominant force in the development of nursing as a profession in the Philippines through the 1930s. This development was not a simple transfer of nursing ideas from the United States to the Philippines by Americans to Filipinos. Travel arrangements enabled Filipino nurses to study nursing trends in the United States and then institute those changes they deemed relevant and appropriate. Between 1930 to1945, Filipino nurses who were able to pursue postgraduate study in the United States returned to the Philippines to perpetuate American nursing trends. The secretary of public instruction appointed a committee to revise the Philippines nursing curriculum. A subcommittee of Filipino nurses who had recently returned from the United States in 1945 reviewed the proposed new curriculum so that it would be "consistent with the latest trends in higher education abroad."

In 1947, thirty-two Filipino delegates and observers attended the first post-World War II congress of the International Council of Nurses (ICN) held in New York City. During a session presided over by Filipina delegate Julita Sotejo, a delegate from Great Britain moved that delegates from all over the world stand for one minute in silent tribute to the achievements and struggles of Filipino nurses during the war. This moment reflected the international nursing community's recognition of the work of Filipino nurses as well as the recent independence of the Philippines from the United States in 1946 (Choy, 2003, pp. 53-55).

In 1948, the U.S. government established the Exchange Visitor Program (EVP). This program would transform the dream of Filipino nurses going abroad into a dream come true. American hospitals and health care agencies started using travel agencies to recruit Filipino nurses to their hospitals under the EVP. One of the advertisements published in the *Philippine Journal of Nursing* (September-October 1965) stated

> "Dear Nurse, We have placed over 8,000 nurses to different parts of the world. So if you're not happy wherever you are right now, why not take the easy way out and go someplace else. We can't promise you'll find happiness, but we can help you chase it all over the place." (Choy, 2003, p. 58)

Filipino Nurses and the U.S. Exchange Program

The establishment of an Americanized training hospital system in the Philippines during the U.S. colonial period created the professional, social, and cultural foundations that enabled a Filipino nurse labor force to work in the United States. Filipina women in general, and Filipino nurses specifically, viewed work and study in the United States as a desirable experience, a prestigious path to professional mobility on their return to the Philippines. These factors are important historical linkages that connect early 20th-century colonization with the mass migration of Filipino nurses to the United States in the post-1965 period. Why did so many Filipino nurses immigrate to the United States through the occupational preference categories of the Immigration Act of 1965? The poor working conditions of nurses in the Philippines added to the prestige and transformative potential attached to work and study in the U.S. Filipino nurses' dissatisfaction with their work schedules, opportunities, and salaries in the Philippines motivated them to go abroad and take a chance on a new work environment. Exchange visitors were supposed to stay in the United States for a maximum of two years, after which they would return to their country of origin. After working and studying in New York City as an exchange nurse, most of these nurses claimed that they liked living in the United States. Mercado, an EVP nurse stated that her salary as an exchange nurse was higher that her earnings as a nurse in the Philippines, enabling her to help her family financially. She stated that in the Philippines, her salary is just enough for her. She also preferred the United States over the Philippines culturally.

"You can go to Broadway, Lincoln Center. You have enough money to travel. There is always something going on. The exchange programs acted as vehicles for transforming nursing into an international profession. The Filipino exchange nurses came to appreciate working abroad because the experience, the travel, professional opportunity, earnings, material accumulation, and the leisure that accompanied it translated into unique form of socioeconomic success in the Philippines. The prestige associated with the new lifestyle of Filipino exchange nurses changed the culture of Filipino nurse migration abroad. For young Filipina women, nursing opportunities abroad, and not in their home country, became motivation for engaging in the study of nursing in the first place. As a result, Filipino nurses, along with Filipino recruiters and U.S. administrators, transformed the EVP into an avenue for the first wave of Filipino nurse migration into the United States (Choy, 2003, pp. 62-65).

The overproduction of nurses in the Philippines has been the prevailing practice since Filipino nurses were introduced to U.S. hospitals through the Exchange Visitor Program (EVP) in 1947 (Brush, 1993). The Philippines has led the world in preparing nurses for export. Much of the country's nurse production was driven by U.S. market demand with explicit policies to send nurses abroad as export products. Filipino nurses were pushed into service as part of the Marcos administration's (Former President of the Philippines) emphasis on creating an export-oriented economy. As the Philippines' new "international specialty" (Choy, 2004, p. 98), nurse migrants were hailed as heroes whose remittances contributed to nation building. With a highly institutionalized system for labor exportation in place, the Philippines stepped up nurse production and exportation considerably between 1975 and 2000, supplying nurse labor to the United States in addition to the Middle East, other Asian nations, and many European Union countries. By the end of the 20th century, an estimated 250,000 Filipino nurses were employed

throughout the world, remitting nearly $8 billion dollars yearly to the Philippines' economy (Ball, 2004). By 2004, there were 251 nursing schools in the Philippines. A year later, 119 new schools opened, raising the total to 370 programs. Filipino nurses' desire to leave their homeland in pursuit of the American dream is then, as now, understandable and even inevitable. According to Filipina Lowery, MA, RN, CNOR, one of the founders of the PNAA, "there aren't enough jobs at home for all the nurses who graduate from universities, colleges and schools of nursing in the Philippines. It's natural for people in developing countries to want to immigrate to other countries where there are better opportunities." "It's economics." "We need to improve the economic conditions in the Philippines" (Minority Nurse Magazine, 2013).

Exploitation of Filipino Nurses in the United States

In the Philippines, the prestige associated with work abroad fueled Filipino nurses' desire to migrate overseas despite troubling reports of U.S. hospital exploitation. The Filipino exchange nurse migration refashioned and yet, also perpetuated the social and racialized hierarchies created by U.S. colonialism in the Philippines. The Filipino nurses were not the sole participants of the EVP. United States' institutions sponsored exchange visitors from countries like Europe and Asia. American nurses also participated in the program, as exchange visitor nurses in foreign countries. By the late 1960s, 80% of exchange participants were from the Philippines. The increasing numbers of Filipino exchange nurses would begin the profound transformation of the racial and ethnic composition of foreign trained nurses in the Unites States. Between 1952 and 1965, 50% of the 377 graduates from the University of the Philippines' School of Nursing went abroad. Some were placed in New York City, Chicago, Pennsylvania, and Michigan. However, on their arrival in the United States, the exploitation of Filipino exchange nurses by Filipino recruitment agencies and U.S. sponsoring hospitals challenged romanticized narratives about

America. Many Filipino nurses encountered discriminatory working conditions and inadequate orientation programs at their sponsoring hospitals. The Filipino nurses were promised housing arrangements but upon arrival, they were told to find their accommodation without assistance. Some stated that "No one really helped us settle in the U.S. Our initiative and determination made us survive the first few difficult years." Some hospital administrators abused the Filipino nurses by assigning them to work as nurse's aides, and most of the nurses did not get any orientation or educational programs. Some of nurses stated "Look, this is the med-surg unit, we have 18 patients here, and they are all yours. Okay?" Many sponsoring hospitals used the Filipino nurses as an inexpensive labor supply to alleviate growing nursing shortages. In 1962, some American hospital administrators took advantage of the Filipino nurses by assigning them the work of registered nurses and then compensating them with a minimal stipend. The general duty nurse in a Philadelphia non-governmental hospital paid the Filipino nurses $46.50 per week and the American nurses were paid $ 71.50 per week. Some U.S. hospital nursing supervisors exploited the Filipino nurses by assigning them to work in the least desirable areas of the hospital and on the least desirable work shifts. They also would change work schedules suddenly, whenever they deemed them necessary. Filipino nurses further criticized nursing supervisors for offering American nurses better working conditions and schedules at their expense. Filipino nurses always got the "dirty jobs. Their supervisors gave U.S. nurses their choice of assignments, while the Filipino nurses were doing night duty for three months or evening duty for six months. Some U.S. supervisors called the Filipino nurses their "little brown sisters" (Choy, 2003, pp. 75-87).

In spite of this exploitation, many Filipino families still view the nursing profession abroad as the ticket to a better life, as seen in more than 500 nursing schools in the Philippines

today. A nurse's salary abroad is 15 times bigger than working in the Philippines. For many Filipinos, being a nurse made it easier to become a professional foreign worker because there is less competition from the local workers and other foreign workers. Working abroad as a nurse is also more profitable compared to other jobs held by Filipinos like domestic helpers and construction workers. Filipino nurses over the years have migrated to practice nursing in a variety of developed countries like Australia, Canada, and the United Kingdom. This practice resulted in brain drain in the Philippines. (Minority Nurse Staff, 2013).

With American-standard nurse training, English fluency and the assumed innate nature of Filipinos to care for the elderly and sick family members, Filipinos fit the bill for nursing. A country with different dialects and a culture formed from different cultural influences, Filipinos were assumed to be adept in adjusting to new cultures as well as learning new languages. Employers also liked the fact that Filipinos would not mind taking longer hours, hoping to earn more money to send back home. (Minority Nurse Staff, 2013). American healthcare organizations and employers stereotyped Filipino nurses and women as being domiciliary workers.

Filipino Nurses in the U.S. Today

Rosario May Mayor arrived in New York City one cold morning in March 1971, a 22 year old with "adventure in her veins," yearning to experience the America portrayed in television shows and movies she watched while growing up in the Philippines. "The draw was a different setting, a different country with lots to offer, opportunities for education, travel and to be independent," she recalls. Mayor took full advantage of all those opportunities. Over the years, she grew to become a top nursing professional and a national leader. Rosario May Mayor, MSN, RN, was a health system specialist to the director and chief of staff of the Bronx VA

Medical Center and later became the Director of Performance Improvement/Quality Management, responsible for the Medical Center compliance with The Joint Commission. In 2006, she was elected President of the Philippine Nurses Association of America (PNAA). She was also a member of the Advisory Council with the Academy Health/MacArthur Foundation initiative on developing ethical guidelines in the recruitment of foreign educated nurses to the U.S. and the Board of Directors of the National Coalition of Ethnic Minority Nurses Association (NCEMNA), where she represented the needs of the ethnic minority nurses, specifically the Asian voices. The NCEMNA is comprised of five ethnic organizations: Hispanic, Black, Asian Pacific Islanders, Native American/Native Alaskan, and Philippine nurses. As President of PNAA and a member of the NCEMNA Board of Directors, she was able to articulate the needs of Philippine nurses, address disparity issues, and help Philippine nurses seek scholarships that will "boost up" their nursing careers (Mayor, 2008).

For decades, the Philippines were the number one source of foreign-trained nurses in the U.S., and the trend has continued into the 21st century. In 2005, out of 21,500 foreign-trained registered nurses who sat for the certification Program Nurse Qualifying Examination administered by the Commission on Graduates of Foreign Nursing Schools (CGFNS), 55% were educated in the Philippines.

Today, as a severe nursing shortage grips the U.S. health care system, a whole new generation of Filipino nurses are coming to America to seek educational and career opportunities unavailable in their homeland. This newest wave of immigrant nurses face a more complex health care system and stricter immigration rules than their counterparts of 30 or 40 years ago. But many of the challenges of adjusting to a new culture, as well as the drive to seek a higher standard of living, have hardly changed at all. Many of the challenges that confront the newly

arrived nurses from the Philippines are not all that different today. One of the biggest difficulties is simply adjusting to a new environment and cultural landscape. They have to adjust to the nuances of American culture. Language differences are another source of culture shock. Even though nurses trained in the Philippines speak English, they often have trouble deciphering the varied American accents and idiomatic expressions. One Filipino nurse recalls looking out of the window in alarm one day when an American roommate said it was "raining cats and dogs." She also remembers puzzling over a store clerk offering her a "rain check" coupon. Some of the Filipino nurses were embarrassed to talk or ask questions afraid that patients or co-workers would laugh at them (Minority Nurse Staff, 2013).

Unfortunately, another aspect of Filipino nurse migration that has not changed much over the years is the potential for nurses to be exploited by unscrupulous employers and recruiters eager to profit from the nurse's desire to achieve a better standard of living in the United States. Filipinas Lowery, MA, RN, CNOR, one of the founders of the PNAA, recalls how recruiters collected fees from hospitals to bring Filipino nurses, and then, the hospital charged the nurses recruiting fees and held their passports until the nurses paid up. The PNAA put a stop to the unethical recruiting practices. Today, immigrant nurses are still vulnerable to this exploitation, especially those in remote areas of the U.S. like the southern part where international recruiting efforts are relatively new. The PNAA is looking about it from time to time, but do not have the documentation to prove it (Minority Nurse Magazine, 2013).

Other challenges facing these new arrivals are new high-tech equipment, paperless records, increased regulation, utilization of review guidelines, and new disease management concepts, to name a few. There are also more barriers to immigration. These days, foreign-educated RNs applying for an occupational visa must obtain a visa screen certificate. This

certificate is issued by the Commission on Graduates of Foreign Nursing Schools (CGFNS), an international authority on credentials evaluation of health care professionals worldwide. The visa screen is an immigration requirement, not a license to practice in the United States. It determines whether the nurse has the equivalent of a U.S. license and education, can speak and write English, and has adequate medical knowledge. To get the visa screen, nurses must pass either the CGFNS certificate exam or the National Council of State Boards of Nursing's NCLEX-RN exam. The CGFNS exam, is a pre-qualifier for the NCLEX-RN (Minority Nurse Staff, 2013).

NCLEX-RN is the nursing board examination for aspiring nurses in the United States. It is a computer adaptive test that assesses the competencies of nurses for U.S. practice. The examination is being administered by Pearson Professional Testing. In August, 2007, the National Council of State Boards of Nursing approved the Philippines as one of the testing locations worldwide. The test is given in a testing center in Manila, Philippines. "As the NCSBN continues to expand internationally, we are pleased to be able to offer nursing candidates in the Philippines the most consistent and secure testing experience possible," said Robert Whelan, President of Pearson VUE. Retrieved from http:www.nurseupdates.com/nclex-testing-center-philippines/ May 16, 2018.

Filipino nurses currently comprise the largest single ethnic group of nurses migrating into the U.S., and the proportion of nurses migrating to the U.S. from other countries continues to increase. Nurses also migrate to countries such as Australia, Canada, and the United Kingdom. Regardless of where the migration is taking place, Internationally Educated Nurses (IENs) must adapt their clinical practice and communication patterns to that of the new environment in order to successfully deliver safe, quality care to patients (Cooper & Aiken, 2006). IENs must also familiarize themselves with the cultural nuances of the new practice and geographic environment

and ensure that their current national, state, and institutional policies guide their professional practice (Adeniran et al.).

Australia, Canada, the United Kingdom, and the United States are leading host countries for internationally educated foreign nurses (IENs). The proportion of IENs in the national nurse workforce range from 5.6% in the United States (Health Resources and Services Administration, 2010) to 17.6% in Australia (Australia Institute of Health and Welfare [AIHW], 2009), 25% in the United Kingdom during 1997-2007 (Buchan, 2009, p. 8), with an average of 10.7% in Organization for Economic Cooperation Countries in 2000 (Yeates, 2010).

Marginalization in the workplace remains an issue of concern for IENs and health care organizations (Baptiste, 2015). Safe patient care requires group cohesion among nurses, physicians, and health care teams formed through mutual respect among colleagues. Workplace environments in which behaviors cause isolation, exclusion, and, in some cases, hostility, result in safety issues, resentment, and job dissatisfaction. For IENs, the transition and adaptation associated with integration into the U.S. nursing workforce is difficult, and more so for those who perceive themselves as recipients of discriminatory behaviors by their nursing colleagues, physicians, and the health care teams. The experience of marginalization is an additional workplace stressor which that requires effective coping and adaptation both to persevere and succeed personally and professionally, and to limit adverse patient-related outcomes associated with job dissatisfaction and nurse turnover. Recruitment of IENs is costly and nursing turnover causes low staffing and low patient satisfaction (Berry et al., 2012; Volpone & Avery, 2013).

When IENs are faced with what they perceive as inescapable and consistent expressions of discrimination and marginalization in an environment in which they are not supported, psychological withdrawal (e.g., disengagement and burnout) begins; this is often followed by

physical withdrawal, including tardiness, absenteeism, and deliberation regarding intention to leave (the predecessor of actual turnover) (Berry et al., 2012; Volpone & Avery, 2013). When nurses vacate their positions, nursing units are often left short-staffed, sometimes with less-skilled nurses in a given specialty area. Remaining staff may be burdened with increased workload, and, for some, the increased workload may also lead to psychological and eventually physical withdrawal from their employer (Wheeler et al., 2014). While research regarding internationally educated nurses is limited in the U.S., there are many studies in the global nursing community that address this subject (Baptiste, 2015).

In England, researchers found international nurses often reported that their competency was challenged and they were placed in less important positions (Allan & Larsen, 2003). Decreased level of responsibility, poor career opportunity, and a lack of adequate orientation have been identified as instrumental in 60% of Filipino nurses verbalizing their intent to leave the United Kingdom (Buchan, Jobanputra, & Gough, 2005). Cultural differences and professional disparity could create similar obstacles to foreign educated nurses practicing in the U.S. workforce.

In Australia, English-speaking nurses were more likely to secure employment within their preferred specialty as compared to IENs without English as a first language (Brunero et al., 2008). Filipino nurses' medium of instruction in school is English but their first language is Philipino. Recruitment of IENs into their clinical specialties also impacts upon job satisfaction and retention of IENs. Cultural dissonance refers, in this case, to a cluster of experiences characterized by extreme anxiety as a result of learning to assimilate in a new country.

In Canada and the UK, IENs experience delay in licensure and registration, which promote the "deskilling process" (O'Brien 2007). IENS are forced to work at lower level jobs

until their credentials are recognized and exams are passed. Bridging and education programs may be available for some IENs, but these programs as a whole are not standardized, which becomes a burden in terms of suboptimal content, time investments, and monetary costs for the organization (Jeans et al., 2005). Pre-hire bridging programs are primarily designed to help IENs "bridge" gaps in education and experiences for the national examination exam (Baumann & Blythe, 2009). According to Smith et al. (2006) and Xu et al (2008), IENs recruited in these countries all expressed discriminatory experiences and also indicated that differences in race, gender, culture, and language place IENs at high risk for marginalization, minimal peer and superior support, unfair treatment, stereotyping, and even rejection by patients and peers.

Internationally educated nurses bring a variety of knowledge, skills, and experience to the new practice areas. Although the benefits of their knowledge, skills, and experience can be enhanced by successfully integrating them in the healthcare system of their new country, this may be a challenging process (Adeniran et al., 2008). The role of the nurse varies from culture to culture, particularly with regard to the delivery of patient care and professional responsibilities. For example, it is common practice in China, Nigeria, and the Philippines for the family, not the nurse, to assume the primary role in caring for the elderly in both the home and hospital setting (Matiti & Taylor, 2005; Taylor, 2005). My 93-year-old father suffered a stroke and respiratory failure in 2012. He was intubated and he was on a ventilator. I went home and I took care of him in our local hospital for 17 days. The only time I saw his nurse was when she brought his medications for me to give to my father. I saw her assess my father one time in her shift by calling his name and asking him "how are you doing Mr. Espino? "My father could hardly talk. The nurse never listened to his heart or lungs nor did she assess his neurological status. She did not have a stethoscope with her. My sister and I gave my father all his personal care, changed the

beddings, turned him every 2 hours, and performed passive exercises. I spoke to the nurse assigned to my father, I asked her if this was the practice of nursing in the Philippines. She stated, it's always been this way since I graduated from nursing in 1980. I cannot argue with her since she does not know the difference between the nursing practice in the Philippines and in the U.S. This is not the case in the UK and the U.S., where the nurse has the primary role in caring for the elderly. Hence, IENs are asked to assume a role that is not only contrary to their culture, but one they have not been educated to perform. IENs also experience difficulty adjusting to their increased levels of autonomy and responsibility, which nurses have in the UK and the in the U.S. IENs found they needed to develop new skills such as discharge planning and increased involvement of the patient and family in the plan of care (Taylor, 2005). Because IENs differ from U.S. trained nurses demographically and within their roles in the workforce, the possibility of not receiving the desired level of respect increases. Some IENs experienced alienation, racism, sexism, and oppression (Di-Cicco-Bloom, 2004). In the UK and in the U.S., Taylor (2005) found that IENs who were educated in a total of six countries felt that their professional qualifications were not respected. These nurses felt they were awarded positions lower than their qualifications merited, resulting in perceived need for the IENs to prove themselves to their colleagues in order to gain respect and trust. Non-white or non-native English speaking nurses experienced more difficulty with respect and discrimination.

The U.S. does not have standardized transition programs for IENs; rather each healthcare organization develops its own education and transition program. Xu and He (2012) assert that the U.S. is the nation that employs the most IENs, but fails to recognize benefits of standardized IENs transition programs. A survey of over 650 U.S. nurse executives by David and Kritex (2003) revealed common methods for assisting the IEN in adapting to his or her new

environment. The mentors and preceptors were by far the most common tools used, followed by a more extensive orientation, clinical assessments, and English classes. Other tools used were cultural workshops for the staff, an introduction to U.S. healthcare, housing assistance, assertiveness training, computer training, and social training. These same executives reported that the most critical skill for IENs is English competency. Use of U.S. technology, and knowledge of U.S. nursing practice, U.S. medications, and clinical skills were also found to be critical to their intervention (Davis & Kristen, 2003)

A review of literature underscores the need to develop transition programs to prepare IENs to offer clinically and culturally safe and effective practice. The literature discusses the opportunities and challenges presented by migrating nurses, as well as the moral and ethical obligations of recruiting agencies and the healthcare organizations who hire IENs (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Bieski, 2007; Blakeney, 2006). Edwards and Davis (2006) and Ryan (2003) have identified gaps between the IENs and U.S. educated nurses which include the use of technology, management of pain, performance assessments and nursing procedures, and administration of medications. The identified gaps between the IENs' previous practice and U.S practices have implications that may affect the quality, safety, and costs of healthcare services. It is important for IENs to quickly learn standard nursing practices in the U.S. and integrate these practices into the U.S. healthcare system. Society is only able to benefit fully from migration when migration is accompanied by successful integration. Without integration, migration gives rise to social issues that can disrupt a society (International Organization on Migration, 2003).

Why Millions of Filipinos Endure Hardship Abroad as Overseas Workers

Families in the Philippines receive billions from the "new heroes"--nannies in Hong Kong, sailors in the arctic, and domestic workers in the Middle East and practically around the world (Almendral, 2018). Recuerdo Morco was 22 when he first saw snow. Wrapped in four layers of coveralls and parkas, he looked up into the swirling sky as huge flakes settled onto the deck of his cargo ship. Standing on the cargo ship slicing through the icy waters near the Arctic Circle, snowflakes tickling his face, and was a dream come true. "I'm really here," he thought. Now 33, Recuerdo has spent the past decade working as a merchant sailor on cargo vessels. He has called his mother, Jeannie, 66, from Finland, the Netherlands, Papua New Guinea, and nearly every country with a port between Sweden and Australia.

Recuerdo is one of an estimated 10 million Filipinos, roughly a tenth of the country's population, who work oversees as a way of escaping unemployment, low wages, and limited opportunities at home. The money sent back by overseas Filipino workers known as Overseas Foreign Workers (OFWs) amounts to $31 billion a year, about 10% of the Philippines' gross domestic products. Filipinos are domestic workers in Angola and construction workers in Japan, Saudi Arabia, Bahrain, and other Middle East countries. They staff the oil fields of Libya and are nannies or domestic helps in Hong Kong and other countries. They sing on the stages of far-flung provinces in China and help run hotels in the Middle East and the United Arab Emirates. They are nurses who help staff rich countries like Australia, Canada, the United Kingdom, and the United States of America. A quarter of the world's seafarers are Filipino.

It is a phenomenon that has reshaped the economy and the education system in the Philippines. Each year about 19,000 nurses, certified and fresh from language training, are deployed to hospitals around the world. Meanwhile, educational institutions and vocational

schools in the Philippines funnel students into industries to get them a job abroad. Merchant marine academies, like nursing schools, churn out thousands of graduates yearly. Training centers for domestic workers school women in how to set a table according to different cultures' standards, fold a sheet into tight hospital corners, and whisper a greeting in Arabic or Chinese. Government agencies were found to deal with the migration of registered workers, negotiate international labor terms, and rescue workers when a diplomatic row flares up or a war breaks out, as when a delegation of government officials traveled to Syria to find domestic workers and ferry them to safety. Some of these domestic workers were sexually abused, were sold for prostitution, and were physically abused by their employers, and few never made it back home to the Philippines (Almendral, 2018).

The steady stream of cash from Filipino workers abroad has helped edge poorer families out of poverty, and houses built with cash from migrant workers have sprouted up in the rice fields of backwater provinces. Nurses abroad are treated as migrant workers and are sometimes mistaken as domestic helpers. In the Philippines, December is celebrated as the national month for overseas workers. Movies and television shows romanticize their hardships and dedication. Those who are part of the diaspora are called *bagong bayani,* "new heroes', sacrificing themselves for the betterment of their families and the country (Almendral, 2018).

No migration flow parallels the immensity of women's labor migration from the Philippines, which constitutes the widest flow of contemporary migration in the world today. The depth of Filipina women's migration is not reflected in the types of jobs they fill in the global labor market, which for the most part remain concentrated in care work. In most countries of the world, Filipina women migrate to do care work as domestic workers, nurses, or entertainers. While a small number of them do other types of labor, such as office work or

manufacturing work, women for the most part leave the Philippines to feed, nurture, care--in other words, to reproduce other societies. They do this in both the informal and the formal labor markets, as documented and undocumented migrant workers, and in the private and the public spheres (as domestic workers and as nurses) (Parrenas, 2008).

The labor market concentration of Filipina migrant women suggests a clash in gender ideologies. The work that migrant women perform outside their home--work that sustains and provides the Philippines economy with one of its largest sources of foreign currency--usually maintains the notion of women's domesticity. Such work includes the care work of nurses and nannies. Preexisting patriarchal relationships determined the social organization, division of labor, and paternalist culture in the workplace, they note how the continuous construction of women as unskilled workers and the battle against based discrimination limited their empowerment in the workplace. Regardless of the contestations posed by women workers, patriarchy remained a valuable social resource used to maximize production at the lowest cost and at the expense of women workers. These women today include factory workers in export-processing zones, migrant domestic workers, and, more generally, the new proletariat of workers who fill informal economies in the "first" world (Parrenas, 2008).

Transition Programs for Internationally Educated Nurses

A transition program is defined as a formal program of learning activities for all newly arrived/hired IENs specifically designed to facilitate and support their adaptation to a new practice environment in a host country. It is needed because of the required proficiency of the working language, as well as differences in nursing education, national health care system, nursing practice, and culture. Challenges of IENs during their transition into foreign health care environments are well documented, especially on those IENs from non-English backgrounds.

These challenges present real and potential risks to patient safety and quality of care (Davis & Nichols, 2002; Edwards & Davis, 2006; Hearnden, 2007; Shen et al., 2012; Takeno, 2010; Tregunno, Peters, Campbell, & Gordon, 2009: Xu, Gutierrez, & Kim, 2008).

In the United States, there is no required transition program for post-hire IENs, who must obtain either a U.S. nurse licensure or a Commission on Graduates of Foreign Schools certificate and secure a job offer before coming to the country. No government funding has been provided to develop such programs. Essentially, transitioning IENs is entirely left to each health care employer, who frequently provides the same orientation or post-hire training to IENs that are no different from domestic hires. In fact, transition programs in the Unites States are grossly under-developed because of lack of recognition of their importance, lack of funding, and standardization, and decentralized regulation in nursing (Baumann & Blythe, 2009).

According to Xu and He (2012), it is critical to conduct competency assessments of internationally educated nurses to ensure public safety, as well as uphold accountability to nursing as a regulated profession. The United States' current hit-and-miss transition program approach is inadequate and inconsistent with the emerging global trend to systematically deal with the transitional challenges of IENs at the national level (see Table 1).

Table 1

Transitioning Program in Australia, Canada, United Kingdom, Mexico and United States Typology and Comparison of Transition Programs for IENs by Registration/Licensure and Employee Status

Type of Programs	Examples	Pros and Cons
Pre-registration/licensure, pre-hire programs	Bridging/Upgrading programs in **Canada and Australia**	Pros: Emphasis on assisting IENs in filing gaps in education, language, and experiences to meet registration/licensure requirements Cons: More remote from the real world; IENs not employees; clinical experiences as students.
Post-registration/licensure, post-hire programs	Transition Programs in the **United States**	Pros: Emphasis on assisting IENs in transitioning into a new work environment; IENs work as licensed registered nurses under supervision of preceptors or mentors with identical work schedules. Cons: No standardized programs nationally: program structures, content, and length left to employers: more rigorous and robust approaches to competency assessments desired
Post-registration/licensure, post-hire programs	Transition Education Program Model (TEP) used by NurseNow International and English Speakers of Other Languages (ESOL) **Mexico**	Pros: Through an intensive, full-time, 6-month transition program that included a living stipend during program participation. Preparation for NCLEX-RN examination, an English language competency test. Once nurses passed the NCLEX, recruiters placed them in U.S. hospitals and starts working as registered nurse. Cons: Cost per student range from $28,500 - $ 35,000 tuition loan with 2% interest. Training time about 2 years. Mexican nurses often provide significant financial and caregiving support to family members that interfere with educational progression and career development.

Xu, Y., & He, F. (2012). Transition programs for internationally educated nurses: What can the United States learn from the United Kingdom, Australia, and Canada? *Nursing Economic$, 30*(4), 215-223, 239.
Squires, A. (2017). *Nursing Economic$, 35*(1), 30-31.

With a population of 33.8 million, Canada had 251,675 registered nurses in 2005; IENs make up about 8% of the Canadian nurse workforce, of which more than half work in Ontario (Baumann, Blythe, Rheaume, & McIntosh, 2006). In 2005, 34.1% of newly registered nurses in Ontario were foreign educated. In the absence of a national regulatory system, each province conducts its own assessment for the Canadian Registered Nurses Examination (CRNE). Passing the CRNE is required for licensure and official registration as a registered nurses. Canadian efforts have been focused on developing pre-registration, pre-hire "bridging/upgrading programs" that are primarily designed to help IENs to "bridge" gaps in education and experiences for the national registration examination (Baumann & Blythe, 2009). While preparing for the CRNE, IENs works as graduate nurses, licensed practical nurses, or nurse aides, which creates dissatisfaction and disillusion among IENs.

The Internationally Educated Nurses Post-Licensure Employment Project is a pilot project involving Vancouver Coastal Health, Providence Health Care, Kwantlen University College, B.C. Ministry of Health, and B.C. Ministry of Economic Development. It has been developed to help IENs become integrated. A combination of classroom work and unit preceptorships provides educational support for their first weeks on the unit, helping them to understand how to work with family members and health care professionals, and to learn how to document to Canadian standards. IENs learn Canada's nursing culture, the communication skills necessary to nurse in the Canadian health care system, and they enhance their knowledge of critical thinking and clinical decision-making. For all 16 weeks of the program, educators support the IENs (at a six to one ratio) and the preceptors in transitioning the IENs successfully to the units. This program focuses on registered nurses educated in another country, who speak English as a second language, who have written or are eligible to write the Canadian Registered

Nurse Examination, and are registered or eligible for registration with CRNBC. Response to the program has been very positive. To date, seven nurses who have successfully completed the program have been hired into full-time acute care nursing positions (Nursingbc, 2007).

With the population of 56 million, the United Kingdom currently has approximately 670,000 nurses and midwives on the Nursing and Midwifery Council (NMC) register (Buchan, 2009). As the biggest provider of health care, the National Health Service (NHS) is also the largest employer of IENs. The United Kingdom has been a major importer of IENs. In fact, IENs have "made major and critical contributions to NHS nurse staffing growth" at a rate of 25% during 1997-2007 (Buchan, 2009, p. 8). To practice nursing in the UK, IENs must officially register with the NMC and obtain a work permit through petition by their employers. Because of concerns over lack of equivalence in educational preparation and work experiences to provide safe and effective care, IENs from non-EU countries are required to complete a 3-6 month "adaptation program." The adaptation program includes 20 days of "protected learning" at NMC-approved universities and a period of "supervised practice" (NMC, 2004). Only after successful completion of the adaptation program with documented verification can IENs be recommended for registration with the NMC.

Australia is a federation consisting of six states and two territories, with a population of approximately 20.5 million. In 2007, the total number of nurses was estimated to be 245,491 registered nurses and just under one-fifth (17.6%) received their initial nurses training outside Australia (AIHW, 2009). Another source indicates international "net migration contributes around one-third of new nursing professionals each year" (Preston, 2009, p. 31). To practice nursing, all nurses in Australia must be registered with state or territory nursing boards. Currently, there are few post-hire transition programs for IENs in Australia (Jeon & Chenoworth,

2007). Fee-charging bridging programs are popular and designed to fill in gaps of education, language, and clinical experiences to meet regulatory requirements. Usually, IENs apply for the programs before landing in Australia with no job offers. With a certified letter from the Australian Health Practitioner Regulatory Agency stating eligibility to complete the program, IENs can apply for a program approved by state or territorial regulatory authority and are allowed to do supervised clinical practice without work permits or licenses. These programs have both an academic and a clinical component designed to meet registration requirements, as well as to facilitate their transition into the Australian work environment. Currently, these programs were decentralized at the state and territory level, with variations in fee scale, structure, length, content, and inevitably, quality (ANMC, 2009).

The shifting demographics in the United States may increase demand for registered nurses and other health care providers in the healthcare system (Health Resources & Services Administration [HRSA], 2014). IENs who come from countries with language skills that match the local immigrant population in their destination area of the country have the potential to reduce health disparities related to language barriers--a primary barrier to accessing the healthcare system that contributes to health disparities among non-English speaking immigrant populations. With one in five U.S. households speaking a language other than English at home and 62% of those speaking Spanish (Ryan, 2013), there is an urgent need for Spanish-speaking nurses in the United States; therefore, it is unsurprising that the Institute of Medicine (IOM) is viewing Mexico as a potential source country for international recruitment. Yet little is known about the potential for Mexican nurses to migrate temporarily or permanently to work as nurses in the U.S. The appeal of recruiting Mexican nurses for work in the U.S. is increasing due to Mexico-U.S. migration patterns in the 21st century. Health disparities in this population are

significant across all indicators and language barriers between patients and providers are a major contributor to the disparities (AHRQ, 2013). A transition educational program was designed and implemented to prepare Mexican nurses with the competencies needed to work in any clinical setting in the United States, through an intensive, full-time, 6-month transitional education program that included a living stipend during program participation. Mexican nurse candidates that passed the NCLEX-RN and an English competency test were placed successfully in a U.S. hospital setting ready to work. U.S. hospitals did not have to create their own programs for them nor incur additional recruitment and orientation costs (Squires & Beltran-Sanchez, 2013).

As the largest importer of IENs in the world, the United States is facing similar challenges of transitioning IENs and can learn from these four countries. The United States should make transitioning IENs a regulatory issue because a growing body of evidence suggests transitioning IENs mount to regulatory importance (Xu, 2012). Furthermore, given that a national standardized transition program for all new U.S. graduates is being piloted by the NCSNB (2011) and data from a 10-year longitudinal study on the efficacy and cost effectiveness of nurse residency programs is available (Ulrich et al., 2010), now is an opportune time to develop a parallel program for IENs who face more transitional challenges. If enacted nationally, this regulatory requirement will facilitate standardization of transition programs thus ensuring quality and maximizing resources.

The Hospital of the University of Pennsylvania's (HUP) Transitioning Internationally Educated Nurses for Success (TIENS) program arose as a product of the Global Nurse Program (GNP) of the HUP, established in November, 2003. The GNP was established under the leadership and vision of Victoria Rich (co-author of this article) with support from Afaf Meleis, Dean of the University of Pennsylvania School of Nursing (UPSN), Barbara Nichols, Chief

Executive Office of the Commission on Graduates of Foreign Nursing School (CGFNS), and Norma Lang, who at that time was the Director of the World Health Organization Collaborating Center of the UPSN. The purpose of the GNP was for HUP Nursing to build initiatives that would be responsible to the global health community. It was with the establishment of the GNP that the position of Global Nurses Ambassador (GNA) was created to lead the GNP initiatives. It was the responsibility of the GNA to help identify priority programs based on the vision of these nurse leaders. TIENS is one of the many outcomes of the GNP (Adeniran et al., 2008).

As the hospital began to receive more IENs, the GNA was increasingly contacted to provide support for IENs, and sometime to help assess the challenges confronting these IENs. Complains of inefficiency, poor learning ability, and poor communication skills were issues reported by U.S. educated nurses. After thorough investigation of the issues, three main concerns were identified. First, there was a difference in nursing practice style between the IENs and U.S. nurses specifically regarding the use of technology and availability of multiple resources that IENs were not accustomed to having. There were communication differences in choice of, and pronunciation of the choice words. The U.S. nurses used many idioms, slang expressions, and euphemisms that differed from the IENs book of choice words. IENs also took idiomatic expressions literally. Thirdly, there were cultural differences that infused the practice style and priority identification of both groups (Adeniran et al., 2008).

Phases of the TIENS Program

Phase 1 *(Pre-Arrival)*

Phase 1 focuses on the needs of the IENs who have received a job offer from the HUP and are making arrangements to leave their previous country to come to the U.S. The goal of this phase is to begin the process of helping each IEN to successfully settle in a new environment.

Activities in this phase include a notification email from the HUP Nursing Recruitment Department informing all stakeholders that the IEN will soon be arriving. These stakeholders include the GNA, the nurse manager of the nursing unit where the IEN will be working, and a selected "buddy," preferably someone from the same culture as the IEN. A welcome letter is sent to the IEN in order to provide information about these stakeholders and other information needed upon arrival in the U.S. In addition, a book titled "Hello USA," a map of the city of Philadelphia, and a schedule of activities for the first few weeks of arrival is distributed to the newly arrived IENs. Human resources paperwork, guidelines for meeting occupational medicine requirements, and an application for social security are provided for the IEN in the welcome letter. Upon arrival in the U.S., a representative for the University of Pennsylvania Healthcare System (UPHS) meets the IEN at the airport. Depending on the situation, a limousine ride may be arranged to pick up and deliver the IEN to a ready apartment, having two months paid rent and located 15 minutes or less by bus ride from the hospital. In securing apartments, three things are always put into consideration: a) safety, b) proximity to the hospital, and c) proximity to shopping areas.

Phase 2 ***(On-Boarding Phase)***

This phase is concerned with familiarizing IENs with information and resources that are necessary for survival in the U.S. The activities include help for the IENs to learn the city transportation system, support for IENs to open a bank account, an orientation to their community, a visit to the grocery to see the variety of foods--which may not be available in their country of origin--and completion of required paper work for both the hospital and the U.S. government.

Phase 3 ***(Formal Classes)***

This is the phase where IENs are given formal education about the U.S. healthcare system as well as U.S. clinical practices. The five main objectives of this preparation are listed in the table. Depending on the number of people in a class, Phase 3 training may take up to 16 hours, or less than a day for just one IEN. The ultimate goal of this formal education is to raise the IENs' awareness of key players of the U.S. healthcare system, who may not have been available or who may have functioned differently in their previous healthcare system, and to equip the IEN with knowledge of the U.S. nursing practice style.

Phase 4 ***(Clinical Orientation)***

This phase focuses on the clinical orientation and integration of the IEN to the HUP practice environment. At HUP, each clinical unit has a Clinical Nurse Specialist (CNS) who is a Master's prepared nurse and an expert in the specific patient population or disease process of the clinical unit in which they work. The CNS works with each nurse, either U.S. prepared or IEN, to ensure that they have the clinical expertise to function on the unit. The CNS and the nurse manager of each nursing unit work collaboratively with the GNA to understand the unique transitional needs of each IEN, and work with each IEN to support successful integration by identifying and preparing preceptors to be sensitive to the orientation and transition needs of each IEN. A positive attitude is key! The CNS and nurse manager work to match preceptor to IEN, define clear and measurable orientation goals, facilitate both observational and educational experiences to the IEN, supervise the IENs orientation progress, and grant extended time as needed to complete clinical orientation. The GNA is consulted and kept abreast of the progress both by the IEN and the unit leadership, which includes the CNS and the Nurse Manager.

A Fifth Phase

Concerted efforts are made to continuously enhance the TIENS program. Currently HUP is in the process of adding the fifth phase of TIENS. This phase will focus on raising awareness of U.S. prepared nurses at HUP to better understand the challenges that confront IENs and themselves during the IENs transition period, and to learn how best to deal with each situation. Education in this phase will focus on how nurses, regardless of origin, can work at effectively understanding, appreciating, and leveraging the inherent creativity that exists in diverse groups. There is a plan to add preceptor training as part of this phase. As the U.S. nursing workforce continues to diversify, it is imperative that all parties work together to provide the best nursing care for the public (Adeniran et al., 2008).

The Hospital of the University of Pennsylvania TIENS (Transitioning Internationally Educated Nurses for Success) Program is presented as a model to help organizations develop programs for IENs to ease their transition into the U.S. healthcare. The authors explain why IENs are a key component of the U.S. nursing workforce now and for the foreseeable future, present a rationale for transition programs that support successful integration of IENs to the U.S. practice environment, describe a model of Transition Program, and advocate for the development of a national policy to standardize transition programs for IENs in the United States (Adeniran et al., 2008).

Summary of Literature Reviewed

The literature review revealed that the introduction of nursing in the Philippines was part of a larger U.S. colonial and medical agenda that racialized Filipinos and Americans in the context of reform. Health care personnel contributed to the overall U.S. colonial project of preparing Filipinos for self-rule through the introduction of American medical practices. It is to

be understood that the health of the Filipinos is vital to their country, the purpose is to transform them from the weak and feeble race into strong, healthy, and enduring people. Nursing in the Philippines was shaped by both Filipinos and Americans; the study and practice of nursing took place in the context of an unequal colonial relationship. American and Filipino nurses shaped Philippine nursing through travel as well as teaching, training, and practice. American nurses traveled to the Philippines to teach and practice nursing, Filipino nurses also traveled to the United States to study and practice nursing and both American and Filipino nurses returned to their own country to share their knowledge and experiences. Filipino nurses started migrating to the U.S. through exchange visa program to help with critical nursing shortage especially after World War II. These Filipino nurses later on stayed longer in the U.S. due to better salary, which afforded them to travel, attend cultural activities, accumulate materials, and assist their family financially.

Although there were reports of exploitation and discrimination, Filipino nurses and their families view the nursing profession abroad as the ticket to a better life. Working abroad as a nurse is also more profitable compared to other jobs in the Philippines. The exchange visa and working visa program afforded many Filipino nurses migration to the U.S. and to the country of their choice. The restrictions of immigrating to the U.S. and the strict immigration requirement did not stop U.S. hospitals in using agencies to recruit nurses for their hospital to fill nursing positions.

Today, as a severe nursing shortage grips the U.S. health care system, a new generation of Philippine nurses is coming to America to seek educational and career opportunities not available in their homeland. One of the biggest difficulties is simply adjusting to a new working environment and cultural landscape. Language differences are another source of culture shock.

Even though nurses trained in the Philippines speak English, they often have trouble deciphering the varied American accents and idiomatic expressions.

An established transition program is vital in integrating IEFNs and IENs into the U.S. nursing workforce. The hospital of the University of Pennsylvania is leading the way in creating a standardized model transition program for other healthcare system to adapt.

The study focused on using the lens of standpoint theory and cultural competency theory. Participants' narrative descriptions of their lived experiences in this study will provide insight on how best to establish a transition program for this newly arrived Filipino nurses here in Alabama.

This study will attempt to fill the gap in the literature related to the lived experiences of IEFNs working in Alabama and the need for development of transition programs. With its focus on the power of storytelling and using the lens of standpoint theory and cultural competency theory, participants' descriptions of their lived experiences during this period of time in their lives will give insight into what transition programs will be beneficial for future IEFNs migrating to Alabama to join the nursing workforce.

CHAPTER III:

METHODOLOGY

This chapter will explain the research methods that will be used to explore the lived experiences of internationally educated Filipina nurses (IEFNs) related to socio-cultural differences, languages barriers, and adjusting to a new living and working environment. The goal of this research is to use the lived experiences of the Filipina nurses in this study to contribute to the development or enhancement of transition programs for IEFNs who are migrating to Alabama to join the nursing workforce. The research questions that guided this inquiry are as follows:

Research Questions

1. How do internationally educated Filipina nurses describe their lived experiences as they transition to the U.S. nursing workforce?

2. How can these lived experiences of Filipina nurses in this study contribute to the development and enhancement of transition programs in Alabama?

(Appendix A – Demographic Data Sheet and Interview Questions)

Setting of the Study

The setting of the study is in the State of Alabama located in the southeastern region of the United States. All interviews were conducted by the principal investigator. Initial interviews of nurse participants occurred in an office space of a university, an office space in the participant's private home, in the privacy of my home, and in a restaurant. These places were

away from the participant's work environment to ensure anonymity. Follow-up interviews occurred in the same places as the initial interview or at the discretion of the nurse participants.

Sweet, Alabama is a city in west central Alabama. Located on the Black Warrior River, it is the fifth-largest city in Alabama. Sweet, Alabama is the regional center of industry, commerce, healthcare, and education for the area of west-central Alabama known as West Alabama. It is the home of the state flag university, community college, and a Christian college that is predominantly for Black students. The community hospital was approved for 550 beds. There are two state hospitals; one served all intellectual disabled residents and the other one served all psychiatric patients. There were approximately 50 Filipino nurses that came in this town in the early 1970s to help staff these three hospitals.

Other Filipino nurses were recruited to work in several rural areas that surrounded West Alabama. Some of this rural areas are Darling, Alabama; Joy, Alabama; Happy, Alabama; Gladly, Alabama; Moon, Alabama; etc. These rural areas served predominantly low income populations, mostly Black, and there were few businesses. Most of them had one bank, one or two gas stations with a convenience store, a small post office, and schools that served free or discounted lunches to students.

Participant Selection and Recruitment

The participants in this study were all internationally educated Filipina nurses who had retired or who are still working in community hospitals located in urban, suburban, and rural Alabama. The ages of the participants ranged from 30 years old to 80 years old. The participants were Filipina nurses who came in the early 1970 and who arrived before 2015. Most Filipino nurses came to Alabama in early 1970 and the second wave of Filipino nurses came before 2015. I sent a letter of invitation to 25 Filipina nurses. If the invitation to participate in the study was

accepted, I met with each participant face to face in a designated private place in my home, their home in a private room, in an office space at the university, and in a restaurant to discuss the informed consent in detail. (Appendix D)

Participant demographic data are depicted in Table 2 and include pseudonyms, age on arrival and present age, year arrived in USA, years of nursing experience, location of employment, and status at present. Participant profile are depicted in Table 3 and include participants pseudonyms, degree obtained, textual descriptions and interview quotes. A total of 12 nurse participants were selected for this study.

Table 2

Participants' Demographic Data

Name	Age Arrived Age at Present	Year Arrived in USA	Years of Nursing Experience	Location of Employment	Status at Present
Juliet	22/67	1973	45	Urban	Working
Yolanda	27/62	1982	40	Suburban/Rural	Working
Feliza	22/67	1974	43	Rural	Retired
Monica	25/69	1973	46	Urban	Working PT
Remedios	22/78	1971	46	Rural	Retired
Corazon	29/62	1980	39	Urban	Working
Rebecca	29/62	1980	39	Urban	Working
Lydia	22/67	1974	42	Suburban	Working PT
Elly	22/66	1974	42	Urban	Retired
Cora	22/66	1974	42	Urban	Working
Dawn	23/61	1980	39	Suburban	Working
Fe	24/70	1972	40	Suburban/Rural	Retired
PT – Part-Time					

Pseudonyms were used for the participants.

Table 3

Participants' Profiles

Participants	Textual Description
Julieta (1)	She is 67 years old, has 2 sons and 1 daughter. She is married to a physician. Her children are highly educated, one son is a CRNA, one son is a CEO of a hospital, and her daughter is VP of Business Development for a healthcare system. She graduated in 1972 and was top 5 of her class. She received the Florence Nightingale Awards for Academic Excellence and Leadership. She holds a BSN degree. She obtained her master's degree at the state flagship university and received the Dean's Outstanding Graduate Student Award. She was very involved with student leadership throughout her college life. She played softball, volleyball, and tennis while in high school and in college. She was recruited by 6 hospitals located in six different states. She received her working visa from Sweet, Alabama. She came to USA in 1973, she worked in a community hospital located in urban Alabama. She worked 11-7/3-11 for 20 years then, she worked 7-3. She held several leadership and management positions in the hospital where she worked. She is also very active in the community. She was elected for the 2nd term as Board of Director for Alabama Rural Health Association and elected Board of Director for a local hospital. She is recognized by her Filipino community as their leader and ambassador. She mentors newly arrived Filipinos and help them get settled. She knows the structure, the politics, and the make-up of the community. Because of her leadership and willingness to always help others, the community recognized her as one of the community leaders. She is very dependable.
Yolanda (2)	She is 62 years old, has 1 son. She is divorced. She graduated in 1978 and holds an ADN degree. She came to USA in 1982 and worked as a clinic nurse in GI practice. She now works as a private nurse and owned her staffing company. She is full of energy and is good at what she does. She took care of some of the prominent people in the community while they were sick. Their family respects her for her caring attitude, joyful personality and for doing things for the family beyond her scope of responsibility. The community recognizes her for her willingness to help other Filipinos in the community. She volunteers when they need a ride to the airport, to the grocery stores and to babysit when needed.
Feliza (3)	She is a 68 years old, has 2 sons who are both serving in the U.S. Air Force. She met her husband in the rural hospital where she worked. She is now divorced. She graduated in 1972 and holds a BSN degree. She came to USA in 1974. She worked in a rural hospital on 3-11/11-7 shift. She was the go to person on 11-7 shift. She later moved to Labor and Delivery and worked 7-3 shift. She was a well- respected nurse in her place of work and in her community. She is very active in the Filipino-American Association of West Alabama. She is one of the go to person when a Filipino/Filipina family encountered any problems. She is called "Inay" (mother) by many of the newly arrived Filipino in West Alabama. She recently retired due to her health but remain active in the community and in the Catholic Church.

(*table continues*)

Participants	Textual Description
Monica (4)	She is a 69 years old, has 1 son who is a dentist and 2 daughters, one is a lawyer and one works in finance and works at BCBS. She is happily married for 50 years. She graduated in 1971 and holds ADN degree. She worked in a community hospital located in urban. She came to USA in 1973. She worked 3-11 in Med/Surg unit since she arrived. She was Assistant Nurse Manager for almost 44 years. She recently changed her status to part-time. She is friendly but would rather stay home and help with her children's needs. She has 7 grandchildren and they are very involved with sports. They keep her busy.
Remedios (5)	She is a 78 years old, has 3 sons, one an RN, one a respiratory therapist and one in IT. She is married to a psychiatrist. She graduated in 1968 with a BSN degree. She joined the Exchange Program after graduation and she came back to the Philippines after 2 years. She came back to USA in 1971. She worked in a mental institution located in rural Alabama. There was no public transportation in the town, the town has 2 gas stations with convenience stores. They drive 1 hour to an urban town to shop for groceries and for their necessities. She paid her co-worker to drive her to town. The hospital had a credit union where she banked. The town had a small post office. Her co-workers bring fresh vegetables and fresh fruits to her little house inside the compound of the hospital. She later moved to a psychiatry hospital located in a suburban area. She became the infection control nurse. She is not active in the community, would rather stay at home. She loves to cook and bake.
Corazon (6)	She is a 62 years old, has 2 daughters, one is an RN and one a pharmacist and 1 son who is an engineer. She is married. She graduated in 1978 with BSN degree. She came to the U.S. in 1980 and worked in a community hospital located in an urban area. She worked in Med/Surg unit on 3-11/11-7 shift. She later moved to the Resource Department and floated all over the hospital. She is still working. She and she husband are very active with the Filipino-American Association of West Alabama. They also volunteer their time in their church. She makes herself available if any of the Filipinos need help or assistance.
Rebecca (7)	She is a 62 years old, has 2 sons, one is an engineer and one is a social worker. She is married. She graduated in 1978 with BSN degree. She came to the USA in 1980, worked 11-7 in med/surg unit in a community hospital. She moved to the Resource Department working 7pm-7am all over the hospital and she is still working. She and her husband are very active in the Filipino community. They volunteer their time in their church. Her husband is good at repairing anything. When any of the Filipinos in the community need help or assistance, they both offer free service. They are good ambassadors for our Filipino community. She was offered a management position in her workplace but refused to take any extra responsibilities. She just wants to work, do her tasks, and go home after work.

(*table continues*)

Participants	Textual Description
Lydia (8)	Lydia is a 68 years old, has two daughters, one is a teacher, one is an interior designer, and two sons, both are in information technology. She is married to a physician. She graduated in 1972 with BSN degree, She came to the U.S. in 1974. She worked in a community hospital located in an urban area. She worked hard and was promoted to Director of the Rehabilitation Department. She sued her community hospital for deleting her director position; 1 month later the hospital hired someone in her position. She sued for discrimination and won the case. She obtained her MSN in Nursing Administration. She left the acute care setting and later became the Director of a Long-Term Facility. She is now working per diem. She possesses strong leadership skills. She and her husband are very active with the Filipino-American Association of West Alabama. They always volunteer their time when needed. They are also active in their church.
Elly (9)	She is a 66 years old and has one daughter who is a nurse practitioner. She is married to another RN. She holds a BSN degree. She came to the U.S. in 1974 and works in the community hospital. She started on the 3-11/11-7 shift, then was moved to the 7-3 shift. She worked initially in the critical care unit, and then went to the float pool. She worked in the in-patient dialysis unit. She got upset with management and retired untimely. She was offered a management position but did not accept the offer. She refused to have extra responsibilities. She always celebrates Thanksgiving and New Year's eve at her house and she invites all the Filipinos and her co-workers. Other than that, she is not actively involved in our community activities. She is very involved in her church.
Cora (10)	She is a 66 years old, has 1 son who is an engineer. She is married. She graduated in 1972 with a BSN degree. She came to the U.S.in 1974. She joined the community hospital located in an urban area. She has worked 3-11 since she arrived. She works in the Pulmonary unit. She was later promoted as Charge Nurse and she is still working. She and her husband are very active with the Filipino-American Association of West Alabama. Her husband is a great cook and he always cooks Filipino barbecue whenever the Filipinos have a get together party. They are both active in their church. They love to travel a lot.
Dawn (11)	She is 61 years old and she is single. She graduated in 1979 with an ADN degree and came to the USA 1980. She worked in a community hospital located in a suburban area. She worked 3-11/11-7 in the Med/Surg unit. She is still working. She is very introverted. She attends the Filipino community get together party but is not involved actively in any of the activities and projects. She goes to work, works hard and stays home. She loves to work in her yard and that is what keeps her busy.
Fe (12)	She is 70 years old and a widow with 1 son who is in IT and 1 daughter who works in the bank. She graduated in 1970 with a BSN degree and came to USA in 1972. She worked in a small rural hospital on 11-7 shift. After her orientation, she was promoted supervisor of 11-7 shift. Her husband was an RN. They owned a staffing company. They were very involved with the Filipino community before he passed away. She retired 5 years ago and she helps babysit her grandchildren. She stated that she really enjoys taking care of them.

Note: These names are pseudonyms. All names are randomly assigned to protect the identity and confidentiality of the actual participants in the study.

Sample Selection

Initially, purposive sampling was used to identify participants who met the criteria of the study. I mailed 25 invitations to possible participants. Once it was determined who met the criteria for the study, I met with each participant to obtain informed consent individually or in groups and made arrangements to complete a tape-recorded interview.

Three of the initial nurse participants recommended two colleagues who were working in rural Alabama, another participant recommended two more colleagues who were working in a suburban/rural area of Alabama. I called four of the nurses who were working in suburban/rural areas and asked if they were interested in participating in my study. If the participant was eligible, I drove to their town and met each of them in a restaurant to obtain the informed consent and I made arrangement to complete a tape-recorded interview.

A total of 12 nurse participants was chosen based on their age, the year they arrived in the USA, and if they were working or retired from a community hospital located in an urban, suburban, or rural area. I had six nurses working in an urban community, and six nurses working in either a suburban/rural community. Nine participants held a Bachelor Degree in Nursing (BSN) and three participants held an Associate Degree in Nursing (ADN)

Methodology Selection

Qualitative research was selected as the method of study because of its appropriateness for this topic. Qualitative research is any type of research that produces findings not arrived at a statistical procedures or other means of quantification**.** It can refer to research about persons' lives, lived experiences, behaviors, emotions and feelings as well as about organizational functioning, social movements, cultural phenomena, and interactions between nations. Some of the data may be quantified, as with the census or background information about the persons or objects studied, but the bulk of analysis is interpretive. (Strauss & Corbin, 1998, p. 11).

Three major components of this type of research are data, procedures, written reports, and verbal reports (Strauss & Corbin, 1998, pp. 11-12). Its characteristics are a natural setting, the researcher as the key instrument of data collection and analysis, the inclusion of multiple sources of data, an inductive data analysis, a focus upon participants' meaning, an emergent design, the incorporation of a theoretical lens, the use of interpretive inquiry, and the pursuit of a holistic account of a problem or issue being studied (Creswell, 2007).

Creswell (2013) defined qualitative research as a design that "begin with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or group ascribe to social or human problems" (p 44). Both Merriam and Creswell acknowledged that there are four essential characteristics to qualitative research: a) the focus is on meaning and understanding from the participant's point of view, b) the researcher is the primary data collection and data analysis instrument, c) the process in inductive, and d) the data collected allows for thick, rich description of the phenomenon studied.

A more in depth assessment of the four characteristics of qualitative research gives insight into the strength and weaknesses of using a qualitative approach. First, my overarching goal was to understand the lived experiences of the IEFNs and how they transition into their new living and working environment. To communicate the perspective of others about their experiences and the meaning they give those experiences in their social context, the researcher must understand their own worldview and biases about the phenomenon studied. Therefore, data analysis must uphold the participant's position, not mine. Second, the researcher as the primary data instrument poses the same issue of bias. For this reason, I carefully monitored and remain cognizant of personal bias and how it shapes data collection and interpretation. Member checks, analytic memo, and reflexivity allowed me to clarify data, check with participants for accuracy

of information, explore any unanticipated answers, as well as maintain an awareness of my own biases. Third, qualitative research is an inductive process that can be used when existing theory fails to adequately explain a phenomenon. Gap in the literature about transition program for newly hired IEFNs can be extrapolated from data offering new insights into the lived experiences of IEFNs. Fourth, data in the form of words from interviews will allow for richly descriptive data, which are not available using quantitative methods. This method give voice to those who experience isolation, intimidation, and discrimination and/or marginalization.

Isolation, intimidation, discrimination and/or marginalization in nursing is an issue that must be examined in the context of nurses' work environments and how the nurse is socialized to exist within that environment. Creswell (2013) stated that one cannot always separate what one feels or says from the place where it occurs; in other words, understanding how a problem or issue is solved requires knowing the context or setting in which it occurred. Qualitative research helps us to understand why people respond as they do and how certain aspects of their life experience came to be. Nurses are bound by historic and social context that helps to shape each individual nurses' perspective on interactions within the work environment. The purpose of this study to explore the lived experiences of IEFNs related to socio-cultural difference, language barriers and adaptation to their new living and working environment. By using a qualitative method through the power of storytelling, my aimed is to use the lived experiences of the participants in this study to help develop transition programs or enhance an existing transition programs for newly hired IEFNs and for future IENs who will migrate to the USA to join the nursing workforce.

Qualitative research includes both the social and human sciences. The process begins with the researcher's assumption, her world view, and her theoretical lens which frames the

study. The researcher chooses a topic about which she has some understanding from reviewing the literature or from observations in daily life. Most topics are about social, cultural, racial, sexuality, and gender issues. Generally, topics are personal, practical, and emotional. To accomplish the task of such studies and to gain a better understanding of the problem, researchers ask questions that require open responses and continuously reframe their understanding of concepts based on participants' responses. Information can be gathered through three basis sources: interviews, observation, and physical and electronic documents. As data are collected, they are analyzed in an attempt to search for common categories or general codes or themes. During this process, the researcher may shape the story or narrative taking great care to allow her participants' experiences to show through their own dialogue and careful description.

Throughout the process she remains aware of ethical issues that may arise which may bring consequences to the participants. It is equally important to ensure the study is true to telling participants' experiences and not the assumptions of the researcher. A manner in which this is done is through triangulating the data from at least three sources such as participants, review boards, and committee members.

Data Collection

Data collection and analysis occur simultaneously in qualitative research. Prior to data collection and analysis, approval was received from the University Of Alabama Institutional Review Board (IRB) as shown in (Appendix C.) Signed informed consent was received from 12 nurse participants before interview were conducted (also in Appendix D). The initial face-to-face interviews with the nurse participants at designated areas and times. This interview occurred August 2018 to January 2019.

This study used individual stories of 12 internationally educated Filipina nurses who were working or had retired in community hospitals located in urban, suburban, and rural Alabama. To explore the nature of the IEFNs transition to the U.S. nursing workforce, firsthand accounts were collected through participant's stories. Because the IEFNs experienced this phenomena, their accounts and perceptions were vital to exploration and understanding of the lived experiences.

During data collection, each interview transcript was assigned identifying notations to easily access them for analysis and write up. Each interview transcript document was coded with pseudonym, age on arrival and age now, year they arrived in the USA, location of employment, years of experience, and working status. As each new transcript or document was coded and placed into categories or themes, they were checked against previously coded transcripts and documents to look for similar themes and to realize when saturation and redundancy of information had been reached (deductive reasoning). Analytic memos were also kept during this study. Analytic memos are reflective writings about what the researcher is learning from the data (Stake, 2006). (Example of analytic memos for this research are available for review in Appendix G.)

The most frequent type of data collected in qualitative study are from interviews and observations. However, written documents, such as memos and internal documents or recorded materials can be used as well (Corbin & Strauss, 2015). Interviews are used when behaviors or feelings cannot be observed or we need people to interpret events that have occurred in their world (Merriam, 2007). Interviews are also used when the events studied happened in the past and cannot be replicated. In semi-structured interviews, there is a list of questions to guide the

majority of the interview. The primary collection source of this study was semi-structured interviews.

The researcher-generated documents include a demographic data survey and interview questions related to the lived experiences of the 12 participants and their recommendation on how to develop or enhance transition programs for newly hired IEFNs joining the nursing workforce. The demographic data survey was used to collect data displayed in Table 2. The participants' profiles, textual profiles, and example of excerpts from their interview are displayed in Table 3. The following sections briefly describe each data collection method and how it was used to inform this study.

Semi-structured Interviews

The primary data collection source was semi-structured interviews with the 12 Filipina nurse participants. Face-to-face interviews were conducted with nurse participants after receiving informed consent. Interviews were audio recorded with participants' consent. Open-ended questions were used in interviews that lasted approximately one hour. During the interviews, a list of questions was used to guide the majority of the interview and this list was used with all participants (Appendix A). However, some interviews had additional questions depending on the nature of the answers given by the participants and the follow-up required. After initial interviews were transcribed, each nurse participant was given a copy of the interview transcript to check for accuracy. I hand delivered the interview transcript to each nurse participant to obtain their feedback and to answer any concerns or questions they have. Follow-up interviews with nurse participants occurred face-to-face as needed to clarify or expound on any data points. (Excerpts from nurse participants' interview are available as Appendix H)

All interview data were securely stored in a password protected computer under UA Box. Data could only be accessed by the researcher (see Appendix A for Demographic and Interview Questions).

Data Analysis

Data analysis in qualitative research is recursive process and helps the researcher make sense of the data (Creswell, 2013). Data analysis begins after the first document is collected or interview is transcribed and is done simultaneously with data collection from each subsequent document, interview or observation. The constant comparative methods allows the researcher to search for concepts within and between all data and place these concepts into categories. These categories will become the eventual themes of the qualitative research analysis.

Data analysis occurred using constant comparative method. This method involves comparing segments of data with one another to search for similarities and differences. Data are assimilated into smaller pieces and each piece is coded and paired together, become a category or theme (Corbin & Strauss, 2015). These themes allow the researcher to find patterns in the data and analyze relationships among the data (Merriam, 2009, p.30). Throughout data analysis, analytic memo were transcribed to capture developing concepts and relationships within and between data. Each theme was developed in terms of properties and dimensions that were integrated around a core category, which became the major theme of the study. When viewed as a whole unit, the core theme and supporting themes provide the structure and foundation for the study (Corbin & Strauss, 2015).

In theoretical sampling, codes are generated through an inductive process and guide data collection (Munhall, 2012). Theoretical sampling is an open form of sampling in which there is identified population, but data collection is otherwise flexible. The number of participants and

data needed are depended upon concept development (Corbin & Strauss, 2015). Data analysis generates concepts. Concepts guide question formation and dictate which participants are needed for further study. As an example, it was noted that more nurses working in an urban setting were being interviewed at the beginning of the study than nurses working in a rural setting.

Interviews were transcribed as they were collected. Coding was used to assign meaning to the data. Coding is a shorthand designation given to various aspects of data so that specific data can easily be retrieved (Creswell, 2013). Codes were analyzed first within, and then between transcripts to assess for recurrent themes in the data. Each code was then sorted in the findings in Chapter IV.

Data Analysis Procedure

Step 1: I conducted semi-structured interviews with the 12 participants involved in the study. The pseudonymous names of the participants were Juliet, Yolanda, Feliza, Monica, Remedios, Corazon, Rebecca, Lydia, Elly, Cora, Dawn, and Fe.

The interview questions were derived from the research questions in such a manner as to collect data that would address each research question.

Interview Questions 1-14 were derived from Research Question 1 to address the issue of participant experiences.

Interview Questions 15-16 were derived from Research Question 2 and designed to address the issue of developing and enhancing transition programs for newly hired internationally educated Filipino nurses and for future Filipino nurses and other internationally educated foreign nurses who will migrate to join the US nursing workforce.

Step 2: I transcribed each interview, using a double-spaced transcription technique to facilitate reading. I left a three inch margin on the right side of the page. The three inch margin

was designed to facilitate the coding of the transcript. Holistic codes and other analytic notes were made in this three inch margin. The transcripts were numbered with Arabic numerals preceded by pseudonyms of the participant (e.g., Juliet 1, Juliet 2, Juliet 3 . . .). This system of numbering facilitated the locating of in vivo material at the stage of write up. I collected 12 transcripts of approximately 25 pages in length. The totality of the interview transcripts was approximately 300 pages.

Step 3: I read each interview in its entirety without making any notes. The reason for this step was to get a feel for the data and view the data from a "real" or "holistic" perspective. This helped me keep from getting bogged down in the particulars of the data and failing to see the larger picture.

Step 4: I read the first transcript a second time. I performed "holistic" coding on the transcript. Holistic codes are one to three words (occasionally five words). Holistic codes are designed to represent the "essence" of the participant's response to the interview question. After each interaction between myself (the researcher) and the participants I would record the holistic codes along with any additional explanatory notes in the right margin of the transcript.

Table 4

Holistic Coding for Lived Experiences of Filipina Nurses' Interviews

Interview Excerpt	Holistic Code	Themes
"I felt like I was in prison and I was counting the days until I can save money and return home for a visit." (Julieta)	*Homesickness*	*Isolation*
"The floor looks like a hospital with semi-private rooms, there was not enough space for luggage, to hang clothes and store personal necessities." (Monica)	*Homesickness*	*Isolation*
"We were a threat to other nurses or at least it seemed that way. We looked different, we were a distinct category of people, and we seemed to garner a certain amount of attention which other nurses did not get, I could never figure out exactly why they had such animosity toward us?" (Remedios)	*Collegial*	*Isolation* *Discrimination*
"I would walk down the hallway, an American nurse is walking towards me, and I would smile and prepare myself to say "hello," she instead looked away from me pretending looking at her watch or the patient's chart. (Feliza)	*Passive/Aggressive*	*Isolation* *Intimidation*
*"*I confronted the doctor why he refused talking to me about my patient, he looked at me and walked away." (Cora)	*Rudeness* *Disrespectful*	*Intimidation*
"I showed up to work one day and I was informed that I was not scheduled to work that day. The unit manager changed my schedule without my knowledge. After confronting her, she stated that she has all the power to change schedule anytime. She never considered that it cost me my transportation and altered my sleeping pattern. She wrote me up for being combative." *(Elly)*	*Rudeness* *Disrespect*	*Discrimination* *Marginalization* *Intimidation*

Note: Excerpts from participant interview

Step 5: I read the first transcript a third time. I performed "in vivo" coding. In vivo coding is technically the recording of the actual words of the participants. I adapted in vivo coding to my particular style of data analysis. Instead of recording specific in vivo codes in the margin of the transcript I use a yellow highlighter to mark "in vivo" material within the text of the transcript. For the "in vivo" codes I look for metaphorical expression used by the

participants. Metaphorical expressions usually come from an emotional part of the personality and carry a significant meaning in the data.

Table 5

In Vivo Coding for Lived Experiences of Filipina Nurses' Interviews (Excerpts from Participants)

Interview Excerpt	In Vivo Code	Themes
"I was so homesick and logging for home. I dialed the international operator, I gave the information she needed, and she then told me that the call will cost me $15.00 per minute. I told her I cannot afford the cost, I hang up, and I went to my bed, cried till I fell asleep." (Monica)	*"so homesick" "longing for home" "cried till I fell asleep*	*Isolation*
"To be treated as less intelligent, less educated, and less capable was especially bothersome to all of us because we knew that none of these assumptions was accurate." (Remedios)	*"less intelligent" "less educated" "less capable"*	*Isolation Marginalization*
"When I ask people for directions they cannot understand me and when they answered I could not understand them because of my accent and their accent. I felt so frustrated that I cannot find the bank, the post office and the church. The taxi fare cost me dearly." (Dawn)	*"I felt so frustrated" "they can't understand me and I can't understand them"*	*Isolation*
"Before I could respond he threw the patient's chart towards by body. I started to cry and ran to the bathroom feeling so embarrassed." (Yolanda)	*"started to cry" "feeling so embarrassed"*	*Intimidation Discrimination*
*"*I picked up the phone immediately and called the physician, when he answered the phone I could tell he was agitated, he screamed at my ears to let me know he was in a stadium watching football. Before I can tell him why I called, he slammed the phone. I was so angry." (Lydia)	*"slammed the phone" "screamed at my ear" "I was so angry"*	*Intimidation discrimination*
*"*I asked my co-worker what is a "slap jar," they just looked at me and ignored me. My co-worker found the incident to be too funny. Instead of making fun of me they could have help me what the patient need was. I was mad and frustrated." (Fe)	*"looked at me and ignored me" "mad and frustrated.*	*Discrimination Marginalization Intimidation*

Step 6: I compiled an analytic memo that recorded all of the analytic material collected from the first transcript. The contents of the analytic memo contained the following sections: introduction, holistic codes, in vivo codes, summary of the responses, salient notes, and interaction with the previous literature, analytic insights, illustrative figures, and potential

applications, potential recommendations, and potential conclusions (see Analytic Memo in Appendix G).

Step 7: I repeated Steps 1-6 with the remaining 11 participants. The data analysis was progressive. The data for participant one was completed before participant two was interviewed. This procedure maximized the advantage of an emergent research design, which is one of the advantages of qualitative research. The materials and the insight I gained from analyzing the initial transcript informed my interview of the second participant and every subsequent participant. This procedure enabled me to refine interview questions and center questions in order to gather data that had been lacking in previous interviews.

The progressive interviews and data analysis allowed me to see the data come to life. After the third interview, certain codes began to emerge as important, certain experiences began to emerge as common among the participants. A structure for the presentation of the findings began to take shape. Also, a number of negative cases began to appear. The negative cases gave added scope and depth to the findings thus adding credibility and reliability to the findings of the research.

Step 8: I performed integrative coding. I progressively assembled the holistic and in vivo codes in such a fashion that would provide architecture for addressing each research question. For research question 1, three major codes emerged from the data: isolation, intimidation and discrimination and/or marginalization. For research question 2, five major codes emerged: pre-orientation at the recruiting agency in the Philippines, living and community orientation, hospital orientation, clinical, and educational orientation. Below is a chart of the integrative outline.

Research Question 1: Personal Experiences

Theme One: Isolation

- Personal Reasons

Homesickness
Communication Problems

- Collegial Reasons/Behaviors

A threatening presence
Passive aggressive ignoring
Mockery
Undermining

- Contextual Reasons

Transportation
Location
Awareness

- Professional Reasons

TOEFL Exam
NCLEX-RN Exam
Time Constraints
Stress

- Social Reasons

Lack of Time
Lack of Knowledge
Lack of Understanding

- Negative Cases

Adoptive Families
Other Mother
Protectors

Theme Two: Intimidation

- Impatience (Examples)

  Doctor Threw Chart
  Doctor Cursed at Nurse
  Doctor Hung Up the Telephone

- Rudeness (Examples)

  Addressed by Last Name
  Doctor Address American Nurses but Not Filipino Nurses

- Mockery (Examples)

  Accent/Pronunciation
  Smell of Filipino Food

- Stereotyping (Examples)

    Less Educated
    Married to GI
    Filipino Baby

- Sexual Harassment (Examples)

    Inappropriate Touching
    Holding hands
    Placing hand around shoulder
    Flirtations

- Professional Intimidation (Examples)

    Misinformation
    Belittling
    English-only language requirement
    Overly rigid scrutiny

Theme Three: Discrimination and/or Marginalization

- Scheduling

  3PM-11PM/11PM-7AM
  Weekends
  Holidays

- Patient Assignments

  Most Serious Patients
  More Patients Assignment
  High Acuity (Total Care)
  Deceived Into Doing Other Peoples Work

- Passive Aggressive Treatment

Refusal of Leadership
Unwillingness to Cooperate
Hiding at Work

Research Question 2: Recommendations

- Pre-Arrival Orientation by Recruiting and Travel Agency

  Video Presentation of hospital type, location, size, number of beds, scope of services, transportation system, cost of utilities, salary and deductions, benefits, living arrangement, culture and values of people, pronunciation lesson, meaning of slangs and idiomatic expressions
  Driver's training and securing driver's license
  Car rental for 2 years
  Review and Preparation to take TOEFL, CGFNS and NCLEX-RN
  in the Philippines
  Welcome Letter to the applicant that include job description and include
  Government applications for social security, and expectations.

- Living and Community Orientation
  Hiring hospital assign a liaison or coordinator to pick up nurses at the airport
  Location of Apartment accessible to transportation
  Transportation system, route and cost
  Assist in identifying necessary needs; kitchen utensils, bathroom supplies,
  Bedroom supplies, groceries and personal necessities.
  Drive around the community and show location of groceries including oriental stores, restaurants, transportation system location, bank, post office, shopping centers, city hall, utility services (electricity, water, gas, telephone), churches, Federal building, immigration office,

Introduction to priest, pastor or church leaders

- Hospital Orientation

  Building Tour--include Radiology, Laboratory, Emergency Room, Pharmacy, etc.
  Introduction to Provider's and Staff (Physicians, CRNPs, Nurses, Healthcare Team)
  Classroom orientation to include hospital mission, vision, values, policy and procedures,
  Job description and expectations, benefits, explanation of salary and deductions, health
  insurance, language lessons, people's values and cultures, shift assignments and off days.

- Clinical Orientation

  Assign a preceptor for the whole duration of orientation for consistency and to develop rapport and trust with each other
  Introductions to other members of the nursing unit health team
  Scavenger hunt (find where supplies are, ice machine, linen carts, etc.
  Assign Filipino nurses to nursing units where they have experience and expertise

- Education Support

  Provide support and resources if newly hired has not passed TOEFL and NCLEX-RN
  Provide reasonable shift assignment to have time for study.
  Provide assistance applying for TOEFL and NCLEX-RN

Theoretical Framework

Harris (2006) suggested that a theoretical framework is a guide that helps to frame, organize, or order a problem, phenomenon, or question. In this view, a theoretical framework helps bring shape and focus to a certain experience. Kearney and Hyle (2006) proposed that a theoretical framework is a road map that is easily visualized and helps one to draw inferences into the study. Henstrand (2006) maintained that a theory is a lens used to filter data. In this definition, theory helps one to focus on meaningful data and suggests that one should view information with an unbiased eye. This assists the researcher to stay focused on the issue in question. In the realm of qualitative research, the researcher uses the theoretical framework to

shape the study and form the presentation and its content so that all who read the results understand the form and direction of the researcher, or more importantly the phenomena or lived experiences of the participants. As a way to capture and ground this study, standpoint theory and cultural competency theory were used as lens to explore and understand the lived experiences of internationally educated Filipina nurses related to socio-cultural differences, language barriers, and adjusting to their new living and working environment and how these lived experiences of the participants in this study help in developing transition programs or assist in enhancing an existing transition programs for newly hires IEFNs or for future IENs migrating to Alabama to join the nursing workforce.

Standpoint Theory

Standpoint theory supports what feminist theorist Sandra Harding calls strong objectivity, or the notion that the perspective of marginalized and/or oppressed individuals can help to create more objective accounts of the world. Through the outside-within phenomenon, these individuals are placed in a unique position to point to patterns of behavior that those immersed in the dominant group culture are unable to recognize. Standpoint theory's most important concept is that an individual's own perspectives are shaped by his or her social political experiences. Standpoint theory gives voice to marginalized groups by allowing them to challenge the status quo as the outsider within (Harding, 1987; Ryan, 2005).

According to standpoint theorists, some social roles (standpoints) can generate more accurate knowledge of particular domains than others. The idea has its roots in Marx's analysis of ideology, but recent work by feminists has freed it from Marx's idiosyncrasies. Many social theorists have held that social relationships are ultimately determined by what people do. Marx called the human activities at the foundation of society "material practices." These are concrete

interactions among people, and between humans and their environment: barter, planting crops, or paying wages to laborers. Power is not always (perhaps never) equal in society, and this is manifested in the practical ways in which people relate to each other. Within a capitalist society, Marx argued, there is a dominant, ruling class and a working class. The ruling class determines many of the material practices that constitute the very social relations that keep them in power. For example, by paying wages for some kinds of work and not others, the dominant class simultaneously creates and marginalizes different way of life. The working class' cooperation in the system is necessary, for they provide the labor that drives capitalism (Risjord, 2010). Example of this theory is hospital administrator and recruiter being in power and being the dominant group and the Filipino nurses are the working class.

Feminist theorists (e.g., Hartsock, 1983) and social scientists (e.g., Smith, 1974) noticed the obvious parallels between gender and class relationships. Insofar as men hold power in a society, they control the material practices that constitute social relations. Masculine dominance, however, is not strictly economic. One of the objections that feminists had to Marxism is that women's work in the home was invisible to standard models of economic exchange. Nonetheless, women's work makes the male roles possible in much the same way as Marx saw workers supporting the capitalist system. Women are in a position to understand both the partial, male perspective and understand what makes that perspective possible. Thus women are in a position to achieve a more adequate understanding of society, especially the ways in which society is structured by gender (Risjord, 2010). Through the outsider-within phenomenon, these individuals are placed in a unique position to point to patterns of behavior that those immersed in the dominant group culture are unable to recognize. Standpoint theory gives voice to

marginalized groups by allowing them to challenge the status quo as the outsider within (Harding, 1987; Ryan, 2005).

In Coombs (2004) study, the primary focus of her research was the "way the knowledge and roles are used within the decision-making process in the delivery of health care." To uncover these processes, Coombs conducted interviews and observed ward rounds. Rounds are crucial sites for understanding how power and knowledge interact. Coombs found that both physicians and nurses used biomedical models of health and the associated knowledge of physiological systems in their response to the patient. She observed and listened to physicians and nurses' conversation during rounds. Coombs's observation of ward rounds documented that the domains of nursing knowledge were recognized only as peripheral issues. Biomedical issues constituted the bulk of the discussion in ward rounds. Issues about relatives, continuity of treatment, patient comfort, and so on tended to be tagged on at the end, if mentioned at all. Occasionally, the team would turn to the nurse for a report, but nurses felt they had to be very assertive if their concerns were to be heard. Coombs's study found both power and knowledge differentials between doctors and nurses. Nurses had recognized expertise in several areas: up-close knowledge of how the patient was responding to treatment, the performance of bodily functions that are essential to life and health but not the focus of treatment, the management of patient's physical environment, and the patient's social relationships. In addition, nurses were conversant with contemporary biomedicine and were able to communicate with the physicians in these terms. The power differential between physicians and nurses was replicated in the relationship between their respective areas of expertise. The physician's knowledge was treated as the more important form, and the areas of nursing expertise were marginalized. It is interesting that, in spite of the

frustration sometimes felt, both physicians and nurses treated the nursing expertise as secondary to the physician's knowledge.

The role of the nurse in health care is oppressed and marginalized as compared with the role of the physician. For centuries, physicians have dominated the practice of medicine. Even though the discipline of nursing has worked hard to get recognition for the contributions of nurses, they participate in a system where their role is largely determined by the needs of the physicians. In Coombs's (2004) study, physicians and nurses regarded the physician as the primary decision-maker, and their discourse dominated the rounds. The nurses' expertise was treated as a "superficial" addition. The relationship of physicians and nurses was largely structured by the needs of the physicians. Even as nurses gained autonomy within the health care system, nurses' responsibilities have been harnessed to the physicians' treatment regimen. While the nursing role is necessary for physicians, nursing work in largely invisible. When I was practicing nursing in the Philippines in 1972-1973, this was exactly how we were treated as nurses. We were the handmaids for the physicians. Many social theorists have held that social relationships are ultimately determined by what people do. Power is not always (perhaps never) equal in society, and this is manifested in the practical ways in which people relate to each other. Standpoint theory gives voice to marginalized groups by allowing them to challenge the status quo as the outsider within (M. Ryan, 2005: S. Harding, 1987).

The crucial final ingredient of standpoint epistemology is the political commitment to develop the knowledge available to those who occupy the marginalized social role. The knowledge available to a standpoint is not automatic; it requires political commitment and empirical work. This is where the nursing role differs from the typical loci of standpoint analysis. For the standpoint of class, gender, and race, the political commitment is to social justice. In

nursing, the commitment is to the values at the core of nursing practice, including the patient's autonomy and well-being, as well as to the valorization of the nursing role itself (Coombs, 2004).

The Johnson-Donaldson-Crowley model used the professional values of nursing to direct the central topics of the discipline. Standpoint epistemology relies on the idea that moral or political values can be constitutive to scientific inquiry. Given a commitment to the central values of nursing, the knowledge that nurses have of human health in virtue of the special role they play in health care can be uncovered. Nursing knowledge would therefore be an outgrowth of the nursing standpoint (Risjord, 2010).

Mark Risjord (2010) argues that nursing is not a basic or an applied science and that it would be better served by a philosophy of nursing science under which discipline of nursing is developed from the 'bottom up' rather than the 'top down.' The bottom-up approach would start from the perspective of nurses' lives, 'the nursing standpoint' (Risjord, 2010, p.74) with a political commitment to the core values of nursing practice and to valorizing nursing practice, providing unity within the profession.

Risjord (2010) says that the nursing standpoint would ensure that the problems of nursing practice are the problems of nursing research so that the discipline of nursing always serves the profession of nursing. What is then the 'nursing standpoint'? Risjord explains that the notion of the nursing standpoint arises from the standpoint epistemology in which it is held that, unlike the oppressor, the oppressed has an epistemically privileged standpoint. This is from that standpoint, the oppressed, unlike the oppressor, is able to gain an understanding of not only its position but also that of the oppressor and thus attain a less distorted view of social relationships.

Risjord (2010) maintains that the nursing standpoint exists in that the nursing profession, oppressed by the medical profession, meets the four conditions for the existence of an epistemically privileged standpoint:

> One role is oppressed relative to another dominant role.
>
> 1. The relationship between the roles is structured by the needs and interest of the dominant role.
> 2. The practices of the subordinate role make the activities of the dominant role possible, and these activities are largely invisible to the dominant group.
> 3. In order to fulfill their role, those who occupy the subordinate role need to understand some domain from both perspective of the dominant role and from their own perspective. (Risjord, 2010, p. 68)

This theory will aid in explaining the following phenomena of the lived experiences of Filipina nurses related to race, ethnicity, gender, inclusion, and class position.

Cultural Competency Theory

Cultural competency results in four main themes: awareness of diversity among human beings, ability to care for individuals, non-judgmental openness for all individuals, and enhancing cultural competence as a long-term continuous process. Culture is defined as the "learned, shared, and transmitted values, beliefs, norms, and life practices of particular group of people" (Leininger & McFarland, 2002). People's culture can be understood through their actions, that is, their behavioral patterns and through understanding why people act in the way they do, their functional patterns. Diversity recognizes the value that everyone and every group brings to a community, regardless of differences. It includes all the ways in which people differ from each other and it encompasses all of the different characteristics that make individuals unique (Stein & Olsson, 2004).

It should be noted that the person who migrates encounters a new culture, a process sometimes called acculturation. This is a "process by which newcomers to a group, work to make sense of the surroundings and come to acquire the kind of knowledge that would enable them to produce conduct that allows established members of the group to recognize them as competent" (Bond & Bond, 1994, citing Dingwall, 1977). The "new" knowledge relates to the host culture, and therefore one would argue that culture would have an influence on the adaptation of nurses to their respective new country of residence and work.

A study done by Matiti and Taylor (2005) with a group of internationally foreign nurses (IRNs) from Mauritius, Philippines, India, and Nigeria recruited to work in the United Kingdom regarding their lived cultural experiences showed that even though these nurses spoke English, it was hard for them to understand patients and "host-country nurses" who used colloquial English. The IRNs stated that patients and host nurses spoke very fast. When they were answering the telephone, they could not understand what the person was saying. The accent was also a problem for some nurses. The IRNs could not understand the host nurses' and patients' accent and equally, host nurses and patients could not understand the IRNs' accents. "Sometimes you have to repeat yourself so many times for others to understand. Some staff regard you as if you do not know anything and you are stupid" (Hospital A: Male Mauritius nurse). Some of the nurses from Mauritius, India, and Nigeria brought their own food with them. Cultural adaptation is not part of their orientation. Some of the IRNs were looking for a grocery store to buy food items from their country, some were looking for their specific church, no one had license to drive, and looking for transportation accommodation was a challenge to all the IRNs.

Adaptation means one has to adapt to the life of the host country. You need to adapt to everything in your surroundings. You have to get used to the money currency because we have

the tendency to compare the prices and values of things if they were expensive or not, it was difficult for most of us. (Hospital A: male RN)

Transcultural Nursing Theory (TCN) has gained acceptance in the United States and Canada as the way of promoting culturally competent healthcare to individuals from diverse cultures. Leininger, the nurse anthropologist who established the subdiscipline of *Transcultural Nursing*, first defines it as "the humanistic and scientific study of all people from different cultures in the world with thought to the ways the nurse can assist people with their daily health and living needs." TCN Theory was also use as a way of thinking through issues of race and other categories of social and human difference (Gustafson, D.L., 2005).

According to TCN Theory, addressing cultural diversity is an important challenge facing nurses. The goal or intended outcome of TCN is to meet client's health needs in ways that are consistent with their cultural beliefs. A systematic review of selected TCN literature suggests that responding to cultural diversity is a challenge that nursing faces with ambivalence. Cultural diversity is regarded as an exciting challenge that appeals to our liberal sensibilities as a profession. At the same time, cultural diversity is perceived as a threat to the concept of nation and the integrity of a racialized order in and beyond nursing (Gustafson, 2005).

The so-called problem of increasing cultural diversity is the starting point for many TCN texts. These sources assert that the changing face of the North American population is impacting the interpersonal relations among nurses, and between nurses and their clients. The dramatic rate at which newcomers are "pouring into this country from all nations of the world supports the push for cultural competence. One text describes the transformation of the healthcare system as an "ongoing healthquake" of global proportions. The "smaller world" brought together by

communication technology, “the potency of television,” and global travel is said to have serious implications for nurses and nursing practice, education and research (Gustafson, 2005). This theory was used to explain the phenomena of socio-cultural difficulties, language barriers, and racism experienced by internationally educated Filipino nurses.

Validity and Reliability

To increase the credibility, or internal validity, of this study’s findings, triangulation, member checks, and reflexivity were utilized. Triangulation can occur using multiple theories to provide corroborating evidence to shed light on a theme or perspective and provide validity to data findings (Creswell, 2013). I also triangulated the data by comparing interview transcripts with all the nurse participants.

Member checks were performed during the study. A member check is the process of soliciting feedback on emerging findings from the study participants (Merriam, 2009). In order to solicit feedback from the nurse participants during data analysis, first the nurse participants were given a copy of the original, verbatim transcribed interview. Participants were then asked to review the preliminary analysis of data from interviews and asked if they agreed with the transcribed data. These transcripts were delivered face-to-face to each participant. Follow-up interviews were scheduled when clarification or more information was needed.

Later in this chapter is my positionality or reflexivity statement, which describes my biases, assumptions, and experiences with isolation, intimidation, discrimination and/or marginalization. Reflexivity helps to clarify biases that the researcher brings to the study. Open and honest self-reflection creates a dialogue with the reader about the researcher’s background and how past experience shapes the interpretations of the study’s findings.

Thick, rich, and detailed description is used to present the study findings in Chapter IV to assist the readers to determine its applicability to their practice setting. Use of descriptive context and quotes from interviews and documents are used to submerge the reader in the evidence. By using variants, such as years of work experience, degree earned, and any other variables that emerged in the study as relevant, transferability is enhanced. However, due to the nature of qualitative research, generalizability is a limitation of the study.

Ethical Consideration

It is important for the researcher to protect the participants in all research studies. Creswell (2013) suggested that researchers develop trusting relationships with participants to promote integrity of the study, protect against misconduct and impropriety, and cope with any new problems that may arise during the course of the study. Ethical issues include privacy of participant's data, personal disclosure, researcher authenticity, and credibility of the research report. To address ethical issues that may arise, the following action were taken.

A site with privacy setting was used for interviews. Participants were given verbal and written information on the purpose of the study, voluntary informed consent, participant anonymity, and any rewards for participating (there was no rewards participating in this study). All data collected was coded for confidentiality. Each participant was invited and agreed to participate in member checks during the analysis phase of the study and received a copy of her transcript. Due to the sensitive nature of isolation, intimidation, discrimination and/or marginalization and the possibility of harmful psychological effects, the participants were instructed on counseling availability. No participants requested counseling service.

Strengths and Limitations

Qualitative research has both strength and limitations. As a strength, qualitative research is founded in real-life situations and offers a rich and holistic account of a phenomenon from the perspective of those involved. Qualitative studies offer insight and illuminate meaning that could lead to tentative hypotheses for future study. One of the most important strengths of this qualitative research is the possibility of establishing a standardized transition program in the United States where high percentages of IENs migrate to join the nursing workforce to help alleviate nursing shortages.

Due to small sample size and subjective nature of qualitative inquiry, the results may not be generalizable and assumptions cannot be made that all internationally educated Filipina nurses will experience the same difficulty that the participants in this study had. I have experienced and witnessed isolation, intimidation, discrimination, and marginalization, it is impossible to remove all researcher bias. Due to the nature of this study, participants were chosen purposively and not randomly.

Researcher Positionality

Researcher's backgrounds (such as work experience, cultural experiences, and history) inform their interpretation of data findings throughout a study (Creswell, 2013). This is known as researcher reflexivity. As such, our readers have the right to know "what prompts our interest in the topics we investigate, to whom we are reporting and what we personally stand to gain from our study" (Wolcott, 2010, p. 36).

My experience as a bedside nurse began in 1973. I was 9 months out of nursing school in the Philippines when I left the country to find better opportunity and to have a better salary here in the U.S. so I could support my family back home. I graduated in May 1972 with a bachelor

degree in nursing. I graduated top 5 in my class and I was awarded the Florence Nightingale award for Academic Excellence and Leadership. My first assigned shift was 11-7 in a Medical/Surgical unit. I was single but engaged. My fiancée was still in the Philippines. I was barely 21, very naïve and carefree. I experienced everything that each of the participants in this study experienced.

As a researcher, I remained open to the data and allowed it to guide me to theoretical discovery. As of this moment, I am positioned in a place that leads me to believe that all nurses and other healthcare workers must be educated as ethical, professional beings who are expected to treat their fellow humans, and should be expected to be treated by fellow humans, with dignity, respect, and a modicum of benevolence. The mere existence of isolation, intimidation, discrimination and/or marginalization in our work environment suggests that there is an infestation among us that we must quickly assess, diagnose, and treat so that nurses, especially native nurses, providers, and other members of the health team can heal our work environments. After all, that is what we do best.

Chapter Summary

This study provided an opportunity for internationally educated Filipina nurses to describe their lived experiences in joining the U.S. nursing workforce related to socio-cultural differences, language barriers, and adjusting to their new living and working environment. A qualitative approach and, in particular, the power of storytelling was selected because it allowed participants to share their stories through individual interviews. It also provided opportunity to contribute in the development of a transition program or contribute in the enhancement of an existing transition program using the lived experiences of the Filipina nurses in the study.

Twelve nurse participants were chosen using purposive, theoretical sampling. Data analysis occurred simultaneously using the constant comparative analysis method. Individual semi-structured interviews were used to gather data. Triangulation, member checks, researcher reflexivity, and the use of multiple data sources served to strengthen the validity of the study. The use of thick, rich description will help the reader of the study determine the transferability of the findings as described in Chapter IV. Due to the nature of qualitative research, it is understood that the findings of this study may not be generalizable, but will represent an abstract construction of the meaning of isolation, intimidation, discrimination and/or marginalization in the workplace experienced by internationally educated Filipina nurses and the importance of developing a transition programs or contributing to the enhancement of an existing transition programs for newly hired IEFNs and for future IENs who will migrate to the USA to join the nursing workforce to help alleviate the critical shortage of nursing.

CHAPTER IV:

FINDINGS

This chapter presents the findings of this qualitative research study using the theoretical framework of standpoint theory and cultural competency theory. The lived experiences of 12 internationally educated Filipina nurses who are presently working or have retired from urban, suburban and rural community hospital in Alabama were documented related to socio-cultural differences, language barriers and difficulty adjusting to their new living and working environment they encountered joining the US nursing workforce to help alleviate the critical shortage of nursing. Excerpts of their stories help to support the themes, properties, and dimensions in this chapter. Initial findings were presented that answer the original research questions. Latter findings present the answer to the research question that emerged as a result of the research process. Through concept and category analysis, data were gathered and analyzed to create themes. Theoretical sampling and constant comparative analysis allowed for the creation of more focused questions as the research process continued and themes began to form and gain properties and dimensions. These data are depicted as codes and themes throughout this chapter.

The approach was used to create themes to label how IEFNs experienced, recognized, coped with, and wished to rid the isolation, intimidation, discrimination and/or marginalization in the workplace and in their living environment. Using open-ended questions during interviews to collect data allowed participants to speak freely and openly about their lived experiences they encountered as they transition into their new world. It was important to allow the participants to speak uninterrupted during the interview process. Through data analysis and open coding

process, concepts began to emerge and new questions began to take form. This new question gave way to the concepts that would formulate the core themes for this research study. Three main themes identified were isolation, intimidation, discrimination and/or marginalization. The research questions that guided the study were as follows:

1. How do internationally educated Filipino nurses describe their lived experiences as they transition to the U.S. nursing workforce?

2. How do these lived experiences of Filipino nurses in this study contribute to the development of transition programs and contribute to the enhancement of existing transition programs in Alabama?

Research Question 1

Isolation Experienced by Internationally Educated Filipina Nurses

One of the dominant experiences of the nurses interviewed for this research project was isolation. The Filipina nurses encountered a number of issues which interfered with their integration into the cultural context into which they found themselves thrust. One participant shared a common sentiment echoed by many individuals who left their social, cultural, and familial networks in order to travel to a foreign land and start a new life. Monica said,

> It was always my desire to go to the USA and work as a nurse. I dreamed of going to the land of opportunity and becoming a success. Unfortunately, after arriving in this new dream world, my life soon turned into a nightmare.

Another participant indicated that she felt so lonely that at the end of her work shift that she would stay in bed to sleep until the alarm sounded to prepare for another work shift. Julieta said, “I felt like I was in prison and I was counting the days until I could save money and return home for a visit.” Five distinct reasons for this feeling of isolation arose from the data: personal,

collegial, contextual, professional, and social. There were three experiences that I labeled as negative cases (Creswell, 2016). By negative case we indicate material that contradicts or goes in the opposite direction of the prevailing tide of data. The predominant amount of data reveal experiences of pain and suffering from loneliness and the difficult consequences that accompany the experience of isolation. There were three experiences that counteracted the negative feelings of isolation. Those experiences were designated as adoptive family, other mother, and protectors.

The primary personal reason for isolation was homesickness. The island of the Philippines is 8539 miles from Alabama. The Philippines is 12 hours ahead in time. When it is daytime in the Philippines it is nighttime in Alabama. The flight takes about 22 to 24 hours with layovers in Hong Kong, Hawaii, San Francisco, Atlanta, and then, Birmingham and another hour of driving from the airport to the final destination. After arriving in a sleep deprived, jet-lag induced stupor, the first group of newly arrived nurses were taken to the 4th floor of an old hospital building. The ward used to house tuberculosis patients and has since closed due to successful treatment of the disease. The 4th floor looked like a hospital with semi-private rooms. Two nurses were assigned to one room. Each room had its own bathroom and a small closet, one small side table, and one chair. Monica stated, “There was not enough room to hang clothes and store personal belongings, the place looked gloomy.” The new arrivals could not wait to find their bed to work off the effects of their journey. The young lady whose name was Monica comes from a traditional family who lived on the outskirts of Manila. Her father was a typical Filipino gentleman who ruled their household. He was the master of the house, the bread winner, and expected to be served when he arrived home. The mother of the house usually prepared meals and had his towel, pajamas, and slippers ready when he arrived. Monica said,

We said our prayers before meals and we ate as a family, hats were not allowed to be worn inside the house especially during mealtime. We were called by our first name and elders were addressed by calling them with Mrs., Miss, Mr., Dr. Etc., as a sign of respect. Monica remembered all the instructions given by her father before she left for the USA. “Work hard, sacrifice for your family, and send money home to help with family expenses and to improve our life.” She covered her face with her pillow, and fell asleep.

From the very moment she arrived, Yolanda knew that things would not be the same as they were back in her hometown. Perhaps it was the effects of the jet lag but everything seemed to be difficult. She had not expected a parade or a welcoming party but she had expected some people to greet her, introduce themselves, and welcome her into their world. However, none of that happened. Everyone seemed to be in a hurry, running here and there. No one stopped to say “Hello” or “Welcome to Alabama.” They just seemed to ignore her. They treated her as though she was not there. It was as if she did not exist in their world. Some nurses scurried past her and stepped around her as though she were a piece of furniture.

Yolanda told herself that things would get better. It would just take some time to get adjusted to the people and the culture. She told herself that she would learn the customs of this new land and everything would eventually be wonderful, just like she had pictured it in her dreams when she was a little girl in the Philippines. Then she was introduced to her living accommodations. She discovered that she would be sharing a one bedroom apartment with three other nurses. There was only one bathroom, one bedroom, a small living room and small kitchen. She sadly stated “there was no place to put my luggage, hang clothes and not enough space to walk around since they turned the small living room into two bedroom separated by a room divider like we used in the hospital semi-private room.”

The next discovery for Yolanda was that there was no public transportation. Back in the Philippines, she had always been able to ride the bus, jeepney, or a tricycle from her apartment to the university and back. The grocery stores were conveniently located along the way. She could buy food, pay bills and take care of her daily affairs in a convenient manner. Such was not the case in her new place where she found herself. There were no buses, no jeepneys, and no tricycles. She did not have money to buy a car and she did not know how to drive. Taxi cabs were expensive and inconvenient. She had to arrange her schedules with the three other nurses in order to share a ride to the hospital. Soon she discovered that these unforeseen expenses were going to decrease her take home pay.

Homesickness and longing for home, Monica desperately wished to call home and talk to her mother. She thought to herself, Inay (means mother) will have a solution to all these problems. Inay will encourage me and give me strength. If I can only hear her voice that will give me joy and courage to forge ahead and make this new life a joyous reality.
She dialed the international operator, gave her the country code, then the Manila code, then her family's telephone number. The international operator said, "This call will cost you $15.00 per minute, do you wish to place the call?" With tears in her eyes, Yolanda said, "no, I cannot afford to place the call." There was one last hope--Yolanda thought perhaps the hospital would allow her to call home from the hospital. When she asked, she was told abruptly that no long distance phone calls were allowed from the hospital telephones.

Yolanda's experience was not unique to her. Every participant in this study endured these same difficulties to one degree or another. The strongest experience that brought about the feeling of isolation was language barriers. Perhaps the most isolating experience came from the inability to communicate. Every participant in this study registered the difficulty of being

understood as an excruciating and painful ordeal. Each participant handled this experience in their own unique fashion. Several of the nurses continued to make efforts to make themselves understood to the doctors at the hospital and their fellow American nurses. Their efforts were met with silence. Most of the American nurses avoided conversations with the Filipina nurses. Doctors addressed the American nurses in order to get information concerning patients that had been assigned to the Filipina nurses. One Filipina nurse had a novel way of dealing with the communication problem. She said, "I simply gave up attempting to communicate with the American nurses and doctors. I carried a pen and a small notebook in my pocket. Whenever I was asked anything I pulled out my notebook and wrote my response on a piece of paper and handed it to the person. I was tired of them saying "can you repeat what you said?" "I did not understand what you said, can you say it again?"

A second group of experiences that brought about isolation among the participants is this study can be classified "collegial." The nurses in the Philippines were the "new kids" on the block. As such, they were due for some kind of hazing. However, the treatment from the native nurses went beyond the traditional or the accepted level of hazing. Remedios painted a not-so-unrealistic scenario. She said, "We were a threat to the other nurses or at least it seemed that way. We looked different, we were a distinct category of people, and we seemed to garner a certain amount of attention which other nurses did not get. It seemed like they thought we were going to take their jobs or their men or leapfrog over them and steal their promotions. I could never figure out exactly why they had such animosity toward us. All I know is that they tried to make our live as miserable as they possibly could."

From the data provided by the participants in this study, their colleagues engaged in five distinct isolating activities: passive aggressive ignoring, mockery, undermining, sabotaging, and manipulation.

Passive aggressive ignoring took many forms. One form reported by Feliza was passing in the hall of the hospital without greetings or exchanging pleasantries. Feliza made the following observation, "I would walk down the hallway in the hospital, an American nurse would be coming toward me, I would smile and prepare myself to say "Hello" and have a pleasant exchange, as she got closer I would expect her to make eye contact with me, instead she would look straight ahead as she passed me or look in the opposite direction or pretend to look at her watch or a chart she was carrying. I knew it was an intentional avoidance of me because shortly after she passed I heard her laughing and I turned around to see her smiling and engaging in conversation with another American nurse."

Mockery was another common technique that native nurses employed in order to isolate participants in this study. Three areas of mockery emerged from the data that was collected from the participants. The mockery centered on the participants' pronunciation, food, and heritage. American co-workers were reported to have made fun of the way the Filipino nurses pronounced certain words. One source of amusement revolved around the pronunciation of the English word "sheet." Many languages do not contain the long "E" phoneme. In place of the long "E" the Filipino language pronounces the short "I." When the participants pronounced the word "sheet" the sound resulted in the English word "shit." They do not use this word in the Philippines, so they do not know its meaning. On many occasions in the hospital context nurses have to make requests for "sheets" for patient's beds. There were many other words that brought about embarrassment when pronounced like panty, urine, hemoglobin, Robitussin, popliteal, pediatric,

cardiology, desert, desserts, cemetery, urban, Mrs. Martin, Mrs. Horton, Mrs. Patton, and many other words. Fe said, “The American nurses and other co-workers never missed an opportunity to laugh at us when we made these pronunciation mistakes.”

A constant source of consternation for the Filipina nurses revolved around the food they ate at work. To save money, Filipina nurses normally cooked at home and brought their lunches to the hospital with them. Dawn mentioned that fish was a staple in their meals. They also used fish sauce and vinegar sauce as condiments. Dawn described,

> During our supper break (3-11 or 11-7 shift), we will go to the breakroom to heat our food in the microwave oven, the smell of the fish will permeate the breakroom and make its way out in the hallway. When the Filipina nurses would enter the breakroom, it was a common occurrence for some of our co-workers to hold their noses with their thumb and index fingers as they exited the room. Some of our co-workers made it a habit of asking us what time was our supper break. They made comments such as “I will take my supper break before you.” Several participants stated that some of the American nurses and co-workers complained to the supervisor and said that patients were complaining about the horrible odor that was coming out of the breakroom while the Filipina nurses were heating their food. They exaggerated about the food odor. The Filipina nurses were instructed by their supervisor to go downstairs in the cafeteria to eat their meal.

The final form of mockery resulted from the heritage of the Filipina nurses. One participant whose name is Remedios gave the following opinion:

> We came from a poor country. People referred to us as “third world” people. Unfortunately, many of the people who worked with us mistakenly considered us to be dumb and uneducated. The fact that we had difficulties understanding them seemed to

reinforce their misconceptions about us. They don't know that we cannot understand how they talk either.

Several participants stated that the American nurses, doctors, and some of their co-workers looked down on them and treated them inferior. That this treatment was ill-informed was articulated by Feliza who said,

> All Filipino nurses arrived in the U.S. with a Bachelor of Science in Nursing (BSN), and 95% of American nurses had an Associate degree from a community college. Filipino nurses went to school for five years and most American nurses only went to school for three years. The Filipino nurses had more academic requirements and more clinical hours than their American counterpart. To be treated as less intelligent, less educated, and less capable was especially bothersome to all of us because we knew that none of these assumptions was accurate.

A final form of collegial isolation was undermining. Undermining took the form of putting the participants in uncomfortable or unenviable situations. Many participants told stories of how they would find themselves in a social gathering and be completely ignored. More than one Filipina nurse shared that they had been in the breakroom having a baby shower or bridal shower for one of their co-workers and the American nurses and some of their co-workers carried on with their conversations and never spoke a word to the Filipina nurses. Feliza said, "But they expected us to bring food for the celebration." Monica shared a very heartbreaking experience:

> I was invited to attend the Medical Society Auxiliary meeting because my husband is a medical doctor. There were at least 30 people present at the meeting. We were there for 3 hours and only one person spoke to me. No one made eye contact with me.

A third cause of isolation concerned contextual reasons. The participants in the study encountered three specific difficulties related to the context in which they found themselves: transportation, location, and awareness. I have previously mentioned that in the Philippines, public transportation was widespread. In many rural areas of Alabama, public transportation is virtually nonexistent. The Filipino nurses did not have cars and the majority of them did not know how to drive. Having to study for a driving test, then find money to buy a car was overwhelming to many of the participants in this study, especially when these responsibilities were added to the enormous amount of other obligations that rested upon their shoulders.

Location was another isolating cause for the Filipino nurses who participated in this study. Typical cities in the Philippines were designed with grocery stores, pharmacies, and other related venues located in strategic areas. In rural areas of Alabama, many stores are located in different sections of the town. In the Philippines, a person can take public transportation to a city center, take care of all their business affairs, and return to their home. In rural Alabama taking care of one's affairs might require traveling five to six miles. Without a car, such an endeavor could prove insurmountable.

Awareness was another contextual item that isolated Filipino nurses. Two causes came to bear on this obstacle which confronted each of the participants in this study. Transportation and communication difficulties coalesced to make it difficult for the Filipino nurses to discover where essential services were located and how to get there. A number of nurses confided that the frustration of finding out where things were located proved to be a monumental chore. Julieta explained the situation in the following manner:

> There were some books or pamphlets which told you the addresses of certain places like church, bank, post office, oriental stores, and other places like restaurants but I had no

idea where those addresses were located or how to get to there. When I asked people for directions they could not understand me because of my accent and when they answered I could not understand them because of their accent. Once I found out where I needed to go I had to hire a taxi to carry me to all these places and the cost was prohibitive. It took me three months before I found the Catholic Church and where to buy rice.

A fourth cause for isolation resulted from professional reasons. There were two professional obligations that brought about an immense amount of stress and absorbed a lot of time. The participants were required to take two major high stakes examinations. The first examination was the Test of English as a Foreign Language (TOEFL). Although English is the medium of instruction in the Philippines, it is not considered as the first language. The first language is the Filipino language. Every foreign graduate whose first language is not English are required to pass this test first before qualifying to take the National Council Licensure Examination for Nurses (NCLEX-RN). The TOEFL is comprised of four sections: Reading, Writing, Speaking, and Grammar. The TOEFL measures on a scale of 1-120 with each section being measured on a scale of 1-30. There is no uniform score that is identified as a passing score. Each institution set a specific numerical total score as acceptable for their institution. The TOEFL examination is considered as an evaluation of the English proficiency and every participant in this study was required to take and make an acceptable score on this examination.

A second high stakes examination that each participant was required to take was the National Licensure Examination for Nurses (NCLEX-RN). It is a standardized exam that each state board of nursing uses to determine whether or not a candidate is prepared for entry-level nursing. The NCLEX-RN has one purpose: To determine if it's safe for you to begin practice as an entry-level nurse. It is significantly different from any test that is taken in nursing school.

While nursing school exams are knowledge-based, the NCLEX-RN tests application and analysis using the nursing knowledge you learned in school. You are tested on how you can use critical thinking skills to make nursing judgments.

Rebecca described the process in the following manner:

> When we arrived at the hospital, we were given a temporary nursing license good for three months. We had to take the NCLEX-RN before the end of the three months but we had to pass the TOEFFL first before we could take the NCLEX-RN. If we did not pass the TOEFL, we could not take the NCLEX-RN. If we passed the TOEFL, we had three chances in a year to pass the NCLEX-RN. If we failed the first attempt, we were demoted as a nursing assistant. If we failed all three attempts, we were deported back to the Philippines since we carry a working visa sponsored by the hiring hospital. If we passed the NCLEX-RN, then we were fully Registered Nurses in the State of Alabama.

The participants in this study were faced with a large number of obstacles that contributed to their feelings of isolation. The requirement of taking these two high stakes exams contributed to their feelings of isolation in two very crucial ways: time constraints and mental, emotional, and physical stress.

The time demands placed upon the new Filipina nurses was immense. The participants were working 40-60 hours per week in the hospital. Additionally, most of them were working the third shift, 11PM-7AM and weekends. When not working at the hospital, an enormous amount of their time was spent trying to find out where essential services were located and to get to and from those services without a car or any form of effective transportation. There was not much time left for any additional activities, but what time could be squeezed out of such a difficult schedule had to be devoted to studying for TOEFL and for NCLEX. Lydia summed up the

sentiment for the rest of the participants when she said, I have to steal time from some place in order to study for the exams and the only place was sleep. We were sleep deprived until we passed both TOEFL and NCLEX-RN. Enduring such a rigorous and exhausting schedule would challenge the strongest of wills. Most of the participants chose to view the situation as a challenge to be overcome rather than as a burden to bear. Many of the participants actually reflected back upon the first three months of their stay with fond memories. Monica said, "It was a time when I learned to multitask." Yolanda said, "It was a time when I gained an immense amount of knowledge about time management." Corazon said, "It was a wonderful experience because it strengthened my determination and became more resilient that I previously did not possess."

The participants put a good face upon their experiences but all of them acknowledged that the experience of having to work full time, work overtime for extra money, and to study full time for these two high stakes exams took a toll on them. The Filipina nurses explained that running the gauntlet of work, study, and exams took a mental, emotional, and physical toll on them. There was an immense mental strain that each of the participants was forced to endure. Juggling the mental responsibilities of work, patients, and cultural acclimation were difficult in themselves, adding to these mental responsibilities.

Intimidation Experienced by Internationally Educated Filipina Nurses

A second experience that was commonly expressed by the nurses who participated in this study was intimidation. The forms of overt intimidation took the following forms: impatience, rudeness, mockery, stereotyping, sexual harassment, and professional punishment.

Impatience took a number of different forms. Most incidents of impatience seem to revolve around cultural and linguistic factors. Three incidents of impatience stood out from the

data and merit inclusion on this report. All three incidents involved an interaction between a Filipino nurses and medical doctors. All three incidents involved some form of cultural and linguistic misunderstanding.

The first incident of impatience was experienced by several of the participants in the study. Yolanda's account of the experience was more dramatic and detailed. Yolanda was taking care of a post-operative patient. The surgeon came to the nursing unit to visit the patient, the surgeon asked Yolanda,

> What is the patient I&O?" Yolanda was slow to respond because, at that time, she did not understand the meaning of I&O. Later, she came to discover that I&O meant "Intake and Output." Yolanda said, "Before I could respond he threw the patient's chart toward my body. I started to cry and ran to the bathroom." Later, the supervisor instructed Yolanda to write up the incident report describing what had taken place. Yolanda followed the instructions of the supervisor but later given a reprimand by the hospital. One of the other nurses explained to Yolanda that "the doctors received priority and that she "needed to respond to him as quickly as she can because they all think that they are "God" and our "bosses" even though she might think he is in the wrong.

The second incident of impatience concerned a phone call at 3 o'clock in the morning regarding the condition of one of the patients. On one shift, Elly was taking care of a post-hysterectomy patient. The patient was complaining of having "too much gas." The patient had not been prescribed any medication for gas pain. Elly called her gynecologist at 3AM and told him about the patient's complaint. The gynecologist screamed at the top of his voice into the phone "what the hell are you talking about?" Elly responded, "I am not talking about hell." The

gynecologist slammed down the phone. Elly asked the supervisor what she should do and the supervisor said that she should call him back again. Elly recounted.

> I was so nervous, I was actually perspiring and my heart was beating so fast. I called the doctor again and he said, "Leave me alone or I am going to get you fired." Elly stated. "I went to the break room and cried. I was so frustrated. I just wanted to go back home and never return.

Elly reported this incident to the supervisor and the supervisor instructed her to write up an incident report. Elly followed the instructions of her supervisor and wrote up the incident. Elly recorded every word that transpired between her and the gynecologist. She was scrupulous not to leave out a single detail. Elly was called to the Director of Nursing's (DON) office when she arrived to work the next day. She was told that the doctor had reported her for calling him twice in the middle of the night and not giving him enough detail concerning the patient's condition. Ultimately, Elly was found to be at fault in the incident and learned the same sad lesson that Yolanda had learned, that doctors were always right.

The third incident of impatience involved a phone call placed to a doctor during the middle of a University of Alabama football game. In a very crucial point in the game, the doctor received a phone call regarding his patient at the hospital. The physician was not too happy about the interruption. The disturbance involved a participant in the study named Lydia. Lydia was scheduled to work the 3-11 shift on an autumn Saturday. When she arrived at the hospital and started her rounds she discovered that one of her patient has undergone surgery earlier that day. The patient had a chest tube. When Lydia entered the room to assess the patient, it was obvious that the patient was having respiratory distress. Lydia was panicked because the patient was having extreme difficulty breathing. Lydia said,

> I picked up the phone immediately and called the physician, I waited on the line for what seemed like forever. The police at the stadium had to summon the doctor, when he answered the phone I could tell that he was agitated. He screamed into the phone and told me that he was in a stadium watching a football game and slammed down the phone.

Lydia reported this incident to her supervisor. The supervisor went to the patient's room to assess the patient's condition. The supervisor felt the patient's condition merited another call to the surgeon so she instructed Lydia to call him again. Lydia placed a second call to the physician and told him the patient's condition was deteriorating. Lydia asked the physician if she should call another doctor since he was attending a football game. According to Lydia, "the surgeon hung up the phone without saying a word."

The supervisor instructed Lydia to write up an incident report after the Emergency Room physician came to see the patient and ordered treatment and medications. The supervisor warned Lydia that the doctor would probably report her to the DON. When Lydia arrived at the hospital the following day, the DON called her into her office and they discussed what happened the day before. The DON told Lydia to be respectful when talking to a physician. Later, Lydia saw the physician making rounds in her nursing unit. She had a conversation with him,

> I was your patient's nurse yesterday and I was the one who called you twice while you were watching football. Do you want me to do nothing while your patient is unable to breathe? Do you want me to let your patient die? If you know that you are going to a football game, you should ask one of your peers to cover for you. You have your malpractice liability and I have my own liability, but I don't want to be sued for not doing my nursing responsibilities. Lydia reported, "in response to my words, the doctor simply turned and walked away without saying a word."

This story has a more equitable ending. Lydia reported that the physician came to speak to her on the next day. She said "The physician apologized to me for his behavior and stated that he respected my decision-making skills."

The second type of intimidation revolved around what the participants described as "rudeness." Acts of rudeness fell into two categories and were characterized by a manner of address or lack of address. Every participant in this study without exception indicated that doctors, co-workers and other healthcare team addressed them by simply calling out their last name. Feliza commented, "It made my skin crawl every time I heard someone bark out my last name." Cora explained the circumstances in the following manner:

> In the Philippines it is considered a common courtesy to address friends by their first name. It is also a custom of politeness to address strangers, people with title, older people, and people with authority by their last name with salutations such as Mrs., Mr., Miss, Doctor, Judge, Sir, Reverend, etc.

The participants in this study considered it demeaning to be addressed solely by their last name. Another custom of politeness that Filipinos do not use is calling someone "Hey, come here" and "waving your finger like calling a dog."

A second example of rudeness revolved around a lack of address. Once again, every participant in this study experienced what they considered to be an act of rudeness. Dawn explained the situation eloquently:

> When the American doctors came into the hospital to make their rounds they would ask the American nurses about our patients. They completely ignored our presence and they gave this perception that they don't like to talk to us. The American nurses would ask me

about my patients; I will give her all the information she needed and then, she will relay all the information to the doctor. This really irked me and it became a normal occurrence.

After few months of this practice, Cora stated,

> I confronted the doctor why he refused talking to me about my patients. I told him that I am capable of giving him all the information he needed. I also told him that starting today I will be making rounds with him. I picked up all his charts and I walked beside him on our way to the patient's room.

The other participants in this study stated that they feel so intimidated and they do not have the courage to confront the doctors.

A third act of intimidation is categorized as "mockery." Mockery took two forms in the data. One form of mockery was linguistic and the other form of mockery was culinary. The participants in the study were not native speakers of English. The participants spoke English fluently and understood English grammar impeccably; however, their pronunciations of certain words and their speech rhythm was dramatically affected by their native language, regional dialects, and accents. This resulted in a difficulty of understanding. On many occasions, the Filipina nurses were asked to repeat what they had spoken. This request for repetition resulted in a demoralization. Corazon commented, "In the Philippines everyone understood me when I spoke English, I never had to repeat what I had spoken." Dawn listed a number of words that her co-workers and people in the community could not understand when she spoke them. That list included the following: hemoglobin, Robitussin, panty, sheet, Riboflavin, urine, popliteal, pituitary, beach, maintenance, ask, often, cardiology, pediatrics, Martin, Horton, Patton, insulin, invalid, broccoli, hanger, delicacy, delicatessen, bank, diapers, diarrhea, tamponade, yes mam, Marietta, cemetery, category, and others.

Another form of intimidation that the participants in this study shared was difficulty understanding patients, co-workers, and other members of the healthcare team. Idioms and slangs words were difficult for them to understand. Corazon and the other participants shared the list of words or comments that were difficult to understand:

> over yonder, he went left field, my get up and go is gone and went, I&O, hot high and hell of a lot, fair to middling, poke, slap jar, hunky-dory, raining cats and dogs, raincheck, BYOB, basket fruit turnover, ain't, I've done done it, branch, Tom-Dick and Harry, you are such a ding bat, she's a scattered brain.

Fe recounted an incident when she went into a patient's room and the Black patient started shouting that he needed a "slap jar." Fe had no idea what the patient was requesting. She went back to the nursing station to ask her co-workers what a "slap jar" was, they all stared at her and did not say anything. She went back to the patient's room and it was too late when she discovered that the patient urinated in his bed already.

> A "slap jar" is a urinal. Fe stated, "My co-worker found the incident to be very funny. Instead of making fun of me, they could have helped by telling me what the patient need was. I was very embarrassed.

A similar incident happened to Juliet. An obstetrics (OB) patient was being discharged. Her husband came to the nurses' station and told Juliet that he needed a "poke." She told the man that she did not understand what he was saying. He repeatedly asked for a poke and became agitated and walked away. Juliet confided,

> The whole time he was asking for a poke I could hear some of my co-workers laughing and giggling in the background. They could have told me that a poke was a brown paper bag but they were having too much fun laughing at my expense.

A final example was recounted by Remedios. She was admitting a patient who was scheduled for surgery. She asked the patient if he had brought his medications from home. He told her that they were "over yonder." Remedios asked the patient again where they were several times but he kept repeating "over yonder." Remedios left the room and went to the nurses' station to find out what "over yonder" was. No one would tell her what the expression meant. However Remedios said, "I could tell from the expressions on their faces that they knew the answer to my question. They just enjoyed laughing at my consternation."

Another source of comical amusement that came about at the expense of the Filipina nurses revolved around their food. In the Philippines, participants mentioned that fish, and vegetables were staples in their diet. Because they were on a limited income and could not go to the grocery store on a regular basis, the participants brought their food to the hospital and heated their meals in the breakroom during their supper break. The fish and sauce they ate carried a very pungent smell whenever they heated it in the microwave. The smell permeated the atmosphere in the break room and often seeped out into the hallways of the nursing unit. This became a source of jokes and humiliation for the American nurses and co-workers. Monica and Rebecca both confided that they were often greeted with comments such as "your food stinks" and "how can you eat that food that smells like feces?" Many of the participants mentioned that the supervisors received so many complaints that they were eventually told not to bring food from home. They were instructed to eat their meal in the cafeteria. Many of the participants stated that their co-workers exaggerated the smell of their food. When our co-workers heat their food and create pungent smells, we never complain. Rebecca stated, "They were so mean to us."

A fourth act of intimidation is characterized as stereotyping. The stereotyping the participants encountered took three forms. The first form was an educational stereotype, the second form was a cultural stereotype, and the third form was a moral stereotype.

The educational stereotype took the form of a condescension. Because the Filipina nurses were from a "third world" country it was assumed that the Filipina nurses were less educated. It was assumed that their educational training must have been beneath the level of training the American nurses received. Also, it seemed to be assumed that people from a "third world" country must be dumb--innately less intelligent than the people from the United States of America. This was the impression the participants received based upon the way they were treated by American doctors, nurses, and co-workers at the hospital where they worked. The following evidence was given in order to substantiate their perception.

Monica mentioned that doctors would talk to the American nurses about her patients rather than talking to her. She was under the impression that the American doctors did not trust her judgement. Dawn encountered similar experiences. Dawn assumed that the American doctors, nurses, and co-workers did not respect her opinion. Rebecca mentioned,

My supervisor constantly asked other nurses to recheck my work to see if I made any mistakes. Since they were not rechecking any of the American nurses' work, I was left to conclude that they were suspicious that I did not know what I was doing.

Many of the participants in this study reported a cultural stereotype, which they considered demeaning. The participants were repeatedly asked if they were married to a G.I. Feliza offered the following example and her perception of that experience;

> Some of my co-workers and patients assumed that I was married to a G.I. I did not even know the meaning of the word G.I. I was talking with some of the Filipina nurses one day

and I told them about this comment, one of them told me that it was very demeaning comment because G.I. was a term used for low -class, unmotivated soldier. I was embarrassed and highly offended by this stereotype.

The cultural stereotype was that women from third world countries would see an American soldier as gullible and easy to manipulate into marriage. One person told Fe that the stereotype was "these women see American soldiers as an easy meal ticket and a free ride to a prosperous country where they could enjoy the fruits of other people's labor."

A third stereotype was of a moral nature. Many of the participants in the study indicated that they were referred to as a "Filipino Baby." Lydia offered her experience with this term. "When I entered the patient's room, patient would say "Here is my Filipino Baby." Their wife or their family members would ask me what was meant by "Filipino Baby" and I would tell them I did not know. Actually, I did not know what the term meant when I first arrived. The term originated when the American soldiers were stationed in the Philippines during World War II and till the American gave us our Independence in 1946. On their day off, the soldiers would go to this place in the Philippines and pick up women who were prostitutes. They would pay them for sexual favors and tell these women that they owned them. These women prostitutes came to be known as "Filipino Babies." The stereotype was that these Filipina nurses must be women of loose moral values, perhaps because they facially resembled the prostitutes the American service men encountered when they had been stationed in the Philippines during World War II.

The three stereotypes served as a strong intimidating factor for the participants in this study. Perhaps the reader can place themselves in the position of the participants for a moment. Can you imagine how intimidated you would be if you experienced a similar scenario? You are in a foreign land thousands of miles from your home. You are homesick and working an

exhausting schedule. You are under the pressure of studying for two high stakes examinations, which you have to pass within the next there months. You do not have a car, you do not know how to drive, and getting from place to place is a monumental obstacle. When you speak people do not understand you. Add to all of these hardships the fact that people think you are dumb, people think you are a conniving individual who takes advantage of gullible men, and people think your moral character is at the level of a prostitute. Then, you will have some idea of the level of intimidation that was experienced by the participants in this study.

A fifth act of intimidation was what could and perhaps should be considered "sexual harassment." The participant did not mention any overt acts of sexual harassment such as groping or propositioning. The sexual harassing was more subtle. Several of the Filipina nurses indicated that certain doctors and male co-workers would put their arm around their shoulder while talking to them. Another example was extended physical touching that went beyond the appropriately expected time limit. Elly noted, "The doctors did not do these actions when they interacted with American nurses or female co-workers." Yolanda addressed this subject with the following words:

> At first I thought it was a cultural custom, I thought perhaps this is the way people interact here in the USA. Once I noticed that we were the only one receiving this treatment, I felt very intimidated. I had already learned that the doctors were the most important people at the hospital. I had learned that if there was a dispute between a doctor and a nurse, the hospital administration would always side with the doctor. Should I report this behavior or complain about it? I found myself in a very difficult position.

A sixth act of intimidation can be best described as "professional intimidation." Professional intimidation was comprised of five specific actions. The first action was an overt

and intensifying scrutiny. The second act involved misinformation. The third act was belittling. The fourth act was bad evaluations, and the fifth act was linguistic oppression.

Most of the participants reported that they had been subjected to what can be described as overt and intensifying scrutiny. Corazon reported that she felt constantly "under the gun." She commented,

> I perceived that my co-workers and my supervisors were constantly combing through every little thing that I did. They seemed to be looking for any tiny mistake that I made. When they discovered a small mistake they seemed to be joyful about the opportunity to scold me about it. When they could not find a mistake they seemed to invent a mistake and accused me of something that I had not actually done. I did not see them treating the American nurses in the same way.

A second act of professional intimidation is best described as "misinformation" or perhaps misleading information. The participants in the study would ask for information the American nurses and the co-workers had and they all would "play dumb." We have already mentioned how the American nurses and co-workers would pretend that they did not know the meaning of idioms like "slap jar," "poke," and "over yonder." On other occasions the participants were certain that they had been given incorrect information by the American nurses and by their co-workers. When they made errors, the American nurses and the co-workers would deny they had given misleading information. Remedios explained the situation in the following way:

> I did exactly what they told me to do and when I got reprimanded they denied that they had told me the wrong thing to do. They said that my English was not good and that I had misunderstood the information they had given me.

Yolanda was certain that she had received the same experience as Remedios. She summed up the experience in the following way, “I felt like I was being set up for failure.”

The third act of professional intimidation is best characterized as “belittling.” We have already mentioned that American nurses and co-workers mocked the pronunciation and the lack of understanding of southern accents as well as idiomatic expressions. We also mentioned the mockery concerning the food participant brought to work. There were a number of other acts with the American nurse and co-workers committed in order to belittle the participants. Juliet captured the experience with the following words:

> American colleagues asked me to repeat what I had just spoken to them but they did it in the type of voice they would use if they were speaking to a child. I felt humiliated and it made me very angry. It was apparent to everyone that they were trying to make me feel inferior to them.

A fourth act of professional intimidation concerned “bad evaluations.” The Filipino nurses were subject to the supervising nurse. The threat of a negative evaluation, or a bad write-up, or denial of a raise was always hanging over the participants’ heads. There were a number of discriminating activities that were imposed upon the Filipino nurses. These activities will be discussed in the next section of this document. For the moment it will suffice to recount an incident which was given by Rebecca:

> I was given a bad schedule. I was required to work the 11-7 shift, weekends, and holidays. Once I complained to my supervisor she gave me a negative write-up that I complaint a lot. She said, I was uncooperative and always complaining. I got a reprimand from the DON. The supervisor gave me a negative evaluation and I was never approved for a raise in salary.

The experience of Rebecca was echoed by a significant number of other participants in the study.

The fifth act of professional intimidation took the form of linguistic oppression. The participants in the study indicated that they were required to speak only English while on the premises of the hospital. This requirement extended to the break room during their supper break and also to the times when they were technically off-duty but still on the hospital property. Fe mentioned an occasion which was evocative:

> Once I was in the breakroom with another Filipina nurse, she did not understand an English word that she had been hearing a lot. I tried to explain what the word meant in English but she did not understand. I explained what the word meant in Tagalog. An American nurse reported us to the supervisor that she heard us speaking in our language. The supervisor gave us a negative write-up and we both received a reprimand from the hospital.

This form of professional intimidation cast a feeling of paranoia over the participants and brought a feeling of what Cora described as "A paralyzing sensation which caused me to hesitate before speaking a word in case I might slip up and say something that was not in English."

Discrimination and/or Marginalization Experienced by the Internationally Educated Filipina Nurses

After coding the data, two particular themes emerged which were labeled as "discrimination" and/or "marginalization." After a thorough examination of these two themes it became apparent that there was a large overlap in the data which contributed to the explanation of both of these themes. After further scrutiny it became evident that when the participants used the word "marginalize" they were referring to a position in which they found themselves. When the participants used the word "discriminate" more often than not, they were describing overt acts that led to their marginalization. The participants used a number of phrases that

characterized their position of being marginalized. For example, Feliza made the comment, “On many occasion I felt like I was not being taken seriously by the doctors, nurses, and other co-workers.” Monica commented, “I felt like I was being treated like a second class citizen.

Some of the acts that contributed to the marginalization of the participants have already been mentioned in the previous sections of isolation and intimidation. Acts such as mockery, undermining, being addressed by last name, and negative stereotyping all contributed to the marginalization of the Filipina nurses who took place in this study. For these themes we have decided to present three specific types of discriminative behavior that contributed to the marginalization of the participants in the study. Those types of behavior fall into the categories of scheduling, patient assignment, and passive aggressive behavior.

When the participants arrived in the USA they were, as Lydia described them, “naïve and just happy to have a job working at a hospital in the United States.” The supervisor and unit manager were in control of assigning nurses to work either the 3-11 or 11-7 shift or alternating shift and were responsible for the work schedule. After a period of time the Filipina nurses discovered a number of differences in their schedules. In order to get a vicarious experience of what the participants encountered I will let Cora explain the situation:

> After working for six months I noticed that I’m always being scheduled to work 3-11 for two weeks then 11-7 the next two weeks. I cannot develop a sleeping pattern and it was affecting my bodily function. I was never assigned the 7-3 shift not unless someone called in sick or on vacation. I noticed that my weekend off was reduced to one weekend a month instead of the every other weekend off and I was scheduled to work every holiday. I noticed that the other Filipina nurses were being given these same unfavorable schedules. I went to the shift supervisor and to my unit manager and asked them why I

was always getting these difficult shifts and working all the holidays. They both told me that I was not married and did not have children. They also mentioned that I was from another country and did not have family in the United States. They told me that the American nurses had children and needed to pick them up from school in the afternoon and to be with them in the evenings. They also told me that the American nurses needed to be able to travel and visit relatives during holidays or celebrate holidays with their children.

Not only did the participants mention an unfairness in scheduling but they also felt like they were subjected to a manipulation of scheduling. Elly recounted the following incident:

> I showed up for work one day and was informed that I was not scheduled to work on that day. I thought to myself "how could I have made such mistake?" I looked at my schedule and it said I was scheduled to work on that day. Then I compared my written schedule to the master schedule which was located in the nursing station bulletin board. My name was listed on a day which was different from the days I had on my schedule. I noticed that the name of the American nurse was in the slot where my schedule had my name recorded. When I asked my unit manager for an explanation the unit manager told me that the American nurse had a conflict and she had to switch our schedule to accommodate her need. She told me that the American nurse had a family matter she had to take care of and since I did not have a family it was easy for her to switch my schedule. I asked her why I was not consulted in the matter and she told me that scheduling was at her sole discretion. She told me that she could switch or rearrange any nurses' schedule without consulting them or anyone else. The next day I discovered that she had given me a negative write-up. She stated in her write-up that I was very

"combative with regard to the schedule." She never considered that it cost me my transportation to and from the hospital and she never considered that I have to alter my sleeping pattern again.

Another form of manipulation was reported by the other participants. This manipulation involved fellow nurses and can best be described as peer-to-peer manipulation. Once again, when the participants first arrived in their new place of employment they described themselves as "young, naïve, and overly trusting. Elly summed up their perception when she said, "I trusted everyone and never expected that anyone would lie to me or take advantage of me." Monica shared an experience that also applied to many of the other participants in the study. She said,

> During the early days when I first arrived at the hospital I was not 100% clear on what my specific responsibilities were. My classroom and unit orientation was brief since they needed me to help staff the medical/surgical nursing unit. So I asked several of the American nurses about what I needed to be doing. They told me a number of activities which were my responsibilities like assist with their patient's admission, start intravenous (IV) treatment, administer patient's pain medication when needed, clean patient's room, and other task as indicated. When I am not attending to my patients, I found myself admitting their new patients, starting their IV, giving their patient's pain medication, inserting Foley catheter, inserting nasogastric tube (NGT), while they were all sitting in the nurses' station socializing. When I was the one needing help, they were pretending they were busy and no one volunteer to help me. The shift supervisor was making nursing round one day and she saw me cleaning a patient's room post-discharge of my patient, the supervisor asked me what I was doing, I told her I was cleaning the patient's room. She told me that was not my responsibility that it was the housekeeping's task to clean

the room post -discharge of patient. When she told me this many things became clear to me. The nurses who were supposed to help me adjust to my working environment were taking advantage of me. Over the next few months, to my surprise, I discovered that five of the American nurses and some of my co-workers had lied to me about my responsibilities. Essentially they had manipulated me into doing most of the jobs for them.

A second form of discriminative behavior can be classified under the category of patient assignment. The Filipina nurses were not only given the most difficult work schedules but they were also given a disproportionate number of patients who were very sick and take a lot of time and energy to take care of them. Remedios noticed that she was "always assigned more patients with high acuity," meaning the patients need total care and cannot help themselves to do anything.

Another form of discrimination involved certain patients. Dawn made the comment "that White patients, especially the females, refused us to take care of them." Fe had a similar experience. She confided that "some rich white patients told the hospital administrator that they did not want to be attended by any of the Filipina nurses." The participants did not mention whether they considered these refusal of services were racially motivated or undermining the skills and knowledge of the Filipina nurses. However, considering the circumstances I would consider that the refusal of services was at least partially due to the racial component.

A third form of discriminative behavior is best described as passive aggressive treatment. Many occasions required nurses to work together in teams. Lydia reported that there were many occasions when the American nurses refused to participate on a team if she or any of the other

Filipina nurses were on the team. Juliet gave an account of how some of the American nurses refused to cooperate with her by employing a passive aggressive strategy:

> The Licensed Practical Nurse (LPN) assigned with me was much older than I was and refused to accept me as her team leader. We were supposed to check every patient's medication cards and match them on what was written in the Kardex. The LPN would always say, "I can do this task by myself, I don't need your help." Lydia insisted that they have to do the procedure, the LPN threw all the medication cards on the floor and walked away.

There were 60 patients in the nursing unit that I was assigned to work, each team consisted of one RN, one LPN, and one nursing assistant and we were responsible for 20 patients. The two RNs on the other team hardly talked to me except when they wanted me to do something for their patients. They made me feel like I did not deserve their respect.

Another form of passive aggressive behavior took the form of "hiding." Many of the participants experienced this form of discrimination. Yolanda related an example of this in her interview:

> There were two other staff assigned to my team, one LPN and one nursing assistant who seemed to be always unavailable when I needed them. On several occasions I looked everywhere for them but could not find them. I asked my other co-workers if they have seen them and they just ignored me. Instead of wasting my time looking for them I ended up doing their assigned tasks and this added to my workload. When they finally showed up in the nursing unit, I asked them where they have been they always had some convenient excuses that seemed plausible. However, their chronic disappearances seemed to be too frequent which added to my workload, frustration level, and increased

complaints from my patients. I finally reported them to my shift supervisor. When the shift supervisors confronted them, they both denied their disappearing act instead they both started complaining that it was too hard working with me because they cannot understand the assignment I was giving them and they cannot understand when I am communicating with them. I told the supervisor that I will not be able how to correct their complaint if they will not tell me directly. The other two RNs in the nursing unit never experienced this problem. I kept thinking that the two American RNs working in the nursing unit with me will not tolerate this kind of behavior with their co-workers. I tolerated a lot because I felt like they would file a complaint against me if I confronted them. I also felt like the supervisor would blame me and give me a negative evaluation.

Research Question 2

The responses of the participants concerning their experiences with respect to transitioning to the USA were considered in formulating their responses to the second research question. The participants were asked one specific question: "Utilizing all your lived experiences, tell me how and what can you contribute in the development of transition programs or in the enhancement of existing transition programs for newly hired Filipino nurses and for future internationally educated Filipino nurses who will migrate to the USA to join the nursing workforce?"

The participants encountered a number of difficulties when they arrived at their destination, which occurred in their living environment, community setting, hospital settings, and education. Many of these difficulties contributed to their isolation, intimidation, discrimination, and/or marginalization. The list of recommendations includes the following:

a) Pre-Arrival Orientation: the recruiting and travel agencies should initiate the transition program using technology like video presentation showing a picture of the hospital, location description (urban, suburban, rural), type of hospital (inpatient, outpatient, ambulatory clinic, urgent clinic, psychiatry hospital, mental retardation hospital, nursing home, rehabilitation hospital, etc.), number of beds, scope of services, staffing, orientation process, benefits, transportation system, provide rental car in their contract, living arrangement, driver's license if needed, and paperwork for government requirements like social security number. The agencies should prepare hired nurses to pass the TOEFL, NCLEX-RN, and the driver's license while in the Philippines. The hiring hospital should send a welcome letter to the applicant, including job descriptions, government paperwork requirements, and include what to expect when she/he/them arrive in the USA.

b) Living and Community Orientation: the hiring hospital should appoint a liaison/coordinator who will pick up the nurses from the airport, take her/him/them into their living area, assist them in unloading their personal belongings, and assist them to identify what they need, such as utensils, cooking equipment, bedroom supplies, bathroom supplies, food, beverages, and other necessities. Drive them to the grocery stores and assist them in finding what they need, especially the food they normally eat in the Philippines. The community orientation should include location, distance, and access to the public transportation system, location of grocery stores--both American and Oriental--shopping centers, banks, city hall, post office, churches, federal building, immigration office, laundromat, parks, restaurants, and other locations of necessity. Assist in identifying what church they will be attending and arrange to meet the priest, the pastor, or the church leaders. The participants encountered a number of difficulties that occurred within the community setting. Many of these difficulties contributed to

their experience of isolation. The participants also mentioned modes of transportation such as bus route, distance to work, taxi service, and the process of purchasing an automobile, and getting a driver's license. The lack of knowledge concerning the location of central services and central places for purchasing necessities caused a serious amount of stress among participants in the study. Feliza summed up this feeling adequately when she said,

> Not knowing where things were located might not seem like a dramatic problem to some people, but for us it was more problematic. We had a lot of obligations at the hospital and we were far from home. We were homesick, isolated, and worried about integrating into the various contexts which surrounded us. On top of this obligations we had to worry about what we were going to eat, how and where we were going to get to the store, how we can go to the federal building to apply for our social security number. All these logistics issues were like the straw that broke the camel's back.

The participants in the study encountered a number of difficulties that were related to their living arrangements which contributed to their experience of isolation. The participants did not have any idea about the cost of living in the United States. Elly said,

> I was amazed when I saw the amount of money I was going to make especially after I converted the dollar to pesos. In one month, I will make the same salary I would make in a year in the Philippines. Once I saw that number I did not bother to ask any further questions, I just said, "Sign me up for the job." When I arrived I discovered that a certain amount will be taken out from my salary to pay for taxes and for my plane ticket. I have to pay for my monthly expenses like my apartment, utilities, transportation, groceries, and my parents were expecting me to send them money every month. I was in a panicked

after I realized my monthly expenses. The recruiting agency should include all this information in their video presentation.

Procuring public services was another difficulty that the participants in the study had to overcome. Yolanda said,

> When I arrived in the apartment that the hospital got for me to rent, I had no water, no electricity, no gas, and no active telephone line. Eventually I found out that I have to go to each service department, request for each service to be connected, and to pay a deposit. The Human Resources director was with me and he saw me crying. I told him that I didn't have enough money to pay for deposit that was required to turn on the services I needed. He paid for the deposit and he told me to pay him on my first pay check. I got everything connected but it was a very stressful process.

This stressful and difficult process was experienced by every participant to one degree or another. The participants recommended that this information should be included in their pre-arrival orientation by the recruiting agency before they arrive in the United States and possibly compile a manual which the newly hired nurses can carry with them.

A second issue that was emphasized by the participants concerned transportation. The participants stated that at least 90% of people in the Philippines do not drive and do not own an automobile. Fe suggested that future nurses be given orientation on availability of transportation, location of bus stations, schedules, routes, and cost. Better yet, the recruiting agency should provide a two-year car service on a rental basis to the hired nurses, provide training how to drive, and help them secure a driver's license while in the Philippines. Orientation should also include information on private transportation such as taxi services. The participants should be instructed on how to hire a taxi and be given information concerning how much they should expect to pay

for a typical fare. Many of the participants were late for work because they did not understand how the taxi system worked. Cora said, “I was late for work on my first day because I did not realize you have to call the taxi two hours in advance.” Several participants were suspicious that taxi drivers had taken advantage of them. Feliza noted, “I took a taxi to work several times, the fare was different on every occasion and on one occasion that fare was twice as much as it had been on any of the other trips.” Monica shared the following story:

> On one trip I got the impression that the taxi driver was just driving around in order to increase the price of the drive. It took a long time to arrive at my destination and the fare was a lot higher than it seemed like it should have been.

The participants realized that public transportation and private transportation information was not the long-term solution to the problem they were facing. Many rural areas in Alabama do not have any form of public transportation and the cost of private transportation is prohibitive. Corazon described the problem in the following way:

> After two weeks of taking a taxi to and from the hospital I realized that I have spent most of my salary for that month. I had to get a loan from the hospital credit union in order to pay my bills and buy groceries for the rest of the month.

Rebecca had the long-term solution to this issue. She said,

> Transition programs need to set up a system where Filipino nurses are taught how to drive and instructed how to obtain a driver’s license in the town where they are going to work. The recruiting agency should provide at least two years of car rental to the newly hired nurses.

c) Hospital Orientation: should include introduction to the staff and providers that includes physicians, physician assistants, certified registered nurse practitioners, residents, and

the hospital management team. The participants felt that early introduction to this group of people would improve the problem of intimidation. Lydia felt that much of the animosity and the intimidation she experienced was because she was not acquainted with fellow nurses and doctors on a "personal" level. Cora said, "I think if we spent some time getting to know our colleagues on a personal level a lot of the animosity and intimidating behavior would be removed from the workplace." Juliet said, "When you know a person as a friend it is difficult to be rude to that person." Hospital orientation should include tour of whole facility to acquaint us where departments are located like the Radiology department, Laboratory, Cardiac Catheterization Lab, Pharmacy, Nursing Department, Human Resources, Emergency Department, etc.

The hospital classroom orientation should include hospital mission, vision and values, job description and expectations, benefits, explanation of salary with deductions, health insurance benefits, language lessons, shift assignment, and off days. The participants felt that clarifications of job descriptions and expectations, would mitigate much of the discriminating behavior they endured. Dawn captured this sentiment appropriately when she said, "If I had a clear description of what my job required, I would have not found myself being manipulated into doing other staff's job for the first nine months of my employment."

d) Clinical Orientation: should include an assigned preceptor during the duration of the orientation for consistency and to develop rapport with each other, introduction to other members of the staff, and to assign new hires to nursing units where they have experience and expertise. The participants felt their transition would have been smoother if they had been assigned to nursing units where they had experience and expertise. Yolanda commented,

> My training and experience had been in surgery and I was assigned to end of life care. I had very little training or knowledge of end of life care. I was having to figure things out

on a day-to-day basis. I felt like I should have been assigned to a surgery unit. If the hospital wanted me to work in end of life care I should have had a training period so I could have been able to better perform the tasks which were required of me.

e) Education Resources: the participants in the study encountered a number of difficulties that can best be categorized as educational issues. Many of these difficulties contributed to their experiences of isolation, discrimination, and marginalization. The list of recommendations included preparing and taking the TOEFL and the NCLEX-RN while in the Philippines, learning how to drive, phonetic instruction, comprehension training, and cultural orientation.

The TOEFL and the NCLEX-RN examinations are two high stakes tests that were very time consuming and very stressful. The participants were required to invest "every waking hour when they were not working to study for these two tests. This requirement served to further isolate the participants because it reduced the available hours in which they could socialize. If the newly hired nurses passed both examinations while in the Philippines, this would remove the burden and stressful use of time once they arrived in the United States. If taking and passing these high stakes examinations is not possible prior to arrival, several participants had alternate recommendations. Elly suggested that resources be made available for participants to prepare for these examinations. Remedios reflected on her experience:

> There were no study books available to us. I went to the university library and discovered that there were books to assist in preparing for the exams; however, they were all checked out. So I had to go to the campus bookstore and order these books. It took two weeks for them to arrive and they were very expensive.

Rebecca recommended that tutors be made available for participants in order to help them learn the most effective strategies for preparing and taking these exams.

Participants recommended linguistic assistance. There were two types of linguistic problems that confronted the participants. One involved pronunciation and the other issue involved comprehension. Both of these issues contributed to the experiences of isolation and intimidation. Not understanding different accents, idioms, slang, and not being understood by native speakers caused many of the participants to retreat into a personal as well as social shell. Not understanding slang and the local meaning of certain words opened the participants up to a certain level of mockery and ridicule. Lydia had a recommendation which covered this issue:

> Future nurses who come to the United States from the Philippines or any other non-English speaking country need to have a person who can help them in these areas. This person needs to be trained in the area of applied linguistic. They need to teach the nurses how to pronounce their words in a way that local people will understand them. They need to teach the nurses to speak with a rhythm that will be comprehensible to the local residents. They need to teach the nurses how to follow the speech patterns of the local people and also learn how to pronounce their words. This person needs to teach the nurses the meaning of slang expressions and the technical meaning of words which are different from their traditional meaning.

Participants recommended a certain type of cultural orientation. Juliet told of an occasion when she and two fellow nurses were approached by two male nursing aides who offered to sell food stamps for cash money. The two male nursing aides told the Filipina nurses that they needed cash to buy milk, bread, and diapers for their child. Because of their compassionate nature, the Filipina nurses gave the two nursing aides their cash money in exchange for the food

stamps. The grocery staff had become acquainted with the Filipina nurses, when they attempted to pay for their groceries using the food stamps, the cashier called the store manager. The store manager took the three nurses in his office with a security guard. The store manager informed them that it was illegal to sell food stamps and to buy them from a recipient. He further explained the law to them. The three nurses started crying and were very upset and they all handed the store manager the food stamps and left the grocery store empty handed.

There was a large number of incidents mentioned by participants in which a lack of understanding of the local culture brought about embarrassment, ill feelings, or lack of propriety. Dawn summed up the feelings of the participants when she recommended that future newly hired nurses have a person, a liaison, or site coordinator who could teach them about local customs and the appropriate way of behaving so as not to unintentionally embarrass themselves or offend any of the people who live in the community.

All of the participants recommended to have a "go to person," a liaison, or a site coordinator that will be assigned to the newly hired nurses. This person will coordinate all of the recommendations suggested by the participants. Corazon described this person when she said,

> It would have been nice to have had a telephone number of someone I could have called and said, "Can you help me get my utilities connected? Can you help me find a used car with reasonable price? Can you assist me in finding an oriental store?" This person would be invaluable to the newly hired nurses who are going through the transition process.

Chapter Summary

This chapter described the research findings that were gathered by conducting semi-structured interviews with 12 internationally educated Filipina nurses who came to the United States in the early 1970s and before 2015. Using standpoint theory and cultural competency

theory and the power of storytelling, three themes emerged from data analysis of the Filipina nurses lived experiences related to socio-cultural differences, language barriers, and adjusting to a new living and working environment. The three themes were isolation, intimidation, and discrimination and/or marginalization. Several recommendations from participants were obtained on how their lived experiences contributed to the development of a transition program or enhancement of an existing transition program for newly hired internationally educated Filipino nurses who are joining the U.S. nursing workforce to help alleviate the critical shortage of nurses.

All participants in this study described their individual experiences that contributed to the feeling of isolation, which included living space; lack of public transportation; cost to commute to and from work; access to necessary services they needed; difficulty for native people to understand how they talk and difficulty for them to understand local people; shift assignment, which most of them worked 11-7 shift, with weekend off once every 3 weeks; preparing and studying for TOEFL and NCLEX-RN examinations; and the fear of not passing these two high stakes examinations

Data collected from all participants described their experiences with isolation, intimidation, and discrimination and/or margination, which contributed to feeling insufficient, less educated, and less trusted, unhappiness and the desire to leave their job, to go back home, or join their relatives in other states for a support system.

The data collected helped provide an understanding of their lived experiences and why they were so eager to provide recommendations to the development of a transition program or to enhance an existing transition program to improve the experience of these newly hired internationally educated Filipino nurses and for other future internationally educated foreign

nurses who will be joining the U.S. nursing workforce to alleviate the critical shortage of nurses in the United States.

CHAPTER V:

DISCUSSION, RECOMMENDATIONS, CONCLUSION

According to the Philippine Overseas Employment Agency, a vast majority of Filipinos are seen to dominate the field of nursing in the Unites States, with registered nurses (RNs) making the largest segment of the country's health care workforce. In the Philippines, an average RN commonly earns only around 5% of the salary that the U.S. can offer, with an average of P170,960 ($3,301) per year. From 2012 to 2017, 92,277 nurses left the Philippines in search of opportunities abroad (Robles, 2019).

A whole new generation of Filipino nurses is coming to America to seek educational and career opportunities unavailable in their homeland. This newest wave of immigrating nurses faces a more complex health care system and stricter immigration rules compared to their counterparts of 30-40 years ago. Many of the challenges, like adjusting to a new culture, language barriers, and the drive to seek a higher standard of living, have hardly changed at all. Filipino nurses' desire to leave their homeland in pursuit of the American dream is now, as then, understandable and even inevitable. There are not enough jobs in the Philippines for all the nurses who graduate from universities, colleges, and schools of nursing (Lowery, 2013). Today's new arrivals encounter a much more complex work environment than that of a generation ago, including new high-tech equipment, paperless medical records, increased regulation, utilization review guidelines, and disease management concepts, to name a few. Filipino nurses are considered a racial minority group in the U.S. Most of them are females who face unique challenges not experienced by males. They are new settlers who can speak English but have

difficulty understanding idioms, acronyms, and deciphering accents. They face new socio-cultural environments and have to adjust to their new living and working conditions. They are highly educated, skilled, and prepared to leave their country for better life and to support their family financially (Lowery, 2013).

The issue of isolation, intimidation, discrimination and/or marginalization and incivility in health care in any form, is its potential negative effect on patient outcomes. According to Hanks (2016), lateral violence is recognized as a threat to patient safety by the American Nurses Association (2015a), as well as a direct dissent from the nurses' code of ethics, the presence of lateral violence is unquestionable and its effects are felt by novice nurses and newly arrived internationally educated Filipino nurses in differing forms.

Internationally educated Filipino nurses recruited in the U.S. all expressed discriminatory experiences and also indicated that differences in race, gender, culture, and language place IEFNs at high risk for marginalization, minimal peer and superior support, unfair treatment, stereotyping, and even rejection by patients and peer. These claims were evident and supported by the lived experiences of 12 Filipina nurses who participated in this study.

Based on these findings, these data indicate that orientation for IEFNs may require formal orientation and informal support from the Filipino community put into place to help with their adaptation to socio-cultural differences and with their adjustment to their new living and working environment. The Filipina nurses found the adaptation process to their host country very difficult. It should be noted that the person who migrates encounters a new culture, a process called acculturation. As newcomers to a group, they need to make sense of their surroundings and to acquire the knowledge that would enable them to produce conduct that allows established members of the group to recognize them as competent. They also found themselves as outsiders,

meaning, they felt like they are not part of the community, and they felt oppressed and marginalized. They were trying to figure out why people in their surrounding act the way they do.

The desired outcome of this study is to develop a transition program or to enhance an existing transition program with the help and assistance of Filipina nurses who are presently working or who have retired from community hospitals here in Alabama using their lived experiences and with the help and assistance of a strong Filipino community. We hope that this transition program will help and assist the newly hired Filipino nurses to experience a better transition process as they join the US nursing workforce.

Discussion

Knowledge of what nurses do remains a mystery to some mainstream Americans. In 2015, nurses were still accused of carrying doctor's stethoscopes. The life-saving practice of clinical nurses somehow gets relegated to the duties of an angel of mercy whose purpose is merely to hold hands, serve as a shoulder on which to cry, empty bedpans, give shots, or take "orders" from physicians without any thoughts to the consequences of enacting those instructions. The cognitive abilities that are required for a nurse to notice subtle warning signs in a patient, whose condition would not be known to a physician who is not present unless the nurse makes him or her aware, goes unnoticed by public entities. In Coombs (2004) study, the primary focus of her research was the "way the knowledge and roles are used within the decision-making process in the delivery of care." Rounds are crucial sites for understanding how power and knowledge interact. Coombs found that both physicians and nurses used biomedical models of health and the associated knowledge of physiological systems in their response to the patients.

Coombs's observation of ward rounds documented that the domains of nursing knowledge were recognized only as peripheral issues.

To successfully acknowledge the legitimacy of nurses as valued members of the health team, we cannot ignore the social climate that allows isolation, intimidation, discrimination and/or marginalization, and lateral violence to persist in the space where nurses work. The experiences of nurses who perform care work must be recognized as important and these experiences used to create opportunities in nursing to make a safer, more efficient environment for patients and nurses.

Using qualitative data findings from the 12 nurse participants in this study, we begin to understand the relevance and importance of developing transition programs or to enhance an existing transition programs to assist the newly hires IEFNs and for future IEFNs migrating to the U.S to join the nursing workforce.

Research Question 1

How do internationally educated Filipina nurses describe their lived experiences as they transition to the U.S. nursing workforce?

How isolation, intimidation, discrimination and or marginalization experienced by Filipina nurses affected their transition process. Filipina nurses encountered a number of issues that interfered with their integration into the cultural context into which they found themselves thrust. Homesickness, communication barriers, undermining, mockery by their peers and time constraints to pass two crucial examination that will determined their future in the U.S. all contributed to isolation of the participants which resulted in feelings of loneliness, inferiority and helplessness. Aggression caused by doctor's behaviors, rudeness, stereotyping, sexual harassment, and being set-up for failure contributed to the intimidation of the participants, which

resulted in feelings of fear, reticence, and anxiety. Unfavorable work scheduling, unfavorable patient assignments, and unwillingness of their co-workers and peers to cooperate and accept them as team leaders contributed to discrimination and marginalization of the participants, which resulted in feelings of stress, being left out, and treated inferior.

Considering the significance of the work that nurses do and the effect that it has on humankind, it would be almost elementary to suggest that a certain level of expertise or competence should be expected of those who are registered nurses. The body of work concerns the way that authority is rooted in individuals' knowledge (a person's perspective) and the power that such authority can exert. Standpoint theory supports what feminist Sandra Harding calls strong objectivity, or the notion that the perspective of marginalized/and or oppressed individuals can help to create more objective accounts of the world. Through the outsider-within phenomenon, these individuals are placed in a unique position to point to patterns of behavior that those immersed in the dominant group culture are unable to recognize. The standpoint theory's most important concept is that an individual's own perspectives are shaped by his or her social political experiences. This theory gives voice to marginalized groups by allowing them to challenge the status quo as the outsider within (Spivak 2012). As new settlers in this country, the participants experienced trying so hard to be friends with their co-workers and to be accepted as one of their peers, better yet, to be one of their circle of friends. They worked very hard and they tried to do some of the tasks not assigned to them just to be accepted. They even volunteered to work for their peers during weekends and during holidays. They felt that they were always outside of the circle looking within. They felt the doctors, especially males, showed their dominance and made them felt inferior. Their feelings of inferiority changed whenever they were with their Filipino community.

Because IEFNs differ from U.S. trained nurses demographically and within their roles in the workplace, the possibility of not receiving the desired level of respect increases. They felt that their professional qualifications were not respected. These nurses felt they were assigned positions lower than their qualifications merited, resulting in perceived need for the IEFNs to prove themselves to their colleagues in order to gain respect and trust. All of these factors contributed to the feeling of isolation, intimidation, and discrimination and/or marginalization among the participants in their workplace and in the community.

Research Question 2

How can these lived experiences of Filipina nurses in this study contribute to the development and enhancement of transition programs in Alabama?

The responses of the participants to this questions were overwhelming with respect to transitioning to the USA by IEFNs. The recommendations were collected under the following: Formal recommendations includes orientations from pre-arrival to the United Stated to the time the Filipina nurses completed their clinical training. Informal training includes what the community of Filipino contributes to the adaptation and adjustment of newly arrived Filipino nurses and Filipinos in general.

Informal Recommendations

The Filipino-American Association of West Alabama was formed in 2010. The association is led by Filipino doctors, nurses, and their families who came in early seventies. Their main purpose is to provide assistance to new Filipino migrants in Sweet, Alabama and neighboring counties who came to work for the community hospitals, Mercedes Benz, Nucor Steel, and for Filipino students attending the flagship state university, community college, and private institution. There are other older Filipinos who are not members of the association but

volunteer to help the new migrants. The new migrants eventually become members of the association.

The Filipino community and the association provide a welcome party to introduce new migrants to their new community of Filipinos and Americans who are married to Filipinos, introduce them to new cultures and to their new surroundings. Other than the welcome party, the Filipino-American Association sponsors a July 4th, Memorial Day, and Labor Day picnic. Everyone is invited and each family brings their favorite Filipino dishes to share. They play games and socialize with each other. This is to bring our cultures and values within the Filipino community and to adapt to new cultures from America. They also sponsor Christmas and New Year's parties to celebrate the holidays and to cure homesickness.

The Filipinos are active members of their respective churches. Some of the Filipinos volunteer to work around the church and grounds for free. The Filipino association sponsors a Filipino night in their respective churches once a year. They cook Filipino dishes and invite all church members to socialize, mingle, and be part of their church community. The Filipinos also volunteer to work in the soup kitchen for indigent and low income members of the community.

When new nurses arrive in town, the hospital community director will normally touch base with the Filipino leadership group to let them know of their arrival. Some members of the Filipino community will volunteer to pick up the newly arrived nurses at the airport and help them settle into their new apartment. Some of the Filipinos will cook food for them and will welcome them with gifts like kitchen and bedroom supplies.

The community hospital appointed the Patient Representative as ambassador for the newly arrived nurses. She is responsible for their community orientation like opening a bank account, showing the nurses the location of shopping malls, grocery stores, oriental stores, post

office, churches, federal building to apply for their social security number, telephone, gas, electric, and water company to open an account and pay the deposit. The Patient Representative will also provide the newly arrived nurses contact names and telephone numbers of key people in the Filipino community.

One of the Filipina nurse is a respected member of the town community leadership group. She's recognized for her volunteerism and involvement in the community. She is considered the Pillar of the Filipino community. She is the go to person if any of the Filipinos encounter any problems, issues, or concerns. She knows everyone in town that holds a political or leadership position. She networks with them and she knows who to contact in time of need.

The American community is more receptive to the presence of Filipinos in their community. The community recognizes them for the contribution they are making as doctors, nurses, engineers, patient representatives, and as volunteers. The American community also recognizes the loyalty, industriousness, and commitment of the Filipinos in their community.

Presently, the new Filipino nurses and students that are coming to Alabama have more resources and assistance to help them adapt and adjust, compared to the Filipinos who came in the 70s and 80s.

Asante and Davis's (1989) study of interracial encounters in the workplace found that because of different cultural perspectives, approaching organizational interactions with others with different beliefs, assumptions, and meanings often leads to miscommunication. Brenda Allen (1996) stated that the organization's members' experiences, attitudes, and behaviors in the workplace are often influenced by race-ethnicity. The Filipina nurses found their adaptation process to their host country very difficult. It should be noted that the person who migrates encounters a new culture, process called "acculturation." This is a "process by which newcomers

to a group, work to make sense of the surrounding and come to acquire the kind of knowledge that would enable them to produce conduct that allowed established members of the group to recognize them as competent." The new knowledge relates to the host culture, and therefore one would argue that culture would have an influence on the adaptation of nurses to their respective new country of residence and work. This theory explained the phenomena of the lived experiences of Filipina nurses related to race, ethnicity, gender, inclusion, and class position.

As the U.S. nursing workforce continues to diversify, it is imperative that all parties work together to provide the best nursing care to the public. Initiating a national policy that would mandate healthcare organizations have transitional programs requires an appreciation of the complexity of the problems and the answers needed to support the creation of such a program. National and local government agencies, professional groups and organizations, policymakers, and healthcare organizations need to sit at the table to discuss how they can work together to create a positive practice environment for IEFNs. If this is not done for any other reason, it should be done for ensuring the safety of those who receive nursing services from IEFNs (Adeniran et al., 2008)

1. The American Nurses Association (ANA), the strongest, largest voice of nursing in the U.S., has an important role to play. As the nurses' voice, the ANA could echo the voices of both domestic nurses and the IENs to facilitate the formation of policy to standardize transition programs for IENs.

2. The International Center on Nurse Migration (ICNM), a joint venture between the CGFNS International and the International Council of Nurses (ICN), understands the road traveled by IENs and their unique positions and challenges. Their presence at the table would

allow the other stakeholders to learn first-hand information about IENs thus providing more light on the issues at stake.

3. Nurse researchers and academicians in the field of nurse migration and global health, can work with the group to carry out further research. This research could validate the need for such programs, as well as perform follow-up studies to assess the impact of these programs on ensuring safe, quality healthcare for the public. Future research on the migration of new IENs in the Southeastern part of the United States will add to the current literature.

4. Healthcare organizations' leadership, both administrators and managers who utilize the service of IENs, would also need to sit at the table. The collective wisdom of each organization's experiences, as well as lessons learned in the process of helping IENs integrate into their organization's practice environment, could serve to guide others in designing policies that would have the most positive impact. Additionally, their participation in influencing and enacting the policies would promote commitment to and compliance with the policies.

5. U.S. recruiting agencies are often the first people with whom the IENs interface in the process of coming to the U.S. to practice nursing, and their representatives would make ideal participants at the table. They could offer important information with regard to IENs expectations, as well as take important information about the planned policy to the IENs in their home countries so these IENs would be aware of the policies before coming to the US. Their participation in developing and influencing the policy could increase their commitment to ensuring that such policy is enacted.

6. Lastly, the most important participants to sit at this table are the internationally educated nurses themselves. These are the nurses who have walked the lonely path of

transitioning from one country's practice style to another, and who could provide insight through their actual experiences to enrich the knowledge of the stakeholders group.

7. Potential benefits of a stakeholder coalition--building a coalition of the above stakeholders could facilitate the development of a standardized IEN transition policy. The synergy of the collective "buy-ins" and resources from the stakeholder groups, as well as their commitment to ensuring that IENs successfully transition to the U.S. healthcare practice environment, could make the difference between the failure or success of such a policy, and more importantly, ensure safe, quality healthcare for the public.

Nurses migrate in order to meet their professional and personal goals, thus allowing nurses to respond to their changing needs and interest and those of society in general. It is a fundamental human right for anyone, including nurses, to use their professional or education qualifications to better themselves or their families. It is the responsibility of a country who recruits migrating professionals to ensure that adequate resources are in place to support their transition. Migration is an inevitable product of the 21st century. Regardless of one's take about migrating nurses, migration will continue to take place as globalization evolves in the 21st century. In the end, it is not what we do not know that will destroy us, but rather the failure to respond appropriately to what we know now.

Formal Recommendations

1. Pre-Arrival orientation--the transition process needs to start in the Philippines by the recruiting and travel agencies. It should include a video-taped presentation informing the newly hired nurses on the type of hospital (examples: outpatient, inpatient, acute care, rehabilitation, psychiatry/mental health, nursing home, assisted living or retirement home) they will be

working, scope of services provided, number of beds, location (urban, suburban, rural), availability of transportation, provide car rental for two years with rent payable monthly, learn how to drive and obtain driver's license, provide copy of job description, salary and salary deductions, benefits, shift assignment, orientation that includes people's cultures and values, someone to explain and/or teach them about language barriers, pronunciation of word(s), meaning of slangs word(s) or phrases, idiomatic expressions, and living arrangement. Provide paperwork for government requirements like securing a social security number. The agencies should prepare hired nurses to pass CGFNS, TOEFL, and NCLEX-RN. The hiring hospital should send a welcome letter that includes the name of the liaison who will pick them up at the airport.

2. Living and Community orientation--appoint a liaison or coordinator or to go to person who will pick up the nurses from the airport, take him/her/them into their living areas, assist in unloading their personal belongings, assist in identifying what they need in terms of bedroom supplies, kitchen supplies, bathroom supplies, food, beverages, and other necessities. Drive them around town and show them the location of grocery stores--both American and Oriental--banks, post office, city hall, federal building, and churches of preference, shopping centers, laundry mat, parks, restaurants, and other necessary locations. Assist them in locating food preferences in the grocery stores. Arrange a meeting with their priest, pastor, or the church leader. One issue most important to all them is the location of public transportation, routes, bus time schedules, accessibility to their location, cost of commuting, taxi services, telephone numbers for taxi, and cost for using taxi services. If the recruiting agency included a rental car, they will need to know the location where to obtain their driver's license.

3. Hospital orientation should include a tour of facility and location of departments like radiology, laboratory, medical records, billing, surgery, emergency department, cafeteria, etc., Introduction to staff, physicians, and to other healthcare team members. The participants felt that an early introduction to this group of people would improve intimidation.

4. Hospital clinical orientation should include the mission, vision, and values of the hospital, discussion of job description and job expectations, discussion of policy and procedures. Introduction to the nursing unit manager, staff, and assigned preceptor. The participants felt their transition would have been smoother if they had been assigned to a nursing unit where they had experience and expertise. If new nurses need to take the TOEFL and NCLEX-RN, resources be made available for participants to prepare for these examination. Rebecca recommended that tutors be made available for participants in order to help them learn the most effective strategies for preparing and taking the examinations.

5. The participants recommended linguistic assistance. There were two types of linguistic problems that confronted the participants. One involved pronunciation of words with a Southern accent and the other issue was comprehension. Both of these issues contributed to the experiences of isolation, intimidation, discrimination and/or marginalization. Not understanding different accents, idioms, slang, and not being understood by local people caused many of the participants to retreat into a personal as well as a social shell. Not understanding slang and local meanings of certain words opened the participants up to certain mockery and slang.

6. Participants recommended a certain type of cultural orientation. Juliet told of an occasion when she and two fellow nurses were approached by two male nursing aides who offered to sell food stamps for cash money. The two male nursing aides told the Filipina nurses that they needed cash to buy milk, bread, and diapers for their child. Because of their

compassionate nature, the Filipina nurses gave the two nursing aides their cash money in exchange for the food stamps. When they attempted to use the food stamps in the grocery store that they normally used, the cashier called the store manager. The store manager took the three nurses in his office with a security guard. The store manager informed the three Filipina nurses that it was illegal to sell food stamps and to buy them from a recipient. He further explained the law to them. The three nurses started crying and were very upset and they all handed the food stamps to the store manager and left the grocery store empty handed. There were several incidences mentioned by participants in which a lack of understanding the local culture brought about embarrassment, ill feelings, or lack of propriety.

Conclusions

It is ironic that nursing and healthcare, in general, an ethical ideal, birthed in caring and altruism, has an issue with isolation, intimidation, discrimination/marginalization, incivility, and lateral violence. Nursing must now conscientiously forge a merger between professional practice and caring that is frowned upon by some in a capitalist market who would rather we denounce the caring nature of our profession, which makes it unique and a model for other professions to emulate, and focus on efficiency and outcomes connected to financial gains (Watson, 2009). For those who believe that nurses are asked to show compassion due to gender differences or the nature of the nurses' work, the literature supported that other professions have an ethical responsibility to show altruism (unselfish concern for the welfare of another), care, and compassion. For those who think that care and professionalism are not qualities that deserve the attention of nursing academia, nursing practice, healthcare organizations, and other health related agencies, the findings of this qualitative study using standpoint theory and cultural competency

theory analysis provides a strong argument to support that ethical training is needed across nursing curricula, nursing practice and across other health care entities.

The shortage of nursing will always be a global issue and migration of internationally educated foreign nurses, not just Filipino nurses, will continue until the next century. Newly hired Filipino nurses arrived in Alabama last year and this year to help alleviate the critical shortage of nursing. Having a standardized transition program that will help them adapt and adjust to their new living and working environment will help tremendously with retention and lower the cost of nursing turnover and recruitment. This will also improve employee and patient satisfaction and will eventually improve the quality of care that our patient deserves.

The best means of affecting change in the nursing profession is to promote collaborations between nursing academia, nursing practice, and other allied healthcare organizations and agencies. Teaching professional, caring, ethical principles in nursing academia and ensuring its nurturance in nursing practice can mitigate all incivility in nursing. Caring relationships need not always lead to friendship, nor is friendship development necessary (Engster, 2005). What is necessary is a conscientious understanding that respect, dignity, and social justice are basic human rights that all nurses should be expected to honor.

Most IEFNs will continue to experience isolation, intimidation, discrimination/marginalization, and incivility in the workplace and in their community, but the financial gain will outweigh the negative experiences and it is due to Filipino's resiliencies, industriousness, living a better life, and their ability to help their family financially.

The presence of a strong Filipino community will help alleviate the experience of isolation, intimidation, discrimination and/or marginalization in the workplace and in the community among IEFNs.

The presence of modern technology and presence of social media will help alleviate the feeling of homesickness and loneliness among IEFNs.

Follow-up research on newly hired Filipino nurses in Alabama and in the Southeastern part of the U.S. who arrived after 2015 to present will add to the current literature on the effectiveness of transition programs both formal and informal implemented after this study.

REFERENCES

Alfara, Jr., V. A., & Mertz, N. T. (Eds). (2006). *Theoretical frameworks in qualitative research*. Thousand Oaks, CA: Sage.

Adeniran, R., Rich, V., Gonzalez, E., Peterson, C., Josh, S., & Gabriel, M. (2008) Transitioning internationally educated nurses for success: A model program. *OJIN*: *The Online Journal of Issues in Nursing, 13*(2), Manuscript 3. http://dx.doi.org/10.3912/OJIN.Vol13No02Man03

Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nurse migration. *Health Affairs, 23*(3), 69-77.

Allen, B. J. (1996). Feminist standpoint theory: A Black woman's review of organizational socialization. *Communication Studies, 47*(4), 257-271. doi: 10.1080/10510979609368482

Alliance for Ethical International Recruitment Practices. (2006). Retrieved May 16, 2017, from http://www.fairinternationalrecruitment.org/index.php/the_code

American Association of Colleges of Nursing. (2014) Nursing shortage fact sheet. Retrieved from www.aacn.nche.edu/medi-relations/nursing-shortage

American Organization of Nurse Executives. (2005). *Healthy work environments: Foreign nurse recruitment best practices, 3*. Philadelphia, PA: Author.

Asante, M. K., & Davis, S. (1989). Race, culture and interpersonal conflict. *International Journal of Intercultural Relations, 16*(4), 437-454.

Baptiste, M. (2015). Workplace discrimination: An additional stressor for internationally educated nurses. *The Online Journal of Issues in Nursing, 20*(3), 1-15.

Berry, C. M., Lelchook, A. M., & Clark, M. A. (2012). A meta-analysis of the interrelationships between employee lateness, absenteeism, and turnover: Implications for model of withdrawal behavior. *Journal of Organizational Behavior, 33*(5), 678-699. doi: 10.1002/job.778

Bieski, T. (2007). Foreign-educated nurses: An overview of migration and credentialing issues. *Nursing Economics, 25*(1), 20-23, 24.

Blakeney, B. (2006). International nurses migration crisis or opportunity. Paper presented at the NNA Meeting. Retrieved May 15, 2017 from www.icn/triad/nna2006/Barbara_Blakeney.pdf

Brush, B.L., Sochalski, J. and Berger, A.M. (2004) Imported care: Recruiting foreign nurses to US health care facilities. *Health Affair, 23*, 787-87. doi: 10.1377/hlthaff.23.3.78

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Los Angeles, CA: Sage.

Choy, C. C. (2003). *Empire of care: Nursing and migration in Filipino American history.* Durham, NC: Duke University Press.

Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Walnut Creek, CA: Left Coast Press.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry experience and story in qualitative research.* San Francisco, CA: Jossey-Bass.

Clandinin, D. J., & Huber, J. (in press). Narrative inquiry. In B. McGraw, E. Baker, & P. P. Peterson (Eds), *International encyclopedia of education* (3rd ed., pp. 1-26). Retrieved from http://www.narrativesig.cahs.colostate.edu

Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn.* Thousand Oaks, CA: Sage.

Commission on Graduates of Foreign Nursing Schools. (2002). *Characteristics of foreign nurse graduates in the United States workforce*, 2000-2001. Philadelphia, PA: Commission on Graduates of Foreign Nursing Schools.

Cooper, R. A., & Aiken, L. H. (2006). Health services delivery: Reframing policies for global migration of nurses and physicians--a U.S. Perspective. *Policy Politics Nursing Practice, 7*(3_suppl), 66S-70.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Los Angeles, CA: Sage.

Creswell, J. W. (2009). *Research design qualitative, quantitative, and mixed methods approaches* (3rd ed.) Thousand Oaks, CA: Sage.

Davis, C. R. (2003). How to help international educated nurses adjust. *Nursing 2003*. Retrieved February 1, 2017 from http://www.nursingcenter.com

Davis, C. R., & Nichols, B. L. (2003). How to help international nurses adjust. *Nursing 2003*. Retrieved November 30, 2016 from http://www.nursingcenter.com

DiCicco-Bloom, B. (2004). The racial and gendered experiences of immigrant nurses from Kerala, India. *Journal of Transcultural Nursing, 15*(1), 26-33

Edwards, P. A., & Davis, C. R. (2006). Internationally educated nurses' perceptions of their clinical competence. *The Journal of Continuing Education in Nursing, 37*(6), 265-269.

Emanuel, E., Abdoler, E., & Stunkel, L. (n.d.). Research ethics: How to treat people who participate in research. Retrieved from www.bioethics.nih.gov

Giegerich, M. (2006). A survey of foreign-educated nurses: Workplace experience. *Honors Project*. Paper 10. http://digitalcommons.iwu.edu/nursing_honpro/10

Gilligan, C. (1982/1993). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* London: Aldine Transaction.

Glesne, C. (2011). *Becoming qualitative researchers: An introduction* (4th ed.). Boston, MA: Pearson Education.

Goulding, C. (2002). *Grounded theory: A practical guide for management, business, and market researchers*. London: Sage Publications

Gustafson, D. L. (2005). Transcultural nursing theory from a critical cultural perspective. *Advances in Nursing Science*, 28(1), 2-16. Philadelphia, PA: Lippincott Williams & Wilkins.

Harding, S. (1987). *Feminism and methodology* (pp. 1-14). Bloomingdale, IN: University Press.

International Council of Nurses. (2005). *The migration of nurses: Trends and policies;* Geneva, Switzerland.

International Organization for Migration. (2005). World migration: Costs and benefits of international migration. Retrieved May 15, 2017 from http://publications.iom.int/bookstore/free/wmr_2005.pdf

Jackson, A. Y., & Mazzei, L. A. (2012). *Thinking with theory in qualitative research: Viewing data across multiple perspective*. New York, NY: Routledge.

Johnstone, M. J., & Kanitsaki, O. (2009). The spectrum of new racism and discrimination in hospital contexts: A reappraisal. *Collegian, 16*(2), 63-69.

Kingma, M. (2006). *Nurses on the move: Migration and the global health care economy*. New York, NY: Cornell University Press.

Kvale, S., & Brinkmann, S. (2009). *Interviews learning the craft of qualitative research: Interviewing* (2nd ed.). Thousand Oaks, CA: Sage.

Leininger, M. & McFarland, M. (2002). Culture care theory: A major contribution to advance transcultural nursing. *Journal of Transcultural Nursing, 8*(2), 32-51. New York, NY: McGraw-Hill.

Lin, L. C. (2014). Filipino nurses' transition into the US hospital system. *Journal of Immigrant and Minority Health, 16*(4), 682-688. http://dx.doi.org/10.1007/s10903-013-9793-9

Mayor, R. (2008). My sojourn in the USA. *OJIN*: *The Online Journal of Issues in Nursing; 13*(2), 5.

Matiti, M. R., & Taylor, D. (2005). The cultural lived experience of internationally recruited nurses: A phenomenology study. *Diversity in Health and Social Care*, *2*, 7-15.

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage.

Minority Nurse Staff. (2013) Discrimination in nursing. Retrieved May 15, 2017, from www.minoritynurse.com

Moreci, J. T. (2012). Bias in the nursing workplace: Implications for Latino (a) nurses. *Journal of Cultural Diversity, 19*(3), 94-101.

National Council of State Boards of Nursing. (2012). *Number of candidates taking NCLEX examination*. Chicago, IL: National Council of State Boards of Nursing. Retrieved on May 15, 2017 from https://www.ncsbn.org/1237.htm.

Osuji, J., Uzoka, F. M., Aladi, F., & El-Hussein, M. (2014). Understanding the factors that determine registered nurses' turnover intentions. *Research and Theory in Nursing Practice, 28*(2), 140-161

Polit, D. F., & Beck, C. T. (2008). *Nursing research generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins. Protecting Human Research Participants. Retrieved from http://phrp.nihtraining.com/quiz_review.php?id=4

Randles, C. (2012). Phenomenology: A review of literature. *National Association for Music*, *30*(2), 11-12

Resnik, D. B. (2015). What is ethics in research & why is it important? Http://www.niehs.nih.gov/research/resources/bioethics/whatis

Roberts, S. J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science, 5*(4), 21-30.

Roberts, S. J., DeMarco, R., & Griffin, M. (2009). The effect of oppressed group behaviors on the culture of the nursing workplace: A review of the evidence and interventions for change. *Journal of Nursing Management, 17*(3), 288-293.

Rossman, G. B., & Rallis, S. F. (2012). *Learning in the field an introduction to qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Roy, C. (2009). The Roy adaptation model (3rd ed.). Upper Saddle River, NJ: Pearson.

Rutledge, P. (2011). The psychological power of storytelling. *Psychology Today*. Retrieved from https://www.psychologytoday.com/blog/positively-media/201101/The-psychology-power-storytelling

Ryan, M. (2005). A buddy program for international nurses: *Journal of Nursing Administration, 33*(6), 350-352.

Saldana, J. (2016). *The coding manual for qualitative researchers*. Thousand Oaks, CA: Sage.

Smith, C. D., & Ho, J. O. (2014). How to positively integrate internationally educated nurses. *Nurse Manage*, *45*(6), 30-36. http://dx.doi.org/10.1097/01.NUMA.0000449761.61253.a7

Sokolowski, R. (2000). *Introduction to phenomenology*. New York, NY: Cambridge University Press.

Steir, J., & Olsson, S. (2004). The theoretical framework of cultural competence. Retrieved from http://www.researchgate.net

Steixner, M., & Heidegger, M. (2013). The power of storytelling; as intercultural practice. Retrieved from https://intercultural-perspective.com/wp-content/…/The_Power_of_storytelling.pdf

Taylor, B. (2005). The experience of overseas nurses in the NHS. Results of a qualitative study. *Diversity in Health and Social Care, 2*, 17-27.

Tregunno, D. (2009). International nurse migration: U-turn for safe transition. *Nursing Inquiry*, *16*(3), 182-190

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press.

U.S. Department of Health and Human. (2005). *March 2004 preliminary findings: 2004 national sample survey of registered nurses* (No. 8) Washington, DC: US Department of Health and Human Services Health Resource and Services Administration.

U.S. Department of Labor Bureau of Labor and Statistics. (2013). Occupations with the largest predicted number of job openings due to growth and replacement needs, 2012 and Projected 2022. Economic News Release. Retrieved May 16, 2017 from http://bls.gov/news.release/ecopro.t08.htm

Volpone, S. D., & Avery, D. R. (2013). It's self-defense: How perceived discrimination promotes employee withdrawal. *Journal of Occupational Health Psychology, 18*(4), 430-448. doi: 10.1037/a0034016

Webb, A. L. (2016). *So you want to do a qualitative dissertation?* Copyright Alan L. Webb 2016

Wheeler, R. M., Foster, J. W., & Hepburn, K. W. (2014). The experience of discrimination by US and internationally educated nurses in hospital practice in the USA: A qualitative study. *Journal of Advanced Nursing, 70*(2), 350-359. doi: 10.1111/jan.12197

Withers, J., & Snowball, J. (2003). Adaptation to a new culture: A study of the expectations and experiences of Filipino nurses in Oxford Radcliffe Hospitals NHS Trust. *NT Research*, 8, 278-290.

Wolcott, K., Llamado, S., Mace, D. (2013). Integration of internationally educated nurses into the U.S. workforce. *Journal of Nurses in Professional Development*: September/October 2013-Volume 29-Issue 5 – p263-268.

Xu, Y., & He, F. (2012). Transition programs for internationally educated nurses: What can the United States learn from the United Kingdom, Australia, and Canada? *Nursing Economics, 30*(4), 215-223, 239.

Xu, Y., & Kwak, C. (2005). Characteristics of internationally educated nurses in the United States, *Nursing Economics, 23*(5), 233-238

APPENDIX A:

PARTICIPANT DEMOGRAPHIC DATA AND INTERVIEW QUESTIONS

Interview Questions:

1. **Demographic Data**

   When did you come to the U.S? _____

   How old were you then? _____

   What is your current age? _____ Gender? _____

   What is your marital status? _____ Sexuality? _____

   Number of children? _____

   Degree completed? _____

   Current occupation? _____

   Location of work? _____

   Number of years of experience? _____

   Place of employment in the Philippines? _____

   Estimated salary in pesos? _____

   Reasons for joining the U.S. nursing workforce? _____

   _____

   Did you work in a hospital? _____ Clinic? _____, public health setting? _____

   Is the area considered urban, suburban, or rural? _____

2. What were some positive experiences of being a nurse in the Philippines? Give me examples.

3. What were the challenges of being a nurse in the Philippines? Give me examples.
4. What were your positive/negative experiences as a nurse in the U.S.? Give me examples.
5. How were these experiences in the U.S. similar and different from your experiences in the Philippines? How did the doctor and supervisors treat you differently?
6. From your standpoint, how does Filipino men's role compare/differ from American men? What were your experiences based on race, gender, and social class?
7. Tell me about your nursing curriculum in the Philippines? What was your experience as a student there? What were some of the positive experiences? What were some of the negative experiences? Give me examples.
    a) What is your primary and secondary language? Do you speak any of the dialects in the Philippines? What medium of instructions did they use in your school?
    b) Does your school have any transition program for graduates who are going to the U.S. to work? If so, can you describe the program? What are the positives and negatives of this program? What would you have wanted to know that is not included? Why?
8. When you came to the U.S., how was your experience here different in terms of education? Curriculum? What were positive differences? What were negative differences? Give me examples.
9. Tell me what preparation and information did your U.S. employer provide you while you were in the Philippines. (Example: place to live, transportation availability, orientation, culture differences, language barriers, preparation for NCLEX, etc.)?
    a) Can you describe to me how you settled down in the U.S.? What were the positive experiences? What were the negative experiences?

b) How did your experiences correlate with the information they gave you?

c) Did you sign a contract with your employer? Can you tell me what was written in the contract? Did they fulfill their promises or any agreement written in your contract? Explain.

10. Tell me about what your employer shared about the hospital setting in which you were going to work?

11. Tell me what positive and negative experiences did you encounter in your social life, working life, and family life while living and working in your new environment?

12. Tell me what positive and negative experiences did you encounter being a Filipina, being a woman of color, being a minority and being new in your living and working environment?

13. Tell me stories about the discrimination and marginalization you experience working with white people, minority people and with other Filipinos? How did these experiences affect you as a Filipina, as a nurse, and as a family person?

14. Tell me your positive and negative experiences about the support you received from your co-workers, managers or from hospital administration?

    a) What resources could have been offered to you in your workplace, in your community, and with your family?

15. If you were able to do this all over again, what would you do differently? What kind of supports would you like? What would you like to have learned in nursing? About the U.S.? About families?

16. If you were invited to design a transition program, what would you include as its key components?

APPENDIX B:

ETHICAL CONSIDERATION

Ethical Considerations

In the August 1947 verdict, the judges included a section called **Permissible Medical Experiments**. This section became known as the **Nuremberg Code** and was the first international code of research ethics. This set of directives established the basic principles that must be observed in order to satisfy moral, ethical, and legal concepts in the conduct of human subject research. The Code has been the model for many professional and government codes since the 1950s and has, in effect, served as the first international standard for the conduct of research.

"To respect autonomy is to give weight to the autonomous person's considered opinions and choices while refraining from obstructing his or her actions." (Belmont Report) (http://phrp.nihtraining.com/history/04_history.php).

Given the importance of ethics for the conduct of research, it should come as no surprise that many different professional associations, government agencies, and universities have adopted specific codes, rules, and policies relating to research ethics (Resnik, 2015). Researchers need to protect their research participants; develop a trust with them; promote the integrity of research; guard against misconduct and impropriety that might reflect on their organizations or institutions; and cope with new, challenging problems (Israel & Hay, 2006). Ethical issues in research command increased attention today. The ethical considerations that need to be anticipated are extensive and they are reflected through the research process (Creswell, 2014, p.92).

Since I will be conducting a research study, one of my primary responsibilities is to always act in an ethical manner, which includes having an independent review committee review my research for its adherence to ethical standards (Sieber & Tolich, 2012). I need to adhere to

the code of ethics by using the ANA code of ethics and abiding by the rules and regulations of The University of Alabama Institutional Review Board (IRB). The population for my study will be internationally Educated Filipino Nurses (IEFNs) who have retired and who are still working in urban, suburban and rural community hospital located in Alabama. The IEFNs are not members of a vulnerable population and there is minimal risk for them to participate in this study. It is my responsibility to obtain necessary documentation before collecting data. I need to write my letter of invitation and provide information about the study and why their involvement is very important if they decide to take part in the study. After obtaining their consent, the participant needs to know the purpose of the study. I will explain to the IEFNs why they are best suited to speak to the various issues related to their lived experiences in transitioning into the U.S. nursing workforce and what transition programs their hospital have to facilitate their transition. The participant needs to know that their participation is voluntary, that it will involve two individual interviews which may last at least one hour and it will take place in a mutually agreed upon location. They may decline to answer any of the interview questions; they may decide to withdraw for the study at any time without any negative consequences. I will obtain participant's permission to use a tape-recorder to facilitate collection of information. After the interview I will transcribe data for analysis. After the interview and after the data have been transcribed and analyzed, I will send copies of the transcript to the participant to give them the opportunity to confirm the accuracy of our conversation and to add or clarify any points which that participant wishes. I will tell the participant that all information provided is considered completely confidential and their name will not appear in any report resulting from the study. Data collected from the study will be retained for one year and will be saved in an encrypted password protected computer under the UA box for privacy and security. The participant needs

to know that only researchers associated with the study will have access and that there is no known or anticipated risks to the participants in the study. I need to share with participants that there is no payment or incentives for participation.

Some ethical issues which may come up could be related to participant sharing their answers with other IEFNs participating in the study. Participants maybe hesitant to answer some of the questions for fear that hospital administrators might find out that they are complaining or reporting dissatisfaction with their job. Being an IEFN myself, I might show bias or create bias with participants and influence their answers. I will make sure that participants are treated fairly. To eliminate the participant's fear, I will tell them repeatedly that all information that they share is confidential, that their name will not appear on any results or on any data collected, that only researchers have access to data and the data will be kept in an encrypted password protected computer under the UA box. I will respect participants and attempt to build trust with them. To eliminate bias, I need to be conscious and aware of my environment when I am asking questions and not give my opinion about the questions being asked.

Other ethical issues that could possibly arise will be the selection of the interview site. Some of the IEFNs may request to be interviewed at the comfort of their home or in a restaurant or other places of their choice. Selecting a site to study in which the researcher has an interest in outcomes is not a good idea. It does not allow for objectivity or for the full expression of multiple perspectives which are needed by qualitative research. Researchers need to respect research sites so that they are left undisturbed after a research study. This requires that inquirers, especially in qualitative studies involving prolonged observation or interviewing at a site, be cognizant of their impact and minimize disruption of the physical setting (Creswell, 2005, p. 96-97).

To summarize, it is very important for researchers to follow ethical codes in conducting a study. Respect for human subjects is on top of the list, accuracy of data and reporting of data honestly is important, and keeping everything secure and private to prevent someone from accessing the data unnecessarily. The confidence of the participants and the public on the researcher and in the results of the study needs to be protected.

APPENDIX C:

IRB APPROVAL LETTER

THE UNIVERSITY OF ALABAMA | Office of the Vice President for Research & Economic Development
Office for Research Compliance

July 16, 2018

Amelia E. Delos Reyes, RN, MSN
Dept. of ELPTS
College of Education
The University of Alabama
Box 870358

Re: IRB # 18-OR-261: "Transition Program for Internationally Educated Filipino Nurses"

Dear Mrs. Delos Reyes,

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your approval will expire on July 15, 2019. If the study will continue beyond that date, you must complete and submit the Continuing Review Form within e-Protocol. If you need to modify the IRB protocol, please complete and submit the Amendment Form. *Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants.* When the study closes, please complete the Final Report Form. Please use the IRB-stamped Consent Form.

Should you need to submit any further correspondence regarding this application, please include the assigned IRB approval number. Good luck with your research.

Sincerely,

[redacted]

Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer
Office for Research Compliance

cc: Dr. Nirmala Erevelles

358 Rose Administration Building | Box 870127 Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 Toll Free 1-877-820-3066

APPENDIX D:

INFORMED CONSENT

UNIVERSITY OF ALABAMA
HUMAN RESEARCH PROTECTION PROGRAM

Informed Consent for a Non-Medical Study

Study Title: Transition Program for Internationally Educated Filipino Nurses

Amelia E. Delos Reyes, Ed.D Candidate, Educational Leadership, Policy, and Technology Studies

You are being asked to take part in a research study.

This study is called the Transition Program for Internationally Educated Filipino Nurses. This study is being done by Amelia E. Delos Reyes, who is a doctoral student at the University of Alabama. Ms. Delos Reyes is being supervised by Professor Nirmala Erevelles, PhD, who is a professor at the College of Education at the University of Alabama.

What is this study about? What is the investigator trying to learn?
This study is being done to explore the lived experiences of internationally educated Filipino nurses related to socio-cultural differences, language barriers and adaptation to new and living environment. The goal of the study is to examine how these lived experiences of the participants in this study contribute to the development or enhancement of transition programs for internationally educated Filipino nurses who will join the nursing workforce in Alabama in the future. Nurses educated in other countries represent a vital part of the U.S. nursing workforce. Nursing shortages impact not only the United States but also countries around the world. As a result, many healthcare agencies in the US and around the world are recruiting and hiring nurses educated in other countries to fill the vacant positions. Despite the increased utilization of foreign-educated nurses in the US, there is lack of knowledge of how these nurses transition into the US nursing workforce.

Why is this study important or useful?
This study is important because it will bring awareness to healthcare organizations to adopt transition programs that will help internationally educated Filipino nurses (IEFNs) in adjusting to their new practice and living environments.

Why have I been asked to be in this study?
This study focuses upon the lived experiences of IEFNs who moved to the US south as they relate to socio-cultural differences, language barriers and adaptation to a new living and working environment. You are one of many IEFNs who is presently working or retired in community hospitals located in urban, suburban and rural part of Alabama. Your experience as IEFN will provide useful data for the study.

How many people will be in this study?
About 20-25 internationally educated Filipino nurses who are presently working or who retired in community hospitals located urban, suburban and rural part of Alabama will be in this study.

What will I be asked to do in this study?
If you agree to be in this study, you will be asked to participate in 3 separate face-to-face interview. The first face to face interview will be to collect data and it will not be more than two hours. The second face to face interview is to ask follow up questions and it will take less than one hour. At the third interview I will share a transcription of the interview with you to check for accuracy. That will take less than an hour. All three interviews will not be more than four hours. If you consent, I will audio-record all the interviews. If you decline to be audio-recorded, I will take notes during the interview. I will transcribe data as soon as our interview is over.

How much time will I spend being in this study?
The first face to face interview will not be more than two hours. The second face to face interview will not be more than one hour. The third interview will not be more than one hour. So you will spend approximately 4 hours in the study.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 7/16/2018
EXPIRATION DATE: 7/15/2019

Will being in this study cost me anything?
The only cost to you from this study is your time and mileage to the interview location.

Will I be compensated for being in this study?
There is no compensation to be in this study.

What are the risks (dangers or harms) to me if I am in this study?
There should be very little or no risk to you as a participant in this study, however, potential risks have been identified. The main risk for you for being in this study is that you will be asked questions that could be potentially uncomfortable. You can control this potential by not being in the study, by not answering any questions that make you feel uncomfortable, or by stopping your participation in the study at any time. There is no penalty or consequences for choosing to stop your participation. By participating in this study, your confidentiality may also be at an increased potential risk. To decrease the risk, you will be identified in this study by a pseudonym, all data collected will be stored in an encrypted computer system under the UA Box. The audio-recording of your interview will be transcribed within 24 hours of the interview, but not later than one week after the interview. Recordings will be deleted as soon as they are transcribed, and no later than one week after the interview.

What are the benefits (good things) that may happen if I am this study?
There are no personal benefits to you for being in the study.
This study will provide an opportunity for you to describe the lived experiences in joining the U.S. nursing workforce related to socio-cultural differences, language barriers and adjusting to the new living and working environment.

What are the benefits to science or society?
Your participation will provide information that can contribute to the development and/or enhancement of existing transition programs for the benefit of new Filipino nurses or other internationally educated nurses joining the U.S. nursing workforce in Alabama.

How will my privacy be protected?
Your privacy will be protected by conducting the interview in a reserved, private area. You have the right to refuse to answer any question(s) that you do not wish to answer.

How will my confidentiality be protected?
Confidentiality refers to the data that you offer and how it will be safeguarded. Data from the interview will be transcribed by the investigator within 24 hours of interview, but not later than one week after the interview. Any recording will be deleted as soon as they are transcribed, and no later than one week after the interview. No other person will have access to the recorded interview or transcription. Interviewees and/or their affiliated organizations will be de-identified through the use of chosen and/or assigned pseudonyms. All hard-copy transcriptions will be shredded. Electronic copies of transcriptions will be kept as password-protected documents on the investigator's personal encrypted computer system under the UA Box for a period of one year. Only the investigator will know the password.

What are the alternatives to being in this study? Do I have other choices?
The alternative being in this study is not to participate.

What are the rights as a participant in this study?
Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. There will be no effect or consequences on your part if you withdraw. Just tell the researcher you are withdrawing from the study. There will be no effect on your relations with the University of Alabama or with the organization you are working at present.

The University of Alabama Institutional Review Board ("the IRB") is the committee that protects the rights of the people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 7/16/2018
EXPIRATION DATE: 7/15/2019

Who do I call if I have questions or problems?
If you have questions about the study right now, please ask them. If you have questions about the study later on, please contact the primary investigator, Amelia Delos Reyes at 205-394-3096 or my doctoral committee chairman, Dr. Nirmala Erevelles at 205-348-1179.

If you have questions about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://ovpred.ua.edu/research-compliance/prco/ or email us at rscompliance@research.ua.edu

I have read this consent form. I have had a chance to ask questions. I agree to take part in it. I will receive a copy of this consent form to keep.

_____ _____

Signature of Research Participant Date

_____ _____

Signature of Investigator Date

Audio Taping Consent

As mentioned above, the individual face to face interview will be audio-recorded for research purposes involving the collection of a large volume of verbal (spoken) data. This spoken data then will be transformed into written data through a process known as transcription. All recordings will be transcribed within 24 hours of interview, but not later than one week after the interview. Recordings will be deleted as soon as they are transcribed, and no later than one week after the interview. All electronic transcribed data will only be accessible to the research staff consisting of Ms. Delos Reyes, the Principal Investigator, and my doctoral research supervisor, Dr. Nirmala Erevelles.

I understand that part of my participation in this research will be audiotaped and I give my permission to the research team to record the interview. Please enter your initial.

_____ **Yes**, my participation in this interview may be audiotaped.

_____ **No**, I do not want my participation in this interview to be audiotaped.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 7/16/2018
EXPIRATION DATE: 7/15/2019

APPENDIX E:

RECRUITMENT LETTER: BY E-MAIL AND TELEPHONE

Research Letter of Invitation

July, 2018

Dear _____:

This letter is an invitation to consider participating in a research study that I am conducting as part of my doctoral degree in the College of Education at The University of Alabama under the supervision of Dr. Nirmala Erevelles. The purpose of this study is to explore the lived experiences of internationally educated Filipino nurses related to socio-cultural difficulties, language barriers and adaptation to their new living and working environment and how these lived experiences of Filipino nurses in this study will contribute to the development of a transition program or contribute to the enhancement of existing transition programs in Alabama. If you agree to participate, you will complete three face-to-face interviews about your experience living and working in the U.S.

Please contact me for additional information at 205-394-3096 or e-mail me at delos002@ua.edu

Thank you in advance for your assistance in the study.

Sincerely.

Amelia E. Delos Reyes, RN, MSN
Student Researcher
College of Education
The University of Alabama

Dr. Nirmala Erevelles
Chair, Doctoral Committee
College of Education
The University of Alabama

E-Mail Letter of Invitation

From: Amelia E. Delos Reyes, MSN, RN
Espino1027@gmail.com

To: Recipient's Name
Recipient's e-mail address

Date: Date and time of e-mail

Dear _____:

This e-mail letter is an invitation to consider participating in a research study that I am conducting as part of my doctoral degree in the College of Education at The University of Alabama under the supervision of Dr. Nirmala Erevelles. The purpose of this study is to explore the lived experiences of internationally educated Filipino nurses related to socio-cultural difficulties, language barriers and adaptation to their new living and working environment and how these lived experiences of Filipino nurses in this study will contribute to the development of a transition program or contribute to the enhancement of existing transition programs in Alabama. If you agree to participate, you will complete three face-to-face interviews about your experience living and working in the U.S.

Please contact me for additional information at 205-394-3096 or e-mail me at delos002@ua.edu

Thank you in advance for your assistance in the study.

Sincerely,

Amelia E. Delos Reyes, RN, MSN
Student Researcher
College of Education
The University of Alabama

Dr. Nirmala Erevelles
Chair, Doctoral Committee
College of Education
The University of Alabama

Telephone Call Script

Greetings: Good Morning; Good Afternoon; Good Evening

Introduction: This is Amelia Delos Reyes

How are you doing? I am calling you because I would like to invite you to consider participating in a study that I am conducting as part of my doctoral degree in the College of Education at The University of Alabama under the supervision of Dr. Nirmala Erevelles. The purpose of this study is to explore the lived experiences of internationally educated Filipino nurses related to socio-cultural difficulties, language barriers and adaptation to their new living and working environment and how these lived experiences of Filipino nurses in this study will contribute to the development of a transition program or contribute to the enhancement of existing transition programs in Alabama. If you agree to participate, you will complete three face-to-face interviews about your experience living and working in the U.S.

Please contact me for additional information at 205-394-3096 or e-mail me at delos002@ua.edu

Thank you in advance for your assistance in the study.

Sincerely,

Amelia E. Delos Reyes, RN, MSN
Student Researcher
College of Education
The University of Alabama

Dr. Nirmala Erevelles
Chair, Doctoral Committee
College of Education
The University of Alabama

APPENDIX F:

TIMELINE

Items that Need to be done	Propose Date	Completed
Comprehensive Exam	May 19, 2017	Done
Present Prospectus for 1st Edit	June 2, 2017	Done
Present Prospectus for 2nd Edit	September 6, 2017	Done
Present Prospectus for Final Approval	September 25, 2017	Done
Defend Prospectus	November 15, 2017	Done
Defend Proposal	May 10, 2018	Done
Meet with Dissertation Chairman for review of final copy of proposal before IRB submission	May 17, 2018 June 13, 2018 - Emailed final copy of proposal to Dr. Erevelles	Done
Prepare and Submit IRB for Approval	Date June 18-22, 2018	Done
Wait for IRB Approval to conduct interview	Approved July 16, 2018	Done
Interview Conducted	Month August, October, 2018 January, 2019	Done
Coding, Analysis of Data and writing final chapter	Month April, May 2019	Done
Final Approval from Dr. Erevelles	May 31 , 2019	Done
Defend Dissertation	Tentative Month June 17-26, 2019	
Graduation	August 3, 2019	

APPENDIX G:

ANALYTIC MEMOS

MEMO 1

October 8, 2018

How Do the Filipina Nurses Experience Isolation in their Living and Work Environment?

Six of the nurses participated in this study encountered a number of issues which interfered with their integration into the cultural content into which they found themselves thrust. One participant shared a common sentiment echoed by many individuals who left their social, cultural and familial networks in order to travel to a foreign land and start a new life. Monica said, *"It was always my desire to go to the USA and work as a nurse. I dreamed of going to the land of opportunity and becoming a success. Unfortunately, after arriving in this new dream world, my life soon turned into nightmare."* Another participant indicated that she felt so lonely that at the end of her work shift she would stay in bed to sleep until the alarm sounded to prepare for another work shift*." Julieta said, I felt like I was in prison and I was counting the days until I could save money and return home for a visit."*

Yolanda told herself that things would get better. It would just take some time to get adjusted to the people and the culture. She told herself that she would learn the customs of this new land and everything would eventually be wonderful, just like she had pictured it in her dreams when she was a little girl in the Philippines. Then, she was introduced to her living accommodations. She discovered that she would be sharing a one bedroom apartment with three other nurses. There was only one bathroom, a small living room and a small kitchen. She sadly stated, *"There was no place to put my luggage, hand clothes and not enough space to walk around since they turned the small living room into a bedroom separated by a room divider like we used in the hospital semi-private room.*" The next discovery for Yolanda and the other Filipina nurses was that there was no public transportation. Back in the Philippines, they have always been able to ride the bus, jeepneys, or a tricycle from their houses or apartments to take them to work, and to take care of their necessities. Taxi cabs in Sweet, Alabama were expensive and inconvenient. The nurses had to arrange their schedules in order to share ride to the hospital and back to their apartment. Soon they discovered that these unforeseen expenses were going to decrease their take home pay.

Homesickness and longing home, Monica and Yolanda desperately wished to call home and talk to their parents and sibling. When Monica dialed the international operator, gave her the country code, then the Manila code, and then, her family's telephone number, the international operator said, *"This call will cost you $15.00 per minute, do you still wish to place the call?"* With tears in her eyes, Monica said, *"No, I cannot afford to place the call"* and she hang up. The strongest experience that brought about the feeling of isolation was language barriers.

Perhaps the most isolating experience came from the inability to communicate. Every participant in this study registered the difficulty of being understood as an excruciating and painful ordeal. Each participant handled this experience in their unique fashion. One Filipina nurse had a novel way of dealing with communication problem. She said, *"I simply gave up attempting to communicate with my co-workers and the doctors. I carried a pen and a small notebook in my pocket. Whenever I was asked anything I will pulled out my notebook and* wrote *my response on a piece of paper and handed it to the person talking to me."* I was tired of them saying *"can you*

repeat what you said?" "I did not understand what you said, can you say it again?' "Can you spell it for me?'

Mockery was another common technique that native nurses employed in order to isolate participants in the study. The mockery centered on the participants' pronunciation, food and heritage. American co-workers were reported to have made fun of the way the Filipina nurses pronounced certain words. One source of amusement revolved around the pronunciation of the English word *"sheet."* Many languages do not contain the long *"E"* phoneme. In place of the long *"E"* the Filipino language pronounces the short *"I".* When the participants pronounced the word *"sheet"* the sound resulted in the English word *"shit."* They do not use this word in the Philippines, so they do not know its meaning.

The final form mockery resulted from the heritage of the Filipino nurses. One participant whose name is Remedios gave the following opinion, *"We came from a poor country, people referred* to us as *"third world people"* or *"brown sister."* Unfortunately, many of the people who worked with us mistakenly considered us to be dumb and uneducated. The fact that we had difficulties understanding them seemed to reinforce their misconceptions about us. They don't know that we cannot understand how they talk either.

Memo 2

January 2019

How Do the Filipina Nurses Experience Intimidation in their Work Environment?

Three of the nurse participants in this study expressed their experiences from intimidation in the workplace. The forms of overt intimidation took the following forms: impatience, rudeness, mockery, stereotyping, sexual harassment, and professional punishment.

Impatience took a number of different forms. Most incidents of impatience seem to revolve around cultural and linguistic factors. All three incidents of impatience involved an interaction between the Filipina nurses and medical doctors. All three incidents involved some form of *cultural and linguistic misunderstanding.* The first incident of impatience was experienced by several of the participants in the study. Rebecca's account of the experience was more dramatic and detailed. Rebecca was taking care of a post-operative patient. The surgeon came to the nursing unit to visit the patient, the surgeon asked Rebecca *"What is the patient I&O?"* Rebecca was slow to respond because at that time, she did not understand the meaning of I&O. Later. She came to discover that I&O meant *"Intake and Output."* Rebecca said, *"Before I could respond he threw the patient's chart toward s my body*. I started to cry and ran to the *bathroom. I was so embarrassed."* Later, the supervisor instructed Rebecca to write up the incident report describing what had taken place. Rebecca followed the instructions of the supervisor but later given a reprimand by the hospital administrator. One of the American nurse explained to Rebecca that "the doctor received priority and that she said, you have to respond to him as quickly as you can because that all think that they are *"God"* and our *"bosses"* even though she might think the doctor is in the wrong."

The second incident of impatient concerned a phone call at 3 o'clock in the morning regarding the condition of one of the patient. On one shift, Elly was taking care of a post hysterectomy patient. The patient was complaining of having *"too much gas."* The patient had not been prescribed any medication for gas pain. Elly called her gynecologist at 3AM and told him about the patient's complaint. The gynecologist screamed at the top of his voice into the phone *"what the hell are you talking about?"* Elly responded, *"I am not talking about hell,"* the gynecologist slammed down the phone. Elly asked the supervisor what she should do and the supervisor said that she should call him back again. Elly recounted, *"I was so nervous, I was actually perspiring and my heart was beating so fast.*" I called the doctor again and he said, *"Leave me alone or I am going to get you fired."* Elly stated, *"I went to the breakroom and cried. I was so frustrated. I just want to go back home and never return."* Elly reported the incident to the supervisor and the supervisor instructed her to write up an incident report. Elly followed the instructions of her supervisor and wrote up the incident. Elly recorded every word that transpired between her and the gynecologist. She was scrupulous not to leave out a single detail. Elly was called to the Director of Nursing (DON) office when she arrived to work the next day. She was told that the doctor had reported her for calling him twice in the middle of the night and not giving him enough detail concerning the patient's condition. Ultimately, Elly found to be at fault in the

incident and learned the same sad lesson that Rebecca had learned, that doctors were always right.

The second type of intimidation revolved around what the participants described as *"rudeness."* Acts of rudeness fell into two categories and were characterized by a manner of address or lack of address. Every participants in this study without exception indicated that doctors, co-workers and other healthcare team addressed them by simply calling out their last name. Feliza commented, *"It made my skin crawl every time I heard someone bark out my last name."* Cora explained the circumstances in the following manner; *"In the Philippines it is considered a common courtesy to address everyone by their first name. It is also a custom of politeness to address strangers, people with title, older people, and people with authority by* the *last name with salutation such as Mrs., Mr., Miss, Doctor, Judge, Sir, Reverend, etc."* The 3 participants in this study considered it demeaning to be addressed solely by their last name. Another custom of politeness that Filipino do not used is calling someone *"Hey, come here"* and *"waving your finger like calling a dog."*

Another example of rudeness revolved around lack of address. Dawn explained the situation eloquently, "When the American doctors came into the hospital to make their patient's round they would ask the American nurses about our patients. They completely ignored our presence and they gave this perception that they don't like to talk to us. The American nurses would ask me about my patients; I will give her all the information she needed and then, she will relay all the information to the doctor. This really irked me and it became a normal occurrence. After few months of this practice, Cora stated, *"I confronted the doctor why he refused talking to me about my patients. I told him that I am capable of giving him all the information he needed. I also told him that starting today I will be making rounds with him. I picked up all his charts and I walked beside him on our way to the patient's room. He did not say a word to me."* The other participants in this study stated that they feel so intimidated and they do not have the courage to confront the doctors.

Another act of intimidation is categorized as *"mockery."* Mockery took two forms in the data. One form of mockery was linguistic and the other form was culinary. The participants in the study were not native speakers of English. The participants spoke English fluently and understood English grammar impeccably; however, their pronunciation of certain words and their speech rhythm was dramatically affected by their native language, regional dialects, and accent. This resulted in a difficulty of understanding. On many occasions, the Filipina nurses were asked to repeat what they had spoken. Dawn listed a number of words that her co-workers and people in the community could not understand when she spoke them. That list included; *"hemoglobin, Robitussin, panty, sheet, Riboflavin, urine, popliteal, pituitary, beach, maintenance, ask, often, cardiology, pediatrics, Martin, Horton, Patton, insulin, invalid, broccoli, hanger, delicacy, delicatessen, bank, diapers, diarrhea, tamponade, yes Mam, Marietta, cemetery,* category, and many other words." Corazon and the other participants shared the list of words, comments, idioms and slag that were difficult for them to understand or decipher. Examples are; *over yonder, he went left field, my get up and go is gone and went, I&O, hot high and hell of a lot enema, fair to meddling, poke, slap jar, hunky-dory, raining cats and*

dogs, rain check, waylaid, fruit basket turnover, ain't, I've done done it, branch, Tom-Dick and Harry, you are into the weeds already, redneck, you are such a ding bat, BYOB, she's a scattered brain.

Another *source of comical amusement* which came about at the expense of the Filipina nurses revolved around their *food*. In the Philippines participants mentioned that rice, fish and vegetables were stable in their diet. Because they were on a limited income and could not go to the grocery store on a regular basis, the participants brought their food to the hospital and heated their meals in the breakroom during their supper break. The fish and sauce they ate carried a very pungent smell whenever they heated it in the microwave. The smell permeated the atmosphere in the breakroom and often seeped out into the hallways of the nursing unit. This became a source of jokes and humiliation for the American nurses and their co-workers. Monica and Rebecca both confided that they were often greeted with comments such as *"your food sticks" and "how can you eat that food that smells like feces?"* Many of the participants mentioned that the supervisors received so many complaints that they were eventually told not to bring food from home. They were instructed to eat their meal in the cafeteria. Monica and Rebecca stated that their co-workers exaggerated the smell of their food. When our co-workers heat their food and create pungent smells, we never complain. Rebecca stated, *"They are so mean to us."*

MEMO 3

October 8, 2018 and May 2019

How Do Filipina Nurses Experienced Discrimination and/or Marginalization in their Living and Working Environment?

The participants used a number of phrases that characterized their position of being marginalized. For example, Feliza made the comment, *"On many occasion I felt like I was not being taken seriously by the doctors, nurses, and other co-workers."* Monica commented, *"I felt like I was treated like a second class citizen."* When the participants arrived in the USA they were, as Lydia described them, *"naïve and just happy to have a job working at a hospital in the United States."* The supervisor and the unit nurse managers were in control of assigning the Filipina nurses to work either 3P-11P or 11P-7A or alternating shift. After a period of time, the Filipina nurses discovered a number of differences in their schedules. In order to get a vicarious experience of what the participants encountered I will let Cora explain the situation: *"After working for six months I noticed that I'm always being scheduled to work 3-11 for two weeks then 11-7 the next two weeks. I cannot develop a sleeping pattern and it was affecting my bodily function. I was never assigned to work 7A-3P shift not unless someone called in sick or on vacation. I also noticed that my weekend off was reduced to one weekend a month instead of the every other weekend off and I was scheduled to work every holiday. I noticed that the other Filipina nurses were being given the same unfavorable schedules. I went to the shift supervisor and to my unit manager and asked them why I was always getting the difficult shifts and working all the holidays. They both told me that I was not married and I did not have any children. They also mentioned that I was from another country and I did not have family in the US. They told me that the American nurses had children and needed to pick them up from school in the afternoon and to be with them in the evenings. They also told me that the American nurses needed to be able to travel and visit relatives during holidays or celebrate holidays with their children."*

Not only did the participants mention an unfairness, they were written up for complaining about their work schedule and for being uncooperative. Filipina nurses were not only given the most difficult work schedules but they were also given a disproportionate number of patients who were very sick and take a lot of time and energy to take care of them. Remedios noticed that she was *"always*

assigned more patients with high acuity," meaning the patients need total care and cannot help themselves to do anything.

Dawn made a commented *"that white patients, especially females, refused us to take care of them."* Fe has similar experience. She confided, *"Some rich while patients told the hospital administrator that they did not want to be attended by the Filipina nurses."* The participants did not mention whether they considered these refusal of services were racially motivated or undermining the skills and knowledge of the Filipina nurses. I would consider that the refusal of services was at least partially due to the racial component.

Another form of discriminative behavior is best described as passive aggressive treatment. Many occasions required nurses to work together in teams. Lydia reported that there were many occasions when the American nurses refused to participate on a team if she or any of the other Filipina nurses were on a team. Julieta gave an account of how some of the American nurses refused to cooperate with her employing a passive aggressive strategy; The Licensed Practical Nurse (LPN) assigned with me was much older that I was and refused to accept me as her team leader. We were supposed to check every patient's medication cards and match them on what was written in the Kardex. The LPN would always say, "I can do this task by myself, I don't need your help." Lydia insisted that they have to the procedure, The LPN threw all the medication cards on the floor and walked away. There were 60 patients in the nursing unit that I was assigned to work, each team consisted of 1RN, 1LPN and 1nursing assistant and we were responsible for 20 patients. The Two RNs on the other team hardly talked to me except when they wanted me to do something for their patients. *"They made me feel like I did not deserve their respect and I feel like an outsider."*

APPENDIX H:

EXCERPTS FROM NURSE PARTICIPANTS' INTERVIEWS

Dawn's Interview

Interviewer: How were these experiences in the U.S. similar and different from your experiences in the Philippines? How did the doctor and supervisors treat you differently?

Similarities
DAWN: Nursing is the Philippines and in the USA are pretty much the same. Nursing procedures are the same like giving patients their bath, changing bed linens, assisting them with their meals, or activities of daily living, administering medications in whatever form (po, IM, subq), changing wound dressing, starting IV infusion, etc. Everyone wears white nursing uniforms and nursing cap and white shoes. We worked by shift; 7AM-3PM, 3PM-11PM, 11PM – 7AM. In the Philippines, most equipment were outdated while in the US, pretty much everything were updated and we used mostly disposable supplies, even the bedpan were disposables.
Negative
DAWN: In the Philippines, I was never called my "Filipino Baby." I was never asked if I'm married to a GI. In the USA, these were constant questions the 1st 2 years I arrived. In the Philippines, everyone understand what I am saying even though we have different regional dialect and we all spoke English. I did not have any communication problems in the PI. In the US, I felt like most of my co-workers especially the white male doctors and white nurses were always having a hard time understanding my English, They were telling me that I had a hard accent and could not understand how I pronounced some words.
I did not feel any isolation or discrimination while working in the PI.
I felt isolated and I felt marginalized. I did not want to carry a conversation with anyone unless they asked me questions about my patients. Most of my co-workers made fun of me. They always asked me what I brought for dinner (I worked 3-11 shift), they made comment such as, "I will not go to the break room while you are eating your food, and your food had a distinct smell." That was truly meanness.

Doctors:

DAWN: PI doctors makes me feel like their maid. They feel entitled like they own nurses. We were expected to do more for them including getting their coffee ready and their food ready. Nurses were treated well if doctors like the nurses especially if the nurses were beautiful and smart. You carry their charts during rounds including progress notes and prescription pads. We were expected to make rounds with them. Doctors in the PI felt entitled because they are MD. Nurses and doctors who went to same University and graduated same year, were buddy-buddy. They joke a lot and flirt a lot while making rounds. It was annoying.

DAWN: USA doctors were so darn intimidating especially the 1st 2 years when I arrived. It gave me chills just knowing they were in our nursing unit making rounds. I get so nervous in front of them especially if I was assigned to their patients. They always seems not to understand what I am saying. They always said "What did you say now?" I have to repeat myself several times for them to understand me. They give me this perception that

they don't trust me and that I don't know anything. It irked me when they asked the American nurses about my patients, and then, the American nurses will turned around and asked me the questions, then, she will relayed my answers to the doctors. I hate carrying a conversation with the doctors especially with the old white doctors. They really made me feel so inferior to them.

Supervisor

DAWN: PI supervisor makes the weekly schedule and approve/deny off day request. They can change your schedule without your consent to meet their staffing needs. They complete the yearly evaluation and very rare we get a salary increase no matter how you perform. Sometimes they used their power to intimidate new graduates so they can manipulate their schedules for their convenient especially during the holidays. The DON does all the hiring and firing of employees. She normally stays in her office and maybe made nursing unit rounds once a day. I addressed our supervisor by calling the Miss, Mrs, or Mr. Last Name.

DAWN: USA supervisors are very intimidating, when I first came for my orientations, the supervisors told me the do's and the don'ts including speaking English while at the hospital/clinic facilities including when we are at lunch break or 10 minutes break. If the Charge Nurse cannot resolve an issue or problem, then they call the supervisor to handle it. The unit Charge Nurse does the schedule for all the staff working in that unit. She is also responsible for performance evaluations, ordering of supplies, approving/denying vacation request. Initially, my Charge Nurse manipulate my schedules w/o telling me. She used to schedule me to work 3-11 or 11-7, all weekends and holidays, her reasons were; I don't have my family with me, I'm single, no children and my co-workers has their families here in the USA to celebrate holidays and they have children. In the beginning, I was not complaining, then I got tired of it and I started complaining about my schedule. I told her that I have relatives in other states, I want to visit with them and I need to celebrate some holidays with them. She reported me to the supervisor that I was very uncooperative and I'm always complaining about my schedule. She also gave me poor evaluations which I refused to sign.

Interviewer: From your standpoint, how does Filipino men's role compare/differ from American men?

DAWN: Filipino men- especially the father rules the household. They are considered the primary breadwinner. The father's words are the law, they expect their wife to do everything for them; from taking care of the children, cooking, cleaning the house, etc., while we are working full time as a nurse. They expect us to have everything done within the household when both husband and wife are working full time. Men in the PI does not do grocery shopping, change their babies' diapers, does not cook, does not do laundry but they do the yard works, vacuum the whole house, take the trash out. They have a lot of respect for women especially when they are college graduate and working. Filipino men are well-mannered and gentlemen. They normally open the door for women, pull chair in the restaurant, etc.

DAWN: American men –the most intimidating creatures that I have ever met. In the beginning of my nursing career in the USA, as a nurse, I will only asked what I need to know. I never carry a conversation. As usual, they will asked me repeatedly to repeat what I asked and what I said, it was very aggravating. I learned to speak very slowly. There were men who called me their "Filipino Baby" and want to hold my hands when I am assessing them; at first, I did not know the meaning other than the literal terms, others asked if I'm married to a GI. Some seems to be respectful, and were very nice and appreciative of our service. I don't know how they are as husband. American men loves to hunt, they did not mind cooking or washing their own. They are very much independent.

Interviewer: What were your experiences based on race, gender, and social class?

DAWN: I felt at first that all healthcare workers (black or white) were very discriminative and did not like having a Filipino nurse making rounds with them. I felt isolated and I hate starting a conversation since everyone made fun of my accent and seems not to understand what I am saying when I am talking to them, and vice-versa. Many time, I just do my work, take care of my patients, carry out my doctor's orders, do my charting, I even hate to ask any questions related to patients. There were times where I will call another Filipino nurse who was working in another unit if I am not sure if I am doing things correctly. I feel like it was easier to make friends with black people compare to white people. I was not comfortable talking to males especially black. I was scared of them in the beginning. I was so intimidated by white males. I did not like making friends with them. Some white patients refused to have a Filipino nurse taking care of them and of course that hurts my feelings so bad. I felt like an outsider trying hard to be accepted. They were a lot of clicks among my co-workers. They make me feel like this women looking inside outside a fence trying to be accepted for who I am. Divorces among white/black couple was so popular and that is one culture that we don't practice. Some of the men in the USA were respectful and they are giving. Some of the white doctors live in rich subdivision and are all members of country club. They were snub.

Interviewer: Did you sign a contract with your employer? Can you tell me what was written in the contract? Did they fulfill their promises or any agreement written in your contract? Explain.

DAWN: Yes, I signed a two year contract. I was approved to work 3 months with temporary license. If I don't passed the TOEFFL and the State Board, I will be send back to the Philippines since my visa was a working visa sponsored by the hospital. The board gave me 2 chances in a year to pass the board exam. It stated that they will help me with living accommodation for 1 month. They did not offer any help reviewing for TOEFFL and for the state nursing examination. I was stress everyday trying to learn all my work responsibilities, applying for the TOEFFL examination (I cannot take the nursing board examination without passing the TOEFFL), and also reviewing at the same time for my nursing board exam.

Interviewer: Tell me about what your employer shared about the hospital setting you are going to work?

DAWN: The hospital recruiter just told me that I will be working in a hospital. I was so naïve that I did not ask what kind of hospital it was. I was told that there were 6 nurses who were recruited and I will work 11-7 shift.

Interviewer: Tell me what experiences did you encounter in your social life, working life, and family life while living and working in your new environment?

DAWN: I really did not have any social life the 1st year I came. I worked many hours and slept in between eating. I did not have a car and I don't know how to drive. Some of my co-workers will ask me every now and then if I need a ride to the grocery store or to church. My aunt was so busy working and helping raise her grandchildren so I did not rely on her picking me up to spend time with them when I was off. When the other Filipino nurses came a year after I came, we will take a taxi to go to the mall or take the bus to see other places. But that was rare because everyone works a lot to earn extra money for our expenses and to send home to our family. There were times were our co-workers will invite us their children's birthday party or children's wedding. It was nice of them to do that. Birthdays and weddings here were so different from our culture and it was a learning experience. I was learning to like most of the food in the restaurant and at the cafeteria where we work.

Interviewer: Tell me what experiences did you encounter being a Filipina, being a woman of color, being a minority and being new in your living and working environment?

DAWN: I felt like everyone in the facility was trying to gauge my knowledge, my skills and my interpersonal relationship with them and with my patients. I came from a region in the Philippines where our dialect affects how we pronounce English words. I will ask my co-worker to do something for me, they will shake their head like they understood what I was saying, and then, they will come back to me to let me know that they did not understand what I told them. That really irked me. There were times when they were in group and started laughing at some of the words I used or pronounced. I felt like the white co-workers were harder to get along with versus the black co-workers. I only spoke to white/black males when it was necessary. They always asked me where I learned to speak English. One time, I came to work in my white uniform, the supervisor told me to go home to change my uniform because the dress I was wearing was too short. I wore the same uniform twice already and I don't know why she thought my uniform was short. I was also reported that I was sleeping at work which was not true. It was so hard to explain myself to our supervisor. She seems to believe everything that was being reported to her. I felt isolated and I felt that my co-workers were always looking for something to report me to our supervisor. There was a time where I really want to quit and just go back to the

Philippines. I am very tough, resilient and I can tolerate a lot of bullying but I am not used being around people who are so critical and so discriminative.

Interviewer: Tell me your stories about the discrimination and marginalization you experience working with white people, minority people and with other Filipinos? How did these experiences affect you as a Filipina, as a nurse, and as a family person?

DAWN: Like I said previously, some of my co-workers will make fun of how I say things and formed my sentences. They always said, "Say that again" or "can you repeat what you said". Some of them will tell me to just write what I want to communicate in a piece of paper. They laughed at me and make fun of me. They also find something to report me to our supervisor who believe everything they report. When I bring my own lunch, some of them will always say "what did you bring this time", and then, they will say "what is that smell". So instead of eating in our break room, I will go to another area in the facility to eat. I found it easier to work with black people versus working with white people. I felt like I was competing with them when we have the same job roles and responsibility. When the other Filipino nurses came, we started being friends and like family, later on, we were all competing for overtime work so we can earn more money. We gossip about each other about some of the Filipino nurses were brown nosing the supervisor for overtime hours. None of us had family who came with us to USA. Some of us were still single and 2 were married with one child but their husband and son were left in the Philippines.

Interviewer: Tell me your experiences about the support you received from your co-workers, managers or from hospital administration?

DAWN: I stayed with my aunt's family the 1st week of my arrival. It was overcrowded in her apartment. When I reported to the hospital for my 1st day, I told the staff development person about my living situation. She noticed that I was very stressed. My luggage were left in her office. She walked me to the Hospital Administrator and to the Director of Nursing office. They were both very happy to see me, they both gave me a hug. After they learned of my living and money situation, they offered me to stay in one of their rental room for family members that was located in the 2nd floor of the facility. They told me that I can eat in the cafeteria and I will pay them monthly for the rent and food. The room is like a little hotel which met my needs during that time. I also didn't know how to drive and I cannot afford to buy a car which decreases my stress. The cafeteria served breakfast, lunch and dinner. Sometimes the food were tolerable and at times they were non-palatable. After few weeks working in my assigned nursing unit, some of my co-workers will volunteered if I want to go to the grocery store, to church, or to eat out for change in scenery. Some of them will invite me to their children's birthday or family gathering like Thanksgiving holiday. My manager was accommodating but at times mean to me. I get angry sometimes because she will changed my shift or off days without telling me. I didn't complain since I was new in the facility. Over-all, I consider my transition fairly good but they could have done more like helping me review for my TOEFFL and for taking the nursing board.

Interviewer: What resources could have been offered to you in your workplace, in your community, and with your family?

DAWN: It could have been better if there was a staff assigned to me to help orient me not only in the hospital but in the community; to show me around where the grocery stores, the church, the eateries nearby were I can walk and considered safe to go since I didn't have a car. It could have been better if someone could have help me how to review for the TOEFFL and for the nursing board, to orient me about people's accent and expectations of having a Filipino nurse to take care of patients and help me develop relationship with other health care staff like PT, OT, Speech Pathologist, especially the doctors. I wished that the travel agency tin the Philippines that arranged for our employment and obtain our visa could have included a short orientation of what to expect when I arrived, described the scope of services of the hospital, the culture of the people and how we should transition to our new environment. I did not have any family when I arrived in the USA.

Interviewer: If you were able to do this all over again, what would you do differently? What kind of supports would you like? What would you like to have learned in nursing? About the U.S.? About families?

DAWN: First, I should have prepared myself and wrote all the questions I need to know about the type of healthcare facility I'm applying to, what scope of service do they provide, bed capacity, salary, benefits, staffing patterns they have, where is the facility located, nearest city to the place, population of the community. I want to know if there will be someone to meet me at the airport, I want to know my living situation, transportation to and from my living place to the site of my employment, if someone will be assign to me as liaison so I will have someone familiar to ask questions and to guide me and familiarize me to my working and living environment. Have someone to introduce me to all the staff, give me tour of the facility and the neighborhood, showing me around time where the stores are, the bank, the church, the city hall, the federal building if there any, the nearest immigration office to the place I'm working. Have someone to tell me how nursing is being practice in the US, tell me if the facility is using paper documentation or electronic documentation, what uniforms to wear and where to buy them, where the laundromat is located. They should prepared me in the Philippines what is TOEFFL and if there is a review materials to study for the test, the same with the nursing board exam. I should have passed this test before leaving for the US.

Interviewer: Utilizing all your lived experiences, tell me how and what can you contribute in the development of transition program or in the enhancement of an existing transition program for newly hired Filipino nurses and for future internationally educated Filipino nurses who will migrate to the U.S. to join the U.S. nursing workforce?

DAWN: Once the nurses are hired by US employer, the travel agency and recruiting coordinator for the healthcare facility should prepare the nurses to review for their TOEFFL and Nursing Board in the Philippines, take and pass the test before leaving for the US.

a. The recruiter should provide orientation and transition process while in the Philippines, that will include, information about the facility we are going to work, what scope of service they provide, staffing, bed capacity, location (urban, suburban, rural), salary/benefits, culture of the organization, diversity of staff working in the facility. Living arrangement and transportation (90% of Filipino does not drive or own a car.) Travel time from our living location to the hospital, what mode of transportation the place has and price. Who will transport us to and from the facility?
b. Once we arrived in the USA, there should be a coordinator assign to our group or to individual nurse, who we will be our go to person, who will help us get things we needed for our living space, to show us where the stores are (grocery, mall, etc.,) where we can buy food familiar to us like an oriental stores, to show us where the bank, the church, the city hall to turn water/power/telephone/cable if we are going to live in an apartment. To give us type/telephone numbers of transportation mode. Introduce us to the church priest/preacher where we intent to join for our worship.
c. At the hospital 1st day, give tour of the facility, introduced us to staff if possible, acculturate us with the environment, tell us what the facility expectations are, provide extensive nursing orientation, assign us a preceptor in the nursing unit where we are going to work. I would like her to tell us if our English is hard to understand, if yes, provide orientation on how people in and out of the facility talk and how we should pronounce certain words so we can be understood. Introduce us to the medical staff, so we can familiarize ourselves who the doctors are and what specialty do they practice, maybe it will lessen our feeling of intimidation.
d. Post orientation, people learn in different phases, some are slow and some are fast learner. They should not shortened orientation just because they are extremely understaff. They should assign us to our nursing specialty if possible (Med/Surg/ICU/ACCU/OR/Labor and Delivery/ED) or cross-train us to get us familiar with each nursing unit. The staff development coordinator should include not just reading the policy and procedure manual but include hands-on training before working on our own.
e. We should be able to speak our native language during break and outside the facility.

Cora's Interview

Interviewer: Reasons for joining the U.S. nursing workforce?

CORA: When I went to nursing school, I always dreamed about going to the USA to work. I heard from our former alumni who were in the USA already how they enjoy their work and their salary. They had good life, and able to support their family back home. I would like to follow their footstep. Before I took the Philippine nursing board, I went to interview for several USA hospitals. I really like to go to California or Hawaii to join my brother's family and relatives. Luckily, I ended up in Alabama. A year after my graduation I left my country with 10 other Filipino nurses who were hired by the same hospital in Alabama. I was single and I knew I can make money, and will be able to help my parents and my other siblings. I have 6 brothers and 2 sisters
I would like to have a better life, to have better opportunity, to live comfortable and be able to travel around the world.
My father was a farmer and my mother was a stay home mother and helped in the farm.
USA hospitals has better equipment and supplies. We heard from our former alumni that most supplies were disposable, the hospitals were clean and they eat whatever they like to eat. Some of my classmates left before me. We were so excited that our dream of going to USA became reality. We all had plans and dreams of visiting families, friends, and classmates and to travel.

Interviewer: What were your positive/negative experiences as a nurse in the U.S.? Give me examples.

<u>Positives:</u>

CORA: USA hospitals provide better salary, better benefits like vacation, holiday, sick time, retirement options.
They have better working environment .The hospital have up to date equipment and supplies. Most supplies are disposable.
I lived comfortably and I can afford to pay for all my expenses and I'm able to support my family financially. I was able to visit some of my classmates, friends and relatives. I traveled and took vacation at Disney World, Six Flags in Georgia, and beaches of Florida with my classmates, friends and my own family. My house was fully furnished with things I like (bedroom suite, nice sofa, refrigerator, extra freezer, TV, stereo, etc.)
I had great living condition with heater and air-conditioning, cold/hot water, garbage disposal. All of these are considered luxuries in my country.
I bought shoes, clothes, nice purse/handbags that I liked and after 1 year in USA, I bought my 1st car even though I did not know how to drive. I have to take driving lessons. I worked as much overtime as I want to and I got paid extra money. I was able to send enough dollars to my parents to help them send my sibling to school, buy the food they like. The hospital use electronic medical records. It was easy to track patient information.

Negatives:

CORA: I was too far away from my families, relatives and friends back home. I got so homesick especially during holidays. My co-workers and patients are having a hard time understanding my English. They told me that they cannot understand my accent. I speak our regional dialect that affects how we pronounced some words. Example of words that they cannot understand were urine, hemoglobin, Robitussin, bed sheets, broccoli, invalid, Decatur, beach, bank, diapers, tamponade, often, hanger, pediatrics, cardiology and many more. These are words American used that we are not familiar with; fruit basket turn over, raining cats and dogs, I will give you a rain check, slap jar, poke, hunky dory, over yonder, over the boondock, my get up and go in gone and went, buttermilk, titi, peepee, drawer (underwear), breaches (panty), sloppy joe and many more. My co-workers will look at me like I was crazy, they all laughed at me and make fun of me." I told some of them they were **obnoxious.** I told them that they can teach me how to pronounce the words instead of making fun of me. I easily get upset and cry. Some of the LPNs that I worked with will always tell me to write in a piece of paper what I needed them to do for the patients. We used a lot of Robitussin when I first came to the US, and the way I pronounce the word was very different, the accent is different and the way they pronounce the word was totally different from mine.

Like other Filipino nurses that just came from the PI; some of my co-workers, patients and families assumed that I was married to a "GI". I don't even know the meaning of GI. This comments truly embarrassed me. I was talking to some of the Filipina nurses in our group and I was telling them about this comment, one of them told me what it meant, it was very demeaning to me because GI meant low class, unmotivated soldiers. They were telling me the same story.

Some male white/black patients will say, "Here's my Filipino Baby" as soon as I entered the patient's room. Their wife will asked me what they meant by Filipino Baby. I normally answer "I don't know." Again, this phrase meant; when the US military gets their off day, they go this place in the Philippines and picked up their own women (Prostitute), the men will tell this women that they own them. Of course, they pay this women to provide them pleasures.

I find it hard to develop working relationship with white nurses. The black nurses and other co-workers like LPNs and nursing assistants seems to be friendlier to me.

There were white and black doctors practicing in our hospital. The white men were pretty intimidating and mean. One time, I admitted a patient for surgery, we routinely call the surgeon to give pre-op orders. The surgeon won't talk to me, he asked for the American nurse and he gave his pre-op orders to her. This same surgeon did this to me at least 3 more times. The 4th time I called him, he asked again for the American nurse, I told him that he is going to give me his pre-op orders since I am his patient's nurse, or he can come to the hospital to write his pre-op orders. Two hours later, he came to our nursing unit with the nursing supervisor. He asked who was taking care of his patient, I said "I do." He then told the supervisor to teach me how to respect physicians. I was written up for disrespecting him I went to the break room and cried, I was so frustrated. I hate it when they start saying "Please repeat what you said" or "what are you talking about." Later on, I stopped talking to them not unless they have questions for me. They made me feel like I'm

a second class citizen and not a professional. Doctors and nurses under estimate my skills and knowledge of nursing.
My roommates and I cooked our meals and we bring our supper to the hospital to save money. My co-workers especially white made fun of the food we cooked and bring to work for our meals. They made comments such as; **"how can you eat that food, it stinks**." **"Did you bring the same food that you brought yesterday?"** "**What is on that food?"** I told them that I brought rice, pork chop, boiled eggs and slice tomatoes. I asked them, "**don't you eat this food here in America?"** They walked away from me and did not say anything. We had an older senior 11-7 supervisor, she was very motherly but stayed mostly in the nursing office doing staffing. She came to our nursing unit and tried to calm me down and told me to be patient and tolerable. If not for her, I have already been back home to the Philippines. I hated going to work.

Interviewer: How were these experiences in the U.S. similar and different from your experiences in the Philippines? How did the doctor and supervisors treat you differently?

CORA: Similarities – Nursing a patient and providing nursing care is the Philippines and in the USA are pretty much the same. Nursing procedures are the same like giving patients their bath, changing bed linens, assisting them with their meals, or activities of daily living, administering medications in whatever form; per mouth, intramuscular, subcutaneous, intravenous, changing wound dressing, starting IV infusion, etc. Everyone wears white nursing uniforms and nursing cap and white shoes. We worked by shift; 7AM-3PM, 3PM-11PM, 11PM – 7AM. In the Philippines, most equipment were outdated while in the US, pretty much everything were updated and we used mostly disposable supplies, even the bedpan were disposables.

CORA: Negative – In the Philippines, I was never called my "Filipino Baby." I was never asked if I'm married to a GI. In the USA, these were constant questions the 1st years I arrived.
In the Philippines (PI), everyone understand what I am saying even though we have different regional dialect and we all spoke English. I did not have any communication problems in the PI. In the US, I felt like most of my co-workers especially the white male doctors and white nurses were always having a hard time understanding my English. They don't know that I was also having a hard time understanding what they were saying. They were telling me that I had a hard accent and could not understand how I pronounced some words. I did not feel any isolation or discrimination while working in the PI.
I felt isolated and I felt marginalized. I did not want to carry a conversation with anyone unless they asked me questions about my patients. Most of my co-workers made fun of me. They always asked me what I brought for dinner (I worked 3-11 shift), they made comment such as, "**I will not go to the break room while you are eating your food, and your food had a distinct smell." They were so rude.** One of the 3-11 supervisor was not a fair person and will not listen to any explanation if any of my co-workers complaint about me. I did not enjoy my 1st 2 year in USA.

Doctors:

CORA: Philippine (PI) doctors are spoiled and feel very privilege (came from Spanish culture.) They made me feel like their hand maid. We were expected to do more for them including getting their coffee and getting their food ready especially those in authority like medical director, department chair or chief residents. Nurses were treated well if doctors like the nurses especially if the nurses were beautiful and smart. I carried their charts during rounds including progress notes and prescription pads. We were expected to make rounds with them. Doctors in the PI felt entitled because they are MD. Nurses and doctors who went to same University and graduated same year, were buddy-buddy. They joke a lot and flirt a lot while making rounds. It was annoying. Most of them were nice and acted gentlemen while some were rude and annoying. The Filipino doctors always wore their white, well -ironed lab coat, with their name and title embroidered and carry stethoscope around their neck. They looked very professional.

CORA: USA doctors most doctors that I encountered were so intimidating especially the 1st year I came. I feel like hiding just knowing they were in our nursing unit making rounds. I get so nervous in front of them especially if I was assigned to their patients. They always seems not to understand what I was saying. They always said "What did you say now?" I have to repeat myself several times for them to understand me. They give me this perception that they don't trust me and that I don't know anything. It irked me when they asked the American nurses about my patients, and then, the American nurses will turned around and asked me the questions, and then, she will relayed my answers to the doctors. I hate carrying a conversation with the doctors especially with the old white doctors. They really made me feel so inferior to them. There were some that were nice to me and to the other Filipino nurses. There were few doctors that gave us encouragement and tried hard to help us how to handle the other doctors who didn't want to speak to us and didn't want to give orders on their patients. Most American doctors will come to the nurses' station, will sat on a chair and propped their feet on the desk. Some even have toothpick on their mouth. Some looks professional and clean. Very few of them carry a stethoscope, they always borrowed the nurse stethoscope. Most of them didn't wear lab coat, most surgeon did.

Supervisor

CORA: PI supervisor makes the weekly schedule and approve/deny off day request. They can change your schedule without your consent to meet their staffing needs. They complete the yearly evaluation and very rare we get a salary increase no matter how we performed. Sometimes they used their power to intimidate new graduates so they can manipulate their schedules for their convenient especially during the holidays. The DON does all the hiring and firing of employees. She normally stays in her office and maybe made nursing unit rounds once a day. I addressed our supervisor by calling them Miss, Mrs, or Mr. Last Name. They are friendly to nurses who graduated from their school of nursing or if they were their classmates in nursing school. They do the nursing budget and order supplies.

CORA: USA supervisors are very intimidating, when I first came for my orientations, the supervisors told me the do's and the don'ts including speaking English while at the hospital/clinic facilities including when we are at lunch break or 10 minutes break. If the Charge Nurse cannot resolve an issue or problem, then they call the supervisor to handle it. The unit Charge Nurse does the schedule for all the staff working in that unit. She is also responsible for performance evaluations, ordering of supplies, approving/denying vacation request. Initially, my Charge Nurse manipulate my schedules w/o telling me. She used to schedule me to work 3-11 or 11-7, all weekends and holidays, her reasons were;" I didn't have my family with me, and my co-workers has their families here in the USA to celebrate holidays and they have children to celebrate Christmas." In the beginning, I was not complaining, then I got tired of it and I started complaining about my schedule. I told her that I have relatives in other states, I want to visit with them and I need to celebrate some holidays with them. She reported me to the supervisor that I was very uncooperative and I'm always complaining about my schedule. She also gave me poor evaluations which I refused to sign. We have one supervisor on 11-7 who was so motherly, very soft-spoken, she always takes care of us and she will always asked if we need anything or if she can help us with anything. I love her to death. If not for her, I could have went back to the PI. She will pick us up on our off days and will drive us around to show us where things are (groceries, churches, banks, restaurant, parks, and nice places to go). She was our other mother. She was also Catholic, she got us going and stayed.

Interviewer: What were your experiences based on race, gender, and social class?

CORA: I felt at first that all healthcare workers (black or white) were very discriminative and did not like having a Filipino nurse making rounds with them. I felt isolated and I hate starting a conversation since everyone made fun of my accent and seems not to understand what I am saying when I am talking to them, and vice-versa. Many time, I just do my work, take care of my patients, carry out my doctor's orders, do my charting, I even hate to ask any questions related to my patients. There were times where I will call another Filipino nurse who was working in another unit if I am not sure if I am doing things correctly. I feel like it was easier to make friends with black people compare to white people. I was not comfortable talking to males especially black. I was scared of them in the beginning. I was so intimidated by white males. I did not like making friends with them. Some rich white patients refused to have a Filipino nurse taking care of them and of course that hurts my feelings so bad. I felt like an outsider trying hard to be accepted. They were a lot of clicks among my co-workers. They make me feel like low class and I was trying hard to be accepted for who I am. Divorces among white/black couple was so popular and that is one culture that we don't practice in the PI. Some of the men in the USA were respectful
But some flirts even though they are married or the nurse is married. Most white doctors live in rich neighborhood and were members of country club. They were treated as the upper echelon of the community. Their wives were snobs and only socialized with same community. There were Americans who truly respected us for coming to USA and appreciated our service. I truly disliked it when man white or black will call me their "Filipino Baby" and when my co-workers or people in the community think I am married to a "GI". When I first attended the Catholic Church in the community, everyone were

curious. They thought at first that we were university students, curious why we know how to speak English. Most people in the community who did not serve during WWII, didn't know much about the Philippines. They were asking us, what we eat and how we cook our food, what we like to do for recreation, do we have coke, chicken, pizza in the Philippines. Some of the people in the community especially when we go to the grocery store, people will be looking at us with curiosity. Some will ask "You speak English", when we say yes, they start conversing with us. They normally asked "how do you know how to speak English", some will asked "Are you a university student?" since the hospital is about 2 miles from the University of Alabama.
Some of our co-workers especially low income black took advantage of our innocence of the system. Some will beg us to give them cash money in exchange for food stamps. They will tell us that they don't have enough cash money to buy their children especially infant milk, bread and other necessary items. Some of the Filipino nurses were victims of this scenario. We went to the grocery stores and we tried to pay with food stamps, the cashiers knew some of us already that we work at the hospital. She called the store manager, the manager took us to his office and started interrogating us where we got our food stamps, and he told us that it was a federal offense. We told him the same story. He told us to give them back to the person who got our cash money and if they refused to give our cash money back to tell them that we will report them to the authority. That was one scary experience.

Interviewer: Tell me about your nursing curriculum in the Philippines?

CORA: The 1st 2 years, we took all the pre-requisite to meet the requirement for admission to the upper division of our nursing school. The subjects included English, Spanish, Chemistry, Social Sciences, Zoology, Psychology, Humanities, Math, American History and American Government. The admission was very competitive. Once admitted to the nursing school, we have 3 years to complete our academic requirement and 8 hours of clinical, 5 days a week and worked every other weekend. After we survived the 1st year in upper division in nursing, we have our capping and pin ceremony. The training was extensive. We went to other hospitals for specialty services like mental health, orthopedic, communicable disease, and public health. It was hard but fun. We were required to volunteer on medical missions during the summer semester. Some of the courses we took in nursing school were Anatomy/Physiology, Pharmacology, Public Health Nursing, Fundamentals of Nursing, Medical/Surgical nursing, Communicable Diseases, Professional Development, Psychiatry, OB/Gyn. Three month after graduation, we were required to take the Nursing Board. The 5 years in nursing was hectic and there were not enough time for social life. The BSN and ADN programs in the PI have the same curriculum.

Interviewer: What is your primary and secondary language? Do you speak any of the dialects in the Philippines? What medium of instructions did they use in your school?

CORA: I speak primarily Ilocano, my regional dialect but I can speak fluent Tagalog and English. English is the medium of instruction. I can also speak some Spanish language.

Public Health. PI nurses when to the hospitals for clinical rotations 8 hours a day, 5 days a week and rotated every other weekend. USA nurses did 8 hours of clinical 3 days a week. They were off during weekends and holidays, we were not. We had more clinical hours compared to USA students.

Interviewer: Did you sign a contract with your employer? Can you tell me what was written in the contract? Did they fulfill their promises or any agreement written in your contract? Explain.

CORA: Yes, I signed a one year contract. I also signed that if I didn't passed the board, I have to work as a nursing assistant till I pass the board within a year. I was approved to work 3 months with temporary license. If I don't passed the TOEFFL and the State Board, I will be send back to the Philippines since my visa was a working visa sponsored by the hospital. It stated about my living arrangement, that I am responsible for my rent, utilities, and transportation. It also stated that I will work 3-11 or 11-7 and my hourly salary will be $8.00 per hour. The benefits included vacation time, holiday, sick time and retirement options. They did not tell me the little things that were important to me like cost of monthly rent, cost of utilities, food, transportation, and my net salary. Somehow, some of this questions/answers were my fault since I did not know what to ask during my interview. I was very disappointed because I was fearful that I will not have enough money to pay for everything. There were no public buses that transport passengers from place to place constantly like in the PI. I did not know that I have to call the taxi company at least 2 hours ahead of time to pick me up for work and to take me back to my apartment.

Fe's Interview

Interviewer: **What were the challenges of being a nurse in the Philippines? Give me examples**.

Fe: The salary was extremely low, it was not enough to support me. I lived in the hospital dormitory for 90 pesos per month until I left for USA. I felt bad that I cannot afford to help my parents financially. I have to ask my parents to help me financially every now and then and that made me feel insufficient. My parents have my other siblings (2) to feed and to send to school. I cannot even buy gifts for my family during their birthday or holidays.
Our hospital was behind with up to date equipment and supplies. We have to boil syringes and needles after each used. We have to roll the cotton to make cotton balls and fold and sterilize the gauze. There was no equipment that is disposable.
We rotate shift between 3-11 and 11-7 every other month. We cleaned all the bedpans with soap and hot water every night on 11-7 shift.
The hospital does not offer any benefits like health insurance, vacation, sick time or educational benefits.

Interviewer: What were your positive/negative experiences as a nurse in the U.S.? Give me examples.
Positives:

Fe: USA provide better salary, better benefits like vacation, holiday, sick time, retirement options.
They have better working environment .The hospital have up to date equipment and supplies. Most supplies are disposable.
I can live comfortably and can afford to pay for all my expenses and I'm able to support my family financially. I'm able to take vacation in places like New York, LA, Texas, Florida, Bahamas and even Europe. My house is fully furnished with things I like (bedroom suite, nice sofa, refrigerator, extra freezer, TV, stereo, etc.)
Better living condition with heater and air-conditioning, cold/hot water, garbage disposal. I dreamed of having this things while I was in the Philippines.
I can buy shoes, clothes, nice purse/handbags and I even bought my 1st car after 1 year even though I did not know how to drive, my co-worker taught me how to drive.
I can work as much overtime as I want to and I get paid extra money. I was able to send enough dollars to my parents to help them send my sibling to school, buy the food they like.

Negatives:

Fe: I am too far away from my families, relatives and friends back home. I get so homesick especially during holidays.
My co-workers and patients are having a hard time understanding my English. They told me I have a "hard tongue"; I really don't know what they meant.
My patients and some co-workers assumed that I am married to a "GI". I don't even know the meaning of GI. This comments truly embarrassed me. I was talking to some of

the Filipina nurses in our group and I was telling them about this comment, one of them told me what it meant, it was very demeaning to me because GI meant low class, unmotivated soldiers.
Male white patients and some male black patient who were in the Philippines during World War II and after the war, will say "Here's my Filipino Baby" as soon as I enter the patient's room. Their wife and families asked me what they meant by Filipino Baby. I normally answer "I don't know." Again, this phrase meant; when the US military gets their off day, they go this place in the Philippines and picked up their own women (Prostitute), the men will tell this women that they own them. Of course, they pay this women to provide them pleasures.
I find it hard to develop working relationship with white nurses. The black nurses and other co-workers like LPNs and nursing assistants seems to be friendlier to me.
There were white and black doctors practicing in our hospital. The white men were pretty intimidating, at least the black doctors will talk to me and carry a conversation. The white doctor, it was questions and answers conversation. The white doctors and white nurses seems to not understand when I was talking especially when I was giving report to the doctors and when I was giving end of shift report. They make me feel bad and felt embarrassed that they cannot understand me. I hate it when they start saying "Please repeat what you said" or "what are you talking about." Later on, I stopped talking to them not unless they have questions for me.
My co-workers especially white make fun of the food we cooked and bring to work for our meals. They will make comments such as; "how can you it that food, it stinks."
I felt like some of my co-workers were trying too hard to find something that I did not do or did not do right and they report me to the supervisor instead of helping me or educate me of what I did not do right.
My co-workers called me by my last name. That is considered very disrespectful in the Philippines. You either call a person by their first name or use salutation such as Miss, Mrs, Doctor, etc.

Interviewer: How were these experiences in the U.S. similar and different from your experiences in the Philippines? How did the doctor and supervisors treat you differently?

Similarities
Fe: Nursing is the Philippines and in the USA are pretty much the same except the discharge process. We did not have any discharge process in our hospital and it was not part of our clinical experience. In the Philippines, the family members took care of their sick patient at home and at the hospital. The family provided the ADL, bath, bed linen changes, feeding the patient. The nurse enters the room and says "how are you doing", if she was giving medication (s), she will hand them to one of the family members to give meds to the patient, they did not wear stethoscope, the doctors normally listen to the patient's heart and lungs. Nursing procedures are the same like giving patients their bath, changing bed linens, assisting them with their meals, or activities of daily living, administering medications in whatever form; per mouth, intramuscular, subcutaneous, intravenous, changing wound dressing, starting IV infusion, etc. Everyone wears white

nursing uniforms and nursing cap and white shoes. We worked by shift; 7AM-3PM, 3PM-11PM, 11PM – 7AM. In the Philippines, most equipment were outdated while in the US, pretty much everything are updated and we used mostly disposable supplies, even the bedpan are disposables.

Negative

Fe: In the Philippines, I was never called my "Filipino Baby." I was never asked if I'm married to a GI. In the USA, these were constant questions the 1st 2 years I arrived.
In the Philippines (PI), everyone understand what I am saying even though we have different regional dialect and we all spoke English. I did not have any communication problems in the PI. In the US, I felt like most of my co-workers especially the white male doctors and white nurses were always having a hard time understanding my English, They were telling me that I had a hard accent and could not understand how I pronounced some words.
I did not feel any isolation or discrimination while working in the PI.
I felt isolated and I felt marginalized. I did not want to carry a conversation with anyone unless they asked me questions about my patients. Most of my co-workers made fun of me. They always asked me what I brought for dinner (I worked 3-11 shift), they made comment such as, "I will not go to the break room while you are eating your food, and your food had a distinct smell." They were so rude.
In the Philippines, people you now and who you worked with call me by my first name or Miss. In the USA, my co-workers called me with my last name, no salutation.

Doctors:

Fe: Philippine (PI) doctors are spoiled and feel very privilege (came from Spanish culture.) They make me feel like their hand maid. We were expected to do more for them including getting their coffee and food ready. Nurses were treated well if doctors like the nurses especially if the nurses were beautiful and smart. We carry their charts during rounds including progress notes and prescription pads. We were expected to make rounds with them. Doctors in the PI felt entitled because they are MD. Nurses and doctors who went to same University and graduated same year, were buddy-buddy. They joke a lot and flirt a lot while making rounds. It was annoying.

Fe: USA doctors most doctors that I encountered were so intimidating especially the 1st year I came. I feel like hiding just knowing they were in our nursing unit making rounds. I get so nervous in front of them especially if I was assigned to their patients. They always seems not to understand what I am saying. They always said "What did you say now?" I have to repeat myself several times for them to understand me. They give me this perception that they don't trust me and that I don't know anything. It irked me when they asked the American nurses about my patients, and then, the American nurses will turned around and asked me the questions, then, she will relayed my answers to the doctors. I hate carrying a conversation with the doctors especially with the old white doctors. They really made me feel so inferior to them. Sometimes they will sit in the nurses' station with their feet prompt up on the nursing desk. That is considered very rude.

Supervisor

Fe: PI supervisor makes the weekly schedule and approve/deny off day request. They can change your schedule without your consent to meet their staffing needs. They complete the yearly evaluation and very rare we get a salary increase no matter how we performed. Sometimes they used their power to intimidate new graduates so they can manipulate their schedules for their convenient especially during the holidays. The DON does all the hiring and firing of employees. She normally stays in her office and maybe made nursing unit rounds once a day. I addressed our supervisor by calling them Miss, Mrs, or Mr. Last Name. They are friendly to nurses who graduated from their school of nursing or if they were their classmates in nursing school.

Fe: USA supervisors are very intimidating, when I first came for my orientations, the supervisors told me the do's and the don'ts including speaking English while at the hospital/clinic facilities including when we are at lunch break or 10 minutes break. If the Charge Nurse cannot resolve an issue or problem, then they call the supervisor to handle it. The unit Charge Nurse does the schedule for all the staff working in that unit. She is also responsible for performance evaluations, ordering of supplies, approving/denying vacation request. Initially, my Charge Nurse manipulate my schedules w/o telling me. She used to schedule me to work 3-11 or 11-7, all weekends and holidays, her reasons were; I don't have my family with me, I'm single, no children and my co-workers has their families here in the USA to celebrate holidays and they have children to celebrate Christmas. In the beginning, I was not complaining, then I got tired of it and I started complaining about my schedule. I told her that I have relatives in other states, I want to visit with them and I need to celebrate some holidays with them. She reported me to the supervisor that I was very uncooperative and I'm always complaining about my schedule. She also gave me poor evaluations which I refused to sign. We have one supervisor on 3-11 who was so motherly, very soft-spoken, she always takes care of us and she will always asked if we need anything or if she can help us with anything. I love her to death. If not for her, I could have went back to the PI. We also have one supervisor on 11-7 who was extremely nice to us. She will picked us up on our off days and will drive us around to show us where things are (groceries, churches, banks, restaurant, parks, and nice places to go). She was our other mother. These were the 2 people that got us going and stayed.

Interviewer: From your standpoint, how does Filipino men's role compare/differ from American men?

Fe: Filipino men- the father rules the household. They are considered the primary breadwinner. The father's words are the law, they expect their wife to do everything for them; from taking care of the children, cooking, cleaning the house, etc., while we are working full time as a nurse. They expect us to have everything done within the household when both husband and wife are working full time. Men in the PI does not do grocery shopping, change their babies' diapers, does not cook, does not do laundry but they do the yard works, vacuum the whole house, take the trash out. They have a lot of respect for women especially when they are college graduate and working. Filipino men are well-mannered and gentlemen. They normally open the door for women, pull chair in the

restaurant, etc. When one of the family member is sick, the doctors will normally go directly to the father to discuss plan of treatment, diagnosis and prognosis. Most of the time the mother is not included in the conversation.

Fe: American men –the most intimidating creatures that I have ever met. In the beginning of my nursing career in the USA, as a nurse, I will only asked what I need to know. I never carry a conversation. As usual, they will asked me repeatedly to repeat what I asked and what I said, it was very aggravating. I learned to speak very slowly. There were men who called me their "Filipino Baby" and want to hold my hands when I am assessing them; at first, I did not know the meaning other than the literal terms, others asked if I'm married to a GI. Some seems to be respectful, and were very nice and appreciative of our service. I don't know how they are as husband. American men loves to hunt, they did not mind cooking or washing their own. They are very much independent.

Interviewer: What were your experiences based on race, gender, and social class?

Fe: I felt at first that all healthcare workers (black or white) were very discriminative and did not like having a Filipino nurse making rounds with them. I felt isolated and I hate starting a conversation since everyone made fun of my accent and seems not to understand what I am saying when I am talking to them, and vice-versa. Many time, I just do my work, take care of my patients, carry out my doctor's orders, do my charting, I even hate to ask any questions related to patients. There were times where I will call another Filipino nurse who was working in another unit if I am not sure if I am doing things correctly. I feel like it was easier to make friends with black people compare to white people. I was not comfortable talking to males especially black. I was scared of them in the beginning. I was so intimidated by white males. I did not like making friends with them. Some white patients refused to have a Filipino nurse taking care of them and of course that hurts my feelings so bad. I felt like an outsider trying hard to be accepted. They were a lot of clicks among my co-workers. They make me feel like this women looking inside outside a fence trying to be accepted for who I am. Divorces among white/black couple is well accepted practices in the USA and that is one culture that we don't practice in the PI. Some of the men in the USA were respectful and they are giving. Some of the white doctors live in rich subdivision and are all members of country club. They were snub.
One time, one of my patient went to surgery and he ended with a chest tube. I came to work on a Saturday, 3-11 shift. When I was making my nursing rounds, my patient was in obvious respiratory distress. I called the surgeon, he answered the phone, before I can tell me about his patient, he screamed at my ear and told me that he was in a football game and hang up the phone. I called the 3-11 supervisor and reported what happened. She came to my nursing unit and assessed the patient with me. She told me to call the physician again and to ask him if someone was taking call for him. I did call the physician again and told him that his patient was getting worse and I asked him if I can call someone in his place since he was attending a football game. He hang up without saying a word. My supervisor told me to go ahead a write an incident report of what had transpired because she knew that this doctor will report me to the Director of Nursing. She was right, I was called by the DON in her office the next day and the incident report I wrote was signed by my 3-11 supervisor was in her hand. She asked me to explain what happened. I

repeated the scenario and then, she dismissed me back to my nursing unit. The doctor came to make round on his patient, I followed him in the hallway and I asked him to tell me what was wrong in me calling him about his patient who was in distress. I also told me him that "I am your patient's nurse, do you want me to not do anything and let your patient die? If you know that you are going to a football game, you should ask one of your peers to cover for you." You have your own malpractice liability and I have my own liability but I don't want to be sued for not doing my nursing responsibilities." He walked away from me and left the nursing unit." The next day, he came to speak to me and apologized for his action and that he respect for decision making." We became friend after that incident but if I did not confront him he will continue to intimidate the hell out of me.

Interviewer: What is your primary and secondary language? Do you speak any of the dialects in the Philippines? What medium of instructions did they use in your school?

Fe: I speak primarily Chabacano which is our regional dialect. It sounds like colloquial Spanish. I speak fluent English and Tagalog. English is the medium of instruction. I can also speak Spanish.

Does your school have any transition program for graduates who are going to the U.S. to work? If so, can you describe the program?

Fe: NONE.I don't know of any school of nursing in the Philippines that offered transition program.

Interviewer: Tell me what preparation and information did your U.S. employer provides while you were in the Philippines. (Example: place to live, transportation availability, orientation, culture differences, language barriers, preparation for NCLEX, etc.)?

Fe: The hospital administrator and the Director of nursing came to the Philippines and recruited 50 Filipino nurses for Tuscaloosa, Pickens, Eutaw, Greensboro, Demopolis and Aliceville, Alabama hospitals. We were interviewed and we were told that we will receive our offer in the mail. I was working at the Philippine Makati Medical Center at that time. I received my offer in September, 1971. In the letter, it stated that my monthly salary will be $650.00 per month, we get paid every other week. It stated that the hospital will assist me with living arrangement and transportation. My working visa was being processed and I was instructed to apply for my US social security number. It also stated that I will be given 3 months of temporary nursing license and I have to take the US nursing board examination before my temporary license expired. The travel agency working with the US hospital made all our travel arrangement, passport and release from the PI Labor Department. My plane ticket was $800.00 payable in 10 months ($80.00 per month) and it will be deducted automatically from my check. She told me that I will fly and stopover in Hong Kong, then to Honolulu as my port of entry, then to San Francisco, Atlanta finally in Tuscaloosa. My working visa came in December, 1971.

Interviewer: Can you describe to me how you settled down in the U.S.? What were the positive experiences? What were the negative experiences?

Fe: Positive - I left the Philippines in May, 1972. I traveled with 8 other nurses. The Hospital Administrator, Director of Nursing, Personnel Director, some head nurses, nursing staff and community leaders were at the airport to welcome us. We were the first group of Filipino nurses hired in this town that arrived. There were a total of 50 nurses that the hospital recruited. They welcomed us and they were very excited of our presence. We all landed in the local town airport. The local newspaper staff were present and were taking pictures. We were actually on the front page of the local newspaper the next day. The drive was about 5 miles to the hospital. The town was considered rural in 1972. There was nothing to see, no building or store from the airport to the hospital. It looks like cotton field and soybean farm. They took us to this old building that look like a hospital. We were told that the hospital was still in operation except the 4th floor. It used to be the region's Tuberculosis Ward. Since TB is well-controlled in the south, CDC told them to close the ward. There were other staff waiting for us in the lobby, had a welcome reception with food and drink. We were introduced to the crowd and everyone was clapping their hands. We were tried from the travel but we all got excited to receive such a warm welcome. After such event, they took all our luggage, rode the elevator to the 4th floor. The 4th floor looked like a hospital ward with 2 beds in each room, side table with lamp, curtain in between 2 beds for privacy, 1 chair on each side of the bed and a bathroom. The beds were made already with 1 pillow and 1 blanket. The bathroom had 4 sets of towels and all amenities like toilet papers, shampoo, soap, etc. There was a common kitchen with cooking stove, a refrigerator, coffee maker, plates, cups, bowls, glasses, flatwares, sets of cookware, dining table that sits 6 people and 4 extra chairs. The refrigerator was full of food like milk, orange juice, and slices of ham, turkey, cheese, fruits like grapes, apple and oranges. On the kitchen table were bananas, bread and cereal boxes. Near the coffee maker were ground coffee, creamer and sugar. There were 2 nurses assigned in each room like a hospital semi-private room but not enough storage room. There was a kitchen in each floor with a refrigerator and cooking stove. The building is a walking distance to the main hospital. We were told that we can stay there as long as we want to. They were very nice and they told us not to worry about anything. We were all so tired and exhausted. The Director of Nursing told us to rest and unwind. She told us that the In-Service Coordinator will pick us up at 7:00AM on Monday. We arrived on Saturday late afternoon. Some of us dropped dead in bed and some stayed up and unable to sleep due to time changes and unfamiliar environment.

Fe: Negative – The building was old and ran down, felt scary since it used to be a hospital ward. I thought of all negative thoughts about the hospital with patient dying. We were using hospital beds, linens, pillows and towels. I felt so homesick, I cannot sleep. I kept looking outside the window and watched car passing by. It was midnight but daytime in the Philippines. I was wondering and eager to know the location of the hospital, the stores, the church, the bank, the post office and other key places in town. Somehow, we all got up late afternoon on Sunday. We all converged in the kitchen and looking for something to eat. We looked at each other and started discussing if we have to pay the hospital for our

stay and how are we going to the grocery store and to other key places we need to go. We were curious on how much will be our take home pay, if we can afford to move to an apartment and how long will it take for us to save money to afford an apartment. Too many questions still unanswered. We found an iron and an ironing board, we alternate ironing our uniform for Monday. We cannot wait for Monday morning to come.

Interviewer: How did your experiences correlate with the information they gave you?

Fe: The offered living arrangement and it was a walking distance to the hospital so I didn't need transportation except to go to the grocery store, mall, bank, church, post office. I also need to go the Federal Office to follow up on my Social Security application. I was not told that I need to take the TOEFFL (English Proficiency Examination for Foreign Graduate) before I can apply for the US Nursing Board Examination. The In-Service coordinator came to our building to meet us at the lobby. The hospital was across from our building about ¼ of a mile. The In-service coordinator took us to a conference room and gave us brief description of the hospital. She told us to read the policy and procedures and some of us rotated reading doctor's orders making sure we can read their handwriting. The Personnel Director came and spent 1 hour with us to answer all our concerns. He told us that we can stay at the TB ward for at least 3 months till we can afford to pay for an apartment and utilities. He told us the average rental fee for 1 or 2 bedroom apartment. The average cost of power bill, telephone, water and garbage. The average cost of transportation and taxi were available on a call-in basis. He told us the every 2 weeks deduction and approximate net income we will receive every 2 weeks. He know that they have to deduct $80.00 per month for 10 months to pay for our plane ticket. He encouraged us to eat at the cafeteria for our 3 meals to save money and transportation. The In-Service coordinator came back to the room and we asked her if they were offering TOEFFL and Nursing State Board review. She explained that the University of Alabama library have a lot of resources and we can check out books we needed for our review course. She told us that we need to take the TOEFFL as soon as we can since we have to schedule our Nursing State Board examination. She explained to us that we are working with a temporary license that is only good for 3 months. She explained that we had 3 chances to take the board within a year. If we don't pass the board, we will automatically work as nursing assistant and if we don't pass the board within a year, we have to go back home since the hospital sponsored our working visa. She explained the orientation schedules, what shift and nursing unit we were assigned to work. We left the conference room for the day full of stress and anxiety.

Interviewer: Did you sign a contract with your employer? Can you tell me what was written in the contract? Did they fulfill their promises or any agreement written in your contract? Explain.

Fe: YES, in the letter of acceptance it stated that I have 1 year contract under working visa. My monthly salary was $650.00 every 2 weeks. I will be provided with living space.

It was explained to me that I will work under temporary license for 3 months, I have to take the TOEFFL before I can take the nursing state board. I have to take the US Nursing Board Examination before the end of my temporary license, which if I didn't passed the board, I have to work as a nursing assistant until I pass the board within a year. If I don't pass the State Board within a year, I will be send back to the Philippines since my visa was a working visa sponsored by the hospital. I did not ask during interview if they offer nursing board review. I was told during orientation that we can review in group or by ourselves. The University of Alabama can be our resource for review books and materials or we can buy them at the book stores. I went to the book store at nearby University and bought a review book. Some of the Filipino nurses got review materials from their former classmates or relatives and they shared copies with us. Since they offered living arrangement and since our building was a walking distance to the main hospital, they did not arrange for any transportation.

Interviewer: Tell me about what your employer shared about the hospital setting you are going to work? During the interview in the Philippines.

Fe: They told me that I am going to work in a community hospital. I assumed that it will be like our university hospital in the Philippines. I was a senior in nursing when I went for my job interview. I did not ask a lot of questions, and I really don't know what to ask. I was so naïve at that time. I was lucky that I ended up working in a hospital like our university hospital. Some were not lucky.

Interviewer: Tell me what experiences did you encounter in your social life, working life, and family life while living and working in your new environment?

Fe: The first year was very challenging since I have to learn the hospital system, their policy and procedures and acclimate to my new working and living environment. There were not enough social life since every one of us want to work overtime, study for the TOEFFL, and then, for the nursing board. I thought I have a good command of the English language till I started working in the different nursing units for my orientation. Some of my co-workers, white and black does not seems to understand what I am saying at times. I got so frustrated especially when they kept repeating for me to say it again or to repeat myself. The way I pronounced some words were different the way they pronounce them (example; hemoglobin, Robitussin, Riboflavin, urine, popliteal, sheet, beach, slap jar, maintenance, ask, often.) For 6 months, I just worked, studied and slept. Every now and then I will go to church if someone offered me a ride. The church members were nice and friendly. They extended invitation for me to attend church function so I can meet the members of the church. I worked whenever they need me to work which was pretty much every day. Some of my nice co-workers or church members will offered ride to go to the grocery stores, to the bank, and to the post office. It was a nice treat when I go out with some of the Filipino nurses, we ate out at a nice restaurant and watch movie. The hospital

administrator approved to install a telephone in our main floor so they can call us if needed and we can call out locally if needed. We cannot use the telephone for oversea calls. My co-workers were half white and half black. The hospital used LPNs on every nursing department. I have to get used working with them since we don't have LPNs in the Philippines. Some of the old LPNs have a hard time accepting us to be their team leader since we were young and new to their working environment. I felt like they don't trust us. Some were nice to work with but some were rude and lazy. I was single when I came to USA. I became friend with one white old nursing assistant whose brother fought and almost died in the Philippines during World War II. Her brother was a very prominent politician in Alabama and own a radio station in Tuscaloosa. She pretty much adopted me especially when she invited me to one of their family get together. I meet her brother and other members of the family. Her brother actually wrote a resolution to the city of Tuscaloosa and to the State Legislature stating for Alabama and counties to embrace the presence of the Filipino nurses helping take care of its citizens during this critical shortage of nursing. Every now and then, she will pick me up and we will attend church function like spaghetti night and bingo. Two months staying at the old TB Pavilion, all the Filipino nurses were told to find a new living space since they will be renovating the building to expand services. We group ourselves into four and rented 2 bedroom apartment for $90.00 per month. The utilities like telephone, water, electric bill will cost us $50.00 per month. We split expenses into 4 including groceries and ride. Two nurses shared 1 bedroom. We have to call Taxi or asked our co-workers if they can pick us up and we will pay for gas. A year later, all the Filipino nurses who stayed in Tuscaloosa bought their own car. Some of our co-workers were curious and some were making fun of us why we hang rosary on the rear mirror of the car. We told them it was a practice in the Philippines. We believe that God will protect us while driving. Some of them think we have weird believes.

Interviewer: Tell me what experiences did you encounter being a Filipina, being a woman of color, being a minority and being new in your living and working environment?

Fe: I just turned 23 years old when I came to USA. I felt like my co-workers especially the older white nurses did not trust me and undermining my skills and talent especially the older LPNs that were assigned to my team. They felt like I'm too young to be a team leader and I don't know their system. My charge nurse always assigned me to chronic patients with high acuity that needed more nursing time. The doctors were so intimidating and most of them did not take their time to know us and nor respect our knowledge and skills. If they have questions about my patients, they will normally go directly to the white nurse to ask the questions and to relay my answers to them. I felt insulted. Some doctors especially the black doctors were nice and carried conversation with us. They were well-mannered. They asked about our cultures, what we like to eat, where we go to church. It made me feel comfortable around them. Some of my white and black patients will say "here comes my Filipino Baby." Some will asked me if I am married to a GI. Some of the men will asked me if I live close to the air force base in Angeles City or if I live near the Subic Bay in Olongapo. I met few military men who were in the Philippines during World

War II. They will tell me stories how they picked up beautiful Filipina girls when they were off and there were plenty of them. (This men were talking about Filipina girls/women who are Prostitute), and they call them their Filipino Baby. After I found out the meaning of a GI and Filipino Baby, I will always responds no I am not married to one nor I am your Filipino Baby. It was hard building relationship with white nurses and doctors. It took a while for me to get their respect and attention.

Interviewer: Tell me your stories about the discrimination and marginalization you experience working with white people, minority people and with other Filipinos? How did these experiences affect you as a Filipina, as a nurse, and as a family person?

Fe: Like I stated above, it was hard in the beginning establishing relationship with our co-workers especially with older while nurses and LPNs. It was hard building working relationship with some white and some black nurses. It felt like they don't trust me and they made me feel like I do not know what I am doing. In the beginning, both white and black nurses will asked me to do their task for them like admitting their new patients, starting an IV, giving pain medications, inserting Foley catheter and nasogastric tube while they were sitting and chatting in the nurses' station. I thought at first that was the norm until one of my nice LPN told me that they were taking advantage of me. The 3-11 charge nurse will always give me more patients and all the chronic patients that needed more of my nursing time. Some of the LPNs and nursing aide were rude and lazy and at times will hide when I needed them to attend to our team patients. Some of the doctors refused to speak to me about my patients and would prefer to ask the American nurse to ask me the questions and for her to relay my answers to them. After they have done that to me few times, I confronted each doctor that I am very capable answering their questions. I will give them comprehensive reports about their patient and I will not give them the chance to ask more questions. Many times, I will hear my co-workers making fun of what I said and I will just ignore them. The one thing that really makes me mad was when they make fun of what we eat and when they make statement such as "whatever you are eating, it stinks and the smell bothers us and the patients were complaining." Sometimes, before my supper break, they will ask me "what did you bring today to eat?" "I guess I have to leave the unit when you start heating your food and you need to close the breakroom door real tight when you and your other Filipino friends starting eating your dinner." They complained to the supervisor about the smell of our food and the supervisor told us to eat at the cafeteria. I finally asked my co-workers who were complaining what smell does our food has? (Sour, Sweet, Pungent, Bitter, Smell of spoiled food, stool smell). They ignored me and did not answer my question. I was also mad with the supervisor for telling us not to bring food from home and eat instead in our cafeteria where they served the same food every time and it was too expensive for us. I was single when I came to the US so I did not have any family members with me.

Interviewer: Tell me your experiences about the support you received from your co-workers, managers or from hospital administration?

Fe: Like I stated in the beginning, the Director of Nursing, Personnel Director and the In-Service Coordinator were nice and accommodating. When I started my 3-11 shift, some of my co-workers were nice but some were rude, lazy, and hide when I need them. Some of

my co-workers tried to take advantage of me by asking me to do their task for them. My charge nurse used to give me more patients and give me all the chronic patients that needed more nursing time. I never complained in the beginning since I am still adjusting to my working environment and of course, I would like to be accepted by everyone. The supervisor at times will believe what my co-workers will tell her and will address the issue without investigating the issues. The other 3-11 supervisor was so motherly and soft spoken, she listened to our concerns. The unit manager who works 7-3 will sometimes meet with me and will asked if I have any concerns to discuss, and then, she will tell me what my co-workers concerns about me. Sometimes I cannot figure her out if she support me or my co-workers. She does not say much. I was very patient the 1st year of my employment. I never complaint, never reported any of my mean co-workers, I just tolerated them, till I became so familiar with everything. I was top 5 in my class and I got the Nightingale Award and Outstanding Leadership and Academic Award in my senior year. I am very strong clinically but I don't need my co-workers to know that, so I just work very hard and took care of my patients and did everything for them and I was always ready to report when the doctors came to do their rounds and I always gave comprehensive end of shift report.

Interviewer: What resources could have been offered to you in your workplace, in your community, and with your family?

Fe: I felt like I was given all the resources I needed to adjust and to transition into my new job and living space. I was lucky to start with other Filipino nurses. We supported each other and consoled each other. Our Director of Nursing and In-service coordinators were nice and accommodating. One of our 3-11 and 11-7 supervisor became like our mother support. They knew how hardworking we are and that they can depend on us staffing the nursing units when they are short especially during weekends and holidays. Our church became like our family extension. They provided us with TV, dining set, plates and other household things we needed for our apartment. Some of our co-workers became very close friends, they will invite us to their farm or gardens to harvest vegetables. The community were receptive to our presence. Sometimes when we are walking from the grocery stores back to our apartment, people will stop their car and will asked us if we need a ride. I like this community that is the reason why I am still here after 45 years in nursing.

Interviewer: If you were able to do this all over again, what would you do differently? What kind of supports would you like? What would you like to have learned in nursing? About the U.S.? About families?

Fe: During our time, there were so many recruiters in the Philippines trying hard to recruit young nurses to work in the USA. Some of us were seniors in nursing about to graduate and some were fresh graduates and so naïve. We just want to get a job and leave for USA. If I have to do it all over again, I will apply to 4-5 hospitals instead of 15-20 hospital. I will prepare my questions before my interview such as: location of hospital, size, and #hospital beds, what services are offered, what specialty they offered. Is the hospital located in rural, sub-urban or urban community? How diversified are the staff? Will there be a person who will be our liaison once we arrived to be our go to person, how long is the orientation. Are there resources available to study for TOEFFL and for the State Board?

Where I am going to live, are transportation available to and from the hospital? How far is the nearest immigration office, where is the city hall, federal government building, the church, the bank, the post office, the grocery stores and the shopping centers. I will ask if they are using paper charting or electronic medical records. Who will train me on EMR. I will ask about staffing ratio.

Interviewer: Utilizing all your lived experiences, tell me how and what can you contribute in the development of transition program or in the enhancement of an existing transition program for newly hired Filipino nurses and for future internationally educated Filipino nurses who will migrate to the U.S. to join the U.S. nursing workforce?

FE:

f. Once the nurses are hired by US employer, the travel agency and recruiting coordinator for the healthcare facility should prepare the nurses to review for their TOEFFL and Nursing Board in the Philippines, take and pass the test before leaving for the US.
g. The recruiter should provide orientation and transition process while in the Philippines, that will include, information about the facility we are going to work, number of beds, what scope of service they provide, staffing, location (urban, suburban, rural), salary/benefits, culture of the organization, diversity of staff working in the facility. Living arrangement and transportation (90% of Filipino does not drive or own a car.) Travel time from our living location to the hospital, what mode of transportation the place has and price. Who will transport us to and from the facility Tell us about language barriers, different accent, how they pronounce the words and how we pronounce them.
h. Once we arrived in the USA, there should be a coordinator assigned to our group or to individual nurse, who we will be our go to person, who will help us get things we needed for our living space, to show us where the stores are (grocery, mall, etc.,) where we can buy food familiar to us like an oriental stores, to show us where the bank, the church, the city hall to turn water/power/telephone/cable if we are going to live in an apartment. To give us type/telephone numbers of transportation mode. Introduce us to the church priest/preacher where we intent to join for our worship. Location of city hall, federal government building, nearest immigration office.
i. At the hospital 1st day, give tour of the facility, introduced us to staff if possible, acculturate us with the environment, tell us what the facility expectations are, provide extensive nursing orientation, assign us a preceptor in the nursing unit where we are going to work. I would like her to tell us if our English is hard to understand, if yes, provide orientation on how people in and out of the facility talk and how we should pronounce certain words so we can be understood. Introduce us to the medical staff, so we can familiarize ourselves who the doctors are and what specialty do they practice, maybe it will lessen our feeling of intimidation.
j. Post orientation, people learn in different phases, some are slow and some are fast learner. They should not shortened orientation just because they are extremely understaff. They should assign us to our nursing specialty if possible (Med/Surg/ICU/ACCU/OR/Labor and Delivery/ED) or cross-train us to get us familiar with each nursing unit. The staff development coordinator should include not just

reading the policy and procedure manual but include hands-on training before working on our own.

k. We should be able to speak our native language during break and outside the facility.

Julieta's Interview

Interviewer: What were the challenges of being a nurse in the Philippines? Give me examples.

Julieta: Low salary, limited nursing advancement, no benefits to further your career, medical equipment were not up to date, most male physicians especially surgeon were rude and they want nurses to hand them everything. We made rounds with them and we have to write even the doctor's orders and progress note. Most patients were from low economic class and they were admitted to charity ward were beds did not have any mattresses. They have to bring their own bed linens, pillows, and blankets. There was too much turnover because the nurses and doctors leave for the US to work.

Interviewer: What were your positive/negative experiences as a nurse in the U.S.? Give me examples.

Julieta: **Positive:** Better salary, better living condition, you can work as much as you want to and you get paid overtime. Better medical equipment and medical supplies, pretty much everything is disposable. Some patients and some hospital staff were kind to us. I was able to assert myself and obtained leadership/management position. I was able to go back to graduate school which is one of my dreams when I left for the US. I was able to gain the respect of our physicians, co-workers and community leaders. I was able to obtain the nursing positions that were part of my goals (Charge Nurse, Nurse Manager, and Director of QI/Accreditation/CIO/Director of Clinical Operations/Staff Development). Presently involved in several community and state association.

Julieta: Negative: I was not given any choice on what shift to work. I worked 11-7 for 3 years before I was moved to 3-11. And then, it took 10 years before I was able to move to 7-3 shift. The US doctors were very rude, they don't have any patience talking and listening to me. They claimed I had heavy accent and they were having a hard time understanding me. If I call them regarding changes on their patient conditions, they normally hang the phone. I have to rely on my night shift nursing supervisor to call the doctors for me. The feeling was likewise, the health care team spoke with heavy southern accent and they were hard to understand. Doctors will threw charts if you cannot answer their questions right away. They have very few doctors that became close to me and were extremely nice, the same with the nurses. The nursing assistants were very friendly and very accepting. I hate it when they call me with my last name. That is very disrespectful in our culture.

Interviewer: How were these experiences in the U.S. similar and different from your experiences in the Philippines? How did the doctor and supervisors treat you differently?

Julieta: **Similarities:** I have to take care of patients no matter who they are, what class they came from, I have to treat them the same. I have to provide the best nursing care for them. We have the same management structure. We have to give respect to all kinds of patients (lower/upper status-rich/poor-educated/non-educated). I have to please physicians

and I have to know my patients conditions/status/progress to provide comprehensive reports during rounds or when I call them on the phone for any patient's issues. I worked with good/great nurses and some lazy and mediocre nurses and LPNs, nursing assistants.

Julieta: **Difference:** We don't have LPNs in the Philippines. I worked with a nursing assistant that functions like a housekeeper. The family members were always in patient's room and provide the personal care of the patients (bath, shaving, shampooing, oral care, provide bedpan or urinal, clean patient after a bowel movement). I prepared patient's oral medications, then I will give them to one of the family members for them to give to the patient. I starts patient's intravenous (IV) and administer patient's intramuscular (IM) and subcutaneous injections. There is no such thing as case manager in the Philippines (PI). Discharge process includes, doctor's order for discharge, the doctor writes prescription and hand them to the family members and then, I will tell the family and patient that they can go home. In the US, the RN works with an LPNs and nursing assistant as a team. The nursing assistants with the help of the LPN or RN, gives their assigned patient their bath, change their gown and bed linen, provides fresh towel, assist patient with oral care, and empty the trash. The LPN administers all oral medications, tube feeding and some certified LPNs can administer uncomplicated medication by IV route (ex. Zantac, Lasix.) RNs are very involve with discharge planning and discharge process. I give the patients their medications and records them in the electronic medical records (EMR) in a timely manner. I provided discharge teaching and I was very involve with the discharge process. The doctors writes the prescription, hand them to the nurse or family members, then nurse in turn will provide discharge teaching regarding their medications. We also use electronic medical records in the US and have so much technology to use like computers, sonogram, MRI machine, PET scan, DaVinci Robotics, etc. US have abundance of disposable supplies. In the PI, we boil syringes and needles, medication cups made of glass, we roll our own cotton ball, wash all bedpan and urinals (mostly done on 11-7 shift).

- **Julieta**: **Doctors/Supervisors in the Philippines** present themselves as being so privileged especially the surgeon. They make us feel like we were their hand made. They shout at you, very demanding, they even expect their nurses to make their coffee or prepare their breakfast or lunch. If you went to school the same year as the physicians and you are both intern/residents in same hospital, the PI doctors highly respect the nurses. If you are smart and beautiful, every doctors (Attending/Faculty/Residents) seems to like you and respect you. There is a lot of camaraderie among nurses and doctors. You can joke with them and have fun during clinical. The supervisors play favoritism. So if you are one of the smart nurses, then you get a lot of preferences and get promotion faster. The supervisor is responsible for making schedules, they take advantage of new graduates. They manipulate the schedules without consulting the staff, they do this especially during weekend and holidays. We did not have annual performance evaluation, so the supervisors play favoritism.
- **Julieta**: **Doctors/Supervisor in the USA –** as I mentioned above, most doctors and supervisors in the US are so intimidating when I first came to the hospital. I experienced a lot of marginalization where doctors will not speak to me nor take time to understand what I was saying. They all seems not to understand my accent and

same with me, I cannot understand their accent. Many times, I will write on a piece of paper what I need to communicate to them especially for things related to our patients. Supervisors tend to take advantage of us. All the Filipino nurses who came with me, worked 3-11 but mostly 11-7. We were scheduled to work most weekends and holidays. We were told that since we don't have family here in Tuscaloosa, it made sense to allow the American nurses to get off days as they please. In the beginning, American nurses took advantage of my presence. I felt like they were testing my nursing skills and knowledge. They gave me more patients and the sickest patients. Doctors will ask the American nurses about my patients instead of asking me. The US nurses will ask me the questions and then, she will turn around and tell the US doctors what they want to know about their patients (lack of respect and lack of confidence in our knowledge).