The Dissertation Committee for Li-Chen Lin Certifies that this is the approved version of the following dissertation:

A GROUNDED THEORY OF FILIPINO NURSES' ROLE PERFORMANCE IN U.S. HOSPITALS

Committee:

Tracie C. Harrison, Supervisor

Sharon A. Brown

Patricia A. Carter

Alexandra A. Garcia

Sharmila Rudrappa

A GROUNDED THEORY OF FILIPINO NURSES' ROLE PERFORMANCE IN U.S. HOSPITALS

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Li-Chen Lin, B.S.N.; M.S.N.

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Dedication

I dedicate this dissertation

to the participants in this study who shared their valuable experiences

and those who referred potential participants.

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A GROUNDED THEORY OF FILIPINO NURSES' ROLE PERFORMANCE IN U.S. HOSPITALS

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In response to the nursing shortages, hospitals in the U.S. have been filling nursing positions by hiring foreign nurse graduates (FNGs). Filipino nurses represent the majority of all FNGs recruited to work in the U.S. Although Filipino nurses are not new to U.S. hospitals, very few studies have detailed how Filipino nurses have adjusted to U.S. nursing practice. The purpose of this study was to explore how Filipino nurses' perceived their role performance in the U.S.

Using grounded theory as the methodology and symbolic interactionism as the philosophical underpinning, the principal investigator (PI) developed a substantive theory using a constant comparative method as the analytical approach. The PI used convenience and theoretical sampling to recruit 31 English-speaking female Filipino RNs practicing in Texas. One interview was conducted with each participant and the data were transcribed verbatim. The PI followed Strauss and Corbin's analytic steps to examine all cases, and the rigor of the theory was safeguarded by following the criteria of evaluation.

All participants experienced challenges while adjusting to the U.S. healthcare system and American society due to differences in cultural expectations and experiences. The theory explains the processes of Filipino nurses' transition to U.S. nursing practice. The core variable was "transitioning from Filipino to U.S. nursing practice," which was shaped by nine relational categories. Based on descriptions from these Filipino nurses, it was clear that role transitioning from the Philippines to the U.S. is a complex phenomenon influenced by the meanings and expectations derived from these nurses' prior context in the Philippines. This theory should be beneficial to the many entities involved with or invested in Filipino nurses' migration by providing knowledge about their role transitioning. However, these findings cannot be applied to all Filipino nurses. Future research studies are needed to expand the scope of this theory and to empirically test it. Filipino nurses perceived that unethical actions were constantly taking place, regardless of existing rules and regulations. However, these nurses did little to correct or address the problems or ethical lapses themselves. Advocacy efforts are needed to ensure full understanding of immigration laws and policies to ensure fair work practices for Filipino nurses working in the U.S.

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CHAPTER 1: INTRODUCTION

Foreign nurse graduates (FNGs) play a vital role in the United States workforce (4-10%) dating back to the 1950s and extending to the present day (Commission on Graduates of Foreign Nursing Schools [CGFNS], 2002; U.S. Department of Health and Human Services [HHS], 2002). Historically, nurses from the Philippines have represented the majority of FNGs employed in the U.S. This trend is likely to continue in the coming decades (Davis & Nichols, 2002). The importance of RNs in determining quality health outcomes makes the migration of FNGs from the Philippines to the U.S. healthcare system a major concern to many stakeholders such as hospital administrators, nurse supervisors, staff nurses, patients and families, and other healthcare professionals. Because of dissimilar cultural backgrounds and value systems, FNGs from the Philippines may perceive their roles in the U.S. differently from domestic nurses, which is evident in the ways they communicate and provide patient care in the U.S. However, the nature of these differences and the effect they may have on FNGs and the care they provide has not been thoroughly explored. In order for healthcare administrators to work with these FNGs, they must be given knowledge of how FNGs perceive their work roles. Given that Filipino FNGs are the largest population of FNGs working in the U.S., it is clear that they represent a group that requires immediate attention.

PURPOSE

The purpose of this study was to explore the social processes contributing to the role performance of registered nurses (RN) from the Philippines who were currently practicing in the U.S. It was the aim of this researcher to build a substantive theory of RN role performance in FNGs from the Philippines using grounded theory methodology. The theory formulated from this study may help hiring facilities, nurse supervisors or managers, administrators, staff nurses in the U.S., FNGs, and other healthcare providers to better understand Filipino nurses' role

performance in the U.S. The theory generated from this study will help further understanding of FNGs from other countries, although the transferability of the theory is limited to Filipino registered nurses because the theory was derived from data from Filipino participants.

BACKGROUND AND SIGNIFICANCE

Nursing shortages in the U.S. have been a problem since the 1960s (Upenieks, 2003). An analysis from the U.S. Department of Health and Human Services (2002) shows that there is a nursing shortage nationwide and it is getting worse. According to the report, in 2000, the United States had a 6% (110,707) shortage in the required number of registered nurses (1,889,243 available versus 1,999,950 needed). More seriously, this shortage will continue to increase if not addressed. The experts projected a 29% shortage (808,416) in nurses by the year 2020. Nurses who are working will very likely be emotionally and physically exhausted because of the extra work caused by these shortages. When nurses are burned out, they have a higher chance of leaving their jobs, which leads to even more nursing vacancies (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002).

The nursing shortage in the U.S. is of concern to hospital administrators trying to fill vacant nursing positions, as well as for health policy analysts and researchers examining health outcomes. The common contributing factors to nursing shortages are poor working environments, non-competitive salaries, declining enrollments in nursing programs, an aging nursing workforce, poor images of nursing, and job dissatisfaction (Goodin, 2003; McNeese-Smith, 1999). A lack of nurses represents a threat to patient health because nurses are the key to providing high quality patient care (Hassmiller & Cozine, 2006). Research has shown that the number of RNs on duty is associated with better nursing outcomes, such as decreased mortality rates, infection rates, failure-to-rescue rates, as well as the number of falls, patient dissatisfaction, and length of stay (Aiken et al., 2002; Lankshear, Sheldon, & Maynard, 2005; Yang, 2003). In

other words, a decline in the number of RNs may increase nurses' workload, and thus, may worsen patient outcomes.

To maintain quality healthcare and to mitigate the nursing shortage, hospitals in the U.S. have been filling RN positions by hiring foreign nurses (Haddad, 2002). In fact, about 10% of U.S. nurses are foreign educated (Cooper & Aiken, 2006). This shift is evident in the number of individuals taking the licensure exam to become RNs in the U.S. According to reports from the Commission on Graduates of Foreign Nursing Schools (CGFNS), 6,920 people passed the qualifying exam in 2006. After passing their exam, these RNs become eligible to take the National Council Licensure Examination (NCLEX-RN) and to become employed, as long as they hold an appropriate work permit. From 2003 to 2006, Filipino nurses represented the majority of foreign nurses who applied for the CGFNS certification program (CGFNS, 2004), making Filipino RNs a population of great interest.

Given the importance of RNs in determining quality health outcomes for U.S. citizens and the strategy of recruiting nurses from overseas, it is imperative to study the role performance of nurses from other countries, specifically Filipino nurses. U.S. nurses often receive advanced training in U.S. hospitals and may be very familiar with U.S. hospital culture before beginning work. This is typically not the case for nurses trained outside of the U.S. The role of nurses in the Philippines may not be the same as in the U.S., and adjustments may be necessary when shifting from practicing in the Philippines to practicing in the U.S. (Pizer**,** Collard, Bishop, James, & Bonaparte, 1994). For instance, nurses in the Philippines are trained and instructed to carry out physicians' orders without questioning whereas nurses in the U.S. are encouraged to ensure the accuracy of orders before executing them.

Although Filipino nurses are not new to U.S. hospitals, very few research studies have focused on how Filipino nurses transition to practicing in the U.S., specifically their nurse role performance. The majority of existing publications focus on issues such as ethical dilemmas

related to recruiting foreign healthcare providers (Carney, 2005; Gamble, 2002; Haddad, 2002; Kline, 2003; Overland, 2005). These publications provide limited information about Filipino nurses' perceptions and performance of their role as nurses in the U.S.

Nurses' roles cover a broad area and often overlap with those of other health care professionals, which makes their role hard to define. Nevertheless, nurse role performance has been used as part of patient outcome indicators (Doran, Sidani, Keatings, & Doidge, 2002). The goal has been to measure how professional nurses apply theory and research to improve their practice, while at the same time they provide comfort, ensure safety, and promote the health and wellness of their clients (Doheny, Cook, & Stopper, 1997). In prior studies, role performance was defined as guidelines set by hospitals or administrators to ascertain if nurses met expectations. Hospital administrators might look at factors such as resignation rates, errors, and the number of complaints to evaluate if Filipino nurses are performing their jobs as required. On the other hand, under an interactionist's point of view, role performance is created by interactions between the organization and the persons occupying the role (Tabari-Khomeiran, Kiger, Parsa-Yekta, & Ahmadi, 2007). If studies are not done from an interactionist's perspective, it will be difficult to understand the process by which role performance is co-created within a healthcare environment. Thus, role performance should be explored using an interactionist's point of view by examining how FNGs from the Philippines perceive their interactions with others and subsequently perceive their role performance.

Research studies show that FNGs face significant obstacles and challenges to fully integrate into the U.S. health care system and U.S. society (DiCicco-Bloom, 2004; Yi & Jezewski, 2000). These challenges include difficulties with communication, uncertainties from variations in nurses' roles, and feelings of alienation and exploitation (Daniel, Chamberlain, & Gordon, 2001; Ea, Griffin, L'Eplattenier, & Fitzpatrick, 2008; Yu, 2007). It is necessary to ensure that these obstacles and difficulties are taken into consideration before a facility decides

to hire FNGs and to prevent potential issues such as low quality of care because of a lack of communication or misinterpretation, as well as unhappy FNGs working in a country far away from their family and friends.

U.S. facilities are potentially hiring FNGs without an understanding of their views about nursing practice. To successfully integrate FNGs into the U.S. healthcare system, more information is needed about their perceptions and expectations of their jobs in the U.S. Healthcare facilities. Government and managers should take responsibility to monitor the work of FNGs, as well as to be more aware of the practices involved in recruiting FNGs to fulfill the requirement of high quality patient care (Carney, 2005). No studies were found that explained the perceptions of RNs from the Philippines. Their voices have not been heard. Thus, using the grounded theory method, this study aimed to discover how Filipino nurses perceived their roles as nurses and how they adjust to U.S. culture. The results from this study may be useful for other researchers interested in similar phenomena, such as the effect of gender on foreign nurses' experience in the West. Possible future research questions might be "What are the cultural components involved in recruiting foreign-educated Asian nurses?"

One of the sources for formulating research questions based on grounded theory is "personal and professional experience" (Strauss & Corbin, 1990, pp. 42-43). The PI has personally gone through the process of becoming a FNG practicing in the U.S. She also works with Filipino nurses who have gone through the process of becoming nurses and working in the U.S. The PI's personal experience prompted her to develop a research study to generate a substantive theory to explain the phenomenon of Filipino nurses' role performance in the U.S. The PI was dedicated and devoted to this study because the theory generated from the proposed study could be beneficial to hiring facilities, staff members in the U.S., FNGs, countries both sending and receiving FNGs, nursing as a profession, and society as a whole.

DEFINITIONS

The following definitions are presented to clarify terms used in this study.

Adjustment

Adjustment means "a change in a person's behavior or thinking" (Collins Cobuild Birmingham University International Language Database [Collins Database], 1987, p. 18). Redfield, Linton, and Herskovits (1936) define it as the course of transformation that results from continuous direct contacts between people from diverse cultures. The person who is adjusting to a new culture must obtain knowledge and skills to fit into the new environment (Shupe, 2007). The process of socializing with others significantly affects nurses' successful adaptation to their working environment (Khoza, 2005).

Asian Nurses

In this study, an Asian nurse is defined as someone who obtained his or her basic nursing training in an Asian country, such as China, the Philippines, or India.

Brain Drain

Brain drain is usually referred to as "a transfer of human capital from one country to another" or "the emigration of professionals from one country to another" (Kingma, 2006, p. 177). The more accurate definition, as pointed out by Kingma (2006), is the circumstances whereby professionals who are desperately needed in a source country decide to migrate; consequently, this results in a lack of certain professionals in that country. The source countries that suffer from brain drain lose their invested resources, as well as skills, to other countries (Koser, 2007).

Culture

Culture is a complex and multidimensional social phenomenon (Kreps & Kunimoto, 1994) that influences a set of beliefs, practices, habits, likes, dislikes, norms, and rituals acquired

by humans as members of a specific group (Spector, 2004). Culture refers to the traits like attitudes, values, and customs that are learned and shared by a group of people that is normally passed on from generation to generation (Spector, 2004). Culture influences sense-making, thinking, decisions and actions in specific ways among group members.

Foreign Nurse Graduates

For the purposes of this study, FNGS will be operationally defined as nurses who obtained their basic nursing training in a country other than the U.S.

Grounded Theory

Grounded theory is a rigorous procedure for generating a formal, substantive theory of social phenomena (Schwandt, 2001). A theory is formed from relationships among relational categories and core variable that is conceptually dense and grounded in the data. A grounded theory is revealed, built, and conditionally confirmed through systematic data collection, as well as through the analysis of data related to the phenomena (Strauss & Corbin, 1990).

Migration

To migrate is to move from one place to another. Usually, the purpose is to find a job or to increase one's chances of survival (Collins Database, 1987). Migration encompasses both voluntary and involuntary movements of people from their place of residence (Veney, 2007).

Role Performance

Nurses' roles concern the tasks and functions for which nurses are held accountable, such as assessment and education. Role performance relates to how successfully a nurse plays his or her roles as advised to them in order to meet the expectations. Role performance improves as a nurse clinician gains knowledge and experience, and is influenced by their attitudes, beliefs, values, as well as the context in which the role is performed (McGarvey, Chambers, & Boore, 2004).

Symbolic Interactionism

Symbolic interactionism is a theoretical perspective rooted in pragmatism (Blumer, 1969) that assumes humans build self, social community, and reality in the course of interaction (Charmaz, 2006). This perspective assumes that humans are dynamic, inventive, and thoughtful and that social life includes processes. Meanings are established and modified through an interpretive procedure undertaken by the individual actor (Blumer, 1969). The investigator must first actively engage and enter the setting or situation of the group of people being studied to understand the participants' interpretations and definitions of the phenomena (Schwandt, 2001).

RESEARCH QUESTION

The primary research question was: How do Filipino nurses come to perceive their roles and adjust to roles as RNs in the U.S.?

The specific aims of this study were:

1. To explore Filipino nurses' perceived role performance in the U.S.
2. To generate a theory describing factors that contribute to Filipino registered nurses' role performance in the U.S.

ASSUMPTIONS

The PI made an effort to reduce personal bias by bracketing her preconceived ideas about foreign nurses' experiences in the U.S. Based on a review of the literature, personal experience, and exposure to other published materials, the following assumptions were made:

1. The foreign nurse population in the U.S. is likely to grow in the near future because of the high demand for nurses and to sustain the supply of nurses.
2. Nurses with different educational backgrounds will perceive nurses' roles differently.
3. Cultural backgrounds, interpersonal interactions, and personal beliefs influence how nurses provide patient care and interact with other members of the health care team.
4. All nurses perceive and perform their role in a way that makes sense to them.

5. All nurses act on the insights they have acquired from past experiences.
6. FNGs can reflect on their experiences and will honestly report their circumstances

SUMMARY

Foreign nurses have been a vital part of the U.S. workforce, especially during nursing shortages. Nurses from the Philippines have comprised a major proportion of the FNGs. Hence, their migration to the U.S. healthcare system deserves attention from many stakeholders. Filipino nurses may have problems adjusting to U.S. culture and its healthcare environment. Although recent publications have touched on foreign nurses' experience in the West, empirical studies about their role performance are still scarce. Because registered nurses are a critical part of quality care, it is essential to understand FNGs' role performance in the U.S. Consequently, this study aimed to investigate Filipino nurses' role performance in the U.S. by interviewing participants about the social processes that lead to their RN role performance. The theory created from this study increased the understanding of Filipino nurses' perceptions about role performance in the U.S.

CHAPTER 2: REVIEW OF THE LITERATURE

INTRODUCTION

The nursing shortage in the U.S. concerns those parties who might be affected by it, such as staff nurses, patients, and hospital administrators. To maintain quality healthcare, hospitals in the U.S. have been filling RN positions by hiring foreign nurses to mitigate the shortage (Haddad, 2002). Given the importance of RNs in determining quality health outcomes for U.S. citizens and the strategy of recruiting nurses from overseas, it is imperative to study the role performance of nurses from other countries, specifically Filipino nurses who are the largest group of nurses from a foreign country who are currently working in the U.S. With the intention of understanding and explaining Filipino nurses' role performance in the U.S., this chapter includes a history of the migration of Filipino nurses to the U.S., healthcare in the Philippines, Filipino nurses' experience in Western countries, and nurses' role expectation/performance in the U.S. The chapter concludes with a discussion of symbolic interactionism, the theoretical perspective that served as a methodological guide for understanding the social processes that contributed to how RNs from the Philippines perceives their role performance in the U.S.

HISTORY OF FILIPINO NURSE MIGRATION TO THE U.S.

Foreign nurses' have been recruited for several decades and will continue to be (Aiken, Clarke, Sloane, & Sochalski, 2001; Gamble, 2002; Kline, 2003). Hospitals and other healthcare facilities have relied on foreign nurse graduates (FNGs) to fill RN vacancies since World War II (Gamble, 2002; U.S. Department of Health, Education and Welfare [HEW], 1975; Xu, Xu, & Zhang, 1999). The Philippines is one of the major suppliers of FNGs to the U.S. (Cooper & Aiken, 2006; Pizer et al., 1994; Xu et al., 1999), as well as other countries in the Middle East and North America. Since the 1950s, the Philippines has served as one of the major donor countries of nurses globally (Ball, 2004; Brush & Berger, 2002). The high immigration rates started in the 1950s when there was a massive outflow of nursing graduates from the Philippines, but limited

ability to employ them (Brush, 1995; Lorenzo, Galvez-Tan, Icamina, & Javier, 2007). Table 1 summarizes the major events in FNG recruitment in the U.S.

Choy (2003) presented detailed documentation and a history of Filipino nurses' migration to the U.S. Filipino nurses entered the U.S. primarily through the Exchange Visitor Program (EVP), which began in 1948, and the 1965 Immigration Act, which allowed them to become permanent residents (Choy, 2003). The American Philanthropic Organization sponsored Filipino nurses to study abroad in the 1940s (Choy, 2003). The program was established by the International Council of Nurses (ICN) and was later sponsored by the American Nurses Association (ANA). The Americanized hospital training system also created the foundation that enabled Filipino nurses to work in the U.S. The ICN and the ANA were both actively involved with the Filipino Nurses Association (FNA) in screening and processing the EVP participants.

The EVP provided a venue for nurses from various countries to seek opportunities and adventure in another country. In fact, prior to 1965, EVP was the primary way Filipino nurses and other FNGs migrated to the U.S. (Brush & Berger, 2002). In the 1960s, Filipinos comprised 80% of the participants in the EVP in the U.S. In 1965, a massive number of the Filipino nurses immigrated to the U.S. in reaction to the 1965 Immigration Act (Brush & Berger, 2002; Choy, 2003). In fact, after 1965, the majority of nurse migrants were hired directly by U.S. healthcare facilities to function as nurses in the U.S. (Brush, 1995). The EVP opened up some restrictions under the 1952 Immigration and Nationality Act. As a result, the percentage of Asian immigrations increased from single digits in the early 1960s to close to 40% in the late 1970s among all immigrants (Brush & Berger, 2002). Because of the attraction of socioeconomic success in the U.S., Filipino nurses and recruiters started to use the EVP as a pathway to recruit nurses from the Philippines, which created the first wave of the Filipino nurses' mass migration to the U.S. from 1965 to 1969 (Choy, 2003). The EVP further encouraged Filipino nurses to migrate to the U.S. by offering a chance to experience adventures. Although the intention of the

countries that both sent and received nurses via the EVP was for them to return to the Philippines, some nurses decided to stay in the U.S. because of their improved socioeconomic status or environment.

Some Filipino participants from the EVP were treated unfairly by being paid less than domestic nurses in the U.S. (Choy, 2003). Other examples of unfairness were sudden alterations in their schedules and assignments to the least desired areas. Arrival and orientation experiences were sometimes disorganized, which created extra stress on the EVP participants. The establishment of nursing associations, such as Filipino Nurses Association (FNA) helped them find a voice and resulted in some of their needs being met.

Since the mid-1960s, there has been a significant increase in the number of nurses admitted to the U.S. from other countries. Despite the efforts of State Boards and the ANA, it was not easy to keep an accurate record of the number of FNGs entering the U.S. (HEW, 1975). Nurses entered the U.S. in various ways; some claimed to be housewives or relatives of other immigrants entering the U.S. FNGs most often entered the U.S. with F, J, TN, and H visas and green cards (HEW, 1975). The F visa is a student visa issued to the applicants primarily for training and educational purposes. The J visa is issued to sponsored participants of education or exchange training programs approved by the Department of State for study or work for special purposes. The TN visa is granted to employees from Canada and Mexico under the North American Free Trade Agreement. The H visa is granted to non-immigrant aliens temporarily coming to the U.S. to work in needed areas. The H1-A, a type of H visa, was granted as a non-immigrant occupational visa for FNGs for 3-5 years (Brush & Berger, 2002). The F, J, TN, and H visas are considered non-immigrant visas, whereas the green card or permanent residency is treated as an immigrant visa. Based on the report by the HEW in 1975, there were 47,339 nurses admitted to the U.S. between 1969 and 1974. Of these, 35,359 (75%) were under immigrant visas and 11,980 (25%) were non-immigrant visas.

Due to political changes, Filipino nurse immigrants were viewed by Filipino citizens in various ways during different periods (Choy, 2003). In the 1960s, they were viewed as turning their backs on their own people if they decided to migrate to other developed countries like the UK or the U.S. after the completion of the EVP. In contrast, in the 1970s, nurse immigrants were treated as heroes for migrating to developed countries because they usually sent money home, which helped the country.

In the 1970s, the majority of Filipino nurses shifted from being EVP participants to holding a temporary work visa, or H-1 visa (Choy, 2003; Gamble, 2002). Nurses from the Philippines held the majority of H-1 visas in the U.S. A large proportion of Filipino workers residing overseas were doctors and nurses, and the funds they sent back to the Philippines played an important role in advancing its economic growth. Prior to 1970, many states offered Filipino nurses, and other foreign nurses, a permit to practice via endorsement. Starting in the early 1970s, some states like New York required foreign-educated nurses to take a board exam called the State Board Test Pool Examination (SBTPE). In the 1970s, the passing rate for foreign-educated nurses was very low (22.5%) compared to domestic nurses (about 85%).

Many organizations are involved in regulating the immigration process for FNGs' employment in the U.S. According to the conference report presented in Maryland (1975) by HEW, the agencies involved were the U.S. Congress, the Immigration and Naturalization Service (INS), the Department of State, the Department of Labor, and the HEW. In order to identify the characteristics of FNGs, the Division of Nursing (DON) of HEW contracted with the ANA to study them. The DON also contracted with Pace University in New York to develop a pre-immigration screening process. The regulations and procedures for licensing FNGs varied considerably in all states in 1975. Moreover, concerns were raised by the State Boards that many foreign-educated nurses lacked training in psychiatric nursing (19%), obstetric nursing (5.2%), medical-surgical and pediatric nursing (2.6%), English language proficiency (20.3%), and

required a secondary education equivalent to U.S.-trained nurses (17%) (HEW, 1975). In other words, most FNGs received adequate training in medical-surgical and pediatric nursing but they received insufficient training in other areas mentioned above. Facilities that plan to hire FNGs should evaluate FNGs' knowledge and previous training in these areas in order to provide them proper orientation.

The low passing rates and the concerns raised by these agencies stimulated the formation of the CGFNS to oversee and administrate the prescreening examination before the SBTPE (Brush & Berger, 2002; Choy, 2003). The exam is intended to test FNGs' proficiency in nursing and English in order to determine the applicant's qualifications for hospital employment in the U.S. A pre-immigration examination would create an opportunity for the FNGs who might have trouble obtaining the license before committing themselves to moving abroad (HEW, 1975). Some Filipinos viewed the exam as "anti-Filipino," while many American nurses viewed it as beneficial towards foreign-educated nurses. Although the responses to the CGFNS examination were twofold, the INS used the CGFNS as part of the process for the immigration of FNGs.

In 1975 FNGs represented about 3.5% of the total RN workforce (HEW, 1975) compared to about 10% today (Brush, Sochalski, & Berger, 2004; Cooper & Aiken, 2006). In 1975, the majority (75%) worked in New York, Michigan, California, Illinois, and New Jersey (HEW, 1975). Filipinos filled most staff vacancies in the 1970s in the U.S., which were previously occupied by European nurses (Brush & Berger, 2002: Brush et al, 2004; Withers & Snowball, 2003). In 1992, 42% of the FNGs were Filipinos (HHS, 2002); in 2001 and 2003, more than half of the FNGs were from the Philippines (Brush et al., 2004; HHS, 2002). In 2005, of the 21,500 people that took the CGFNS exam, 55% were from the Philippines (CGFNS, n.d.). The Philippines is viewed by many countries as the leading exporter of nurses worldwide, especially by the U.S., UK, and Saudi Arabia (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Lorenzo et al., 2007). Today, an estimated 250,000 Filipino nurses work abroad (Ball, 2004). In

the UK in 2004, the number of nurses recruited from overseas continued to increase from 8,404 in 2000 to 11,477 in 2004, with India and the Philippines producing the most. In 2001 and 2004, 8,229 and 7,411 nurses, respectively were sent from these two countries alone (Brush & Sochalski, 2007; Solano & Rafferty, 2007; Smith & Mackintosh, 2007). Since 2000, nurses from these two countries represented more than half the nurses recruited to the UK from overseas (Solano & Rafferty, 2007).

Beginning in the 1990s, the U.S. government began to define a way to control the flow of FNGs into the U.S. healthcare system. In 1996, as a response to the Illegal Immigration Reform and Immigration Responsibility Act, a visa screen took place, which required that FNGs obtain certification, such as the CGFNS, of their professional qualifications and English language proficiency, before obtaining a visa to the U.S. In 1997, the exam significantly increased the passing rate of the National Board for Nursing Licensure Examination (NCLEX) from less than 20 % to about 90% (CGFNS, 2006). The major events in FNG recruitment in the U.S. are summarized in Table 1. Passing the CGFNS exam is required of applicants for H-1 visas, the NCLEX-RN in most states, and permanent residency (Xu et al., 1999). As the authors mentioned, the evaluation of credentials by the CGFNS is in three areas: credentials evaluation, education verification, and licensure confirmation.

There are three steps in evaluating the eligibility of applicants to take the certifying exam. The first step is to determine if the applicant has an adequate secondary education. The second is to ensure that the applicant has met minimum requirements as a 'first level nurse,' as defined by the ICN. A first-level nurse is defined as a nurse who graduated from a two-or more-year program that provides theory and didactic education, including medical, surgical, obstetric, pediatric, and psychiatric nursing. A first-level nurse is similar to a registered nurse in the U.S. (Xu et al., 1999). The third step is to determine if the applicant is licensed in his or her country of origin. In addition to passing the board exam, FNGs were also required to have proof of licensure

as a professional nurse from their countries of origin (Brush et. al, 2004). The completion of prescribed amounts of didactic and clinical instruction as first level nurses in medical, surgical, obstetric, psychiatric, and pediatric nursing as defined by the ICN are also required. Moreover, most States mandated FNGs to show English proficiency by taking a pre-determined test developed in the 1970s. Despite the additional requirements imposed by the U.S. government, Filipino nurses, as well as nurses from other countries, continued to immigrate to the U.S. (CGFNS, 2006; Gamble, 2002). According to the 2006 CGFNS annual report, 59,477 visa screen certificates were issued to RNs between 1998 and 2005.

The 1999 Nursing Relief for Disadvantaged Area Act created another type of temporary visa called the H-1C, which was for understaffed facilities in critical shortage areas in the U.S. (U.S. Department of Labor, 2005). The 1999 Act, and its reauthorization in December 2006, permitted hospitals that qualified to hire temporary FNGs for up to three years under H-1C visas. Only 500 H-1C visas were issued each year during the three-year program, according to the U.S. Department of Labor (2005).

It is obvious that nurses' mobility in employment will keep increasing internationally in the future, which makes foreign-educated nurses a unique population. The migration of Filipino nurses to Western countries has been a trend since the 1950s. Despite the changing laws, Filipino nurses are likely to migrate to or seek employment in the West for various reasons, such as socio-economic status, adventure, and a better educational opportunity. Although Filipino nurses working in the U.S. are a distinct population, their experiences and role adaptations have not been studied.

HEALTHCARE IN THE PHILIPPINES

The Philippines is a country of many islands located in Southeast Asia (Sy, 2003). The population increased from 31 million in 1965 to approximately 80 million in 2005 (Philippines National Statistics Office, 2007). As of 2004, the population of the Philippines was estimated at

82,663,560 and it was growing rapidly, making it one of Southeast Asia's most heavily populated areas. The population is primarily young with about 70% aged 40 and younger; those 65 years and older comprise only 4.34% of the population (World Health Organization [WHO], 2005). Most Filipinos speak the national language, Tagalog; however, there are 87 dialects of Tagalog spoken in the Philippines. English and Tagalog are the two main languages used by Filipinos to communicate (Spangler, 1992). The Filipino culture is a blend of Asian, Indian, American, and colonial Spanish influences, which created a unique mix of Eastern and Western cultural values and beliefs (Charest, 1992). Most Filipinos are Roman Catholic, a consequence of 300 years of Spanish colonization (Ordonez & Gandeza, 2004).

The health problems in the Philippines are somewhat different from those in the U.S. The 10 leading causes of death in the Philippines are acute lower respiratory infection and pneumonia, acute watery diarrhea, bronchitis/bronchiolitis, hypertension, influenza, tuberculosis, heart disease, acute febrile illness, malaria, and dengue fever (Department of Health, 2005). In contrast, the 10 leading causes of death in the U.S. are heart disease, cancer, stroke, chronic lower respiratory diseases, accidents/unintentional injuries, diabetes, Alzheimer's disease, influenza/pneumonia, kidney diseases, and septicemia (Centers for Disease Control and Prevention [CDC], 2005).

In 2005, of the 702 government healthcare facilities in the Philippines, 272 were primary care facilities, 26 were secondary care facilities, and 61 were tertiary care facilities, together totaling 42,559 beds (Department of Health, 2005). Combining public and private facilities, the estimated number of hospitals in the Philippines is 1,600; 60% of these are private providers (Lorenzo et al., 2007). The Philippine healthcare system consists of a managed public healthcare system and privately initiated healthcare coverage that is mostly paid for out-of-pocket. The majority (60.9%) of Filipinos do not have health insurance (Dror, Koren, & Steinberg, 2006; Hadwiger & Hadwiger, 1999; Obermann, Jowett, Alcantara, Banzon, & Bodart, 2006).

Hadwiger and Hadwiger (1999) found that to minimize costs, medical equipment and disposable items are not commonly used in the Philippines.

There are two major healthcare approaches in the Philippines: Westernized medicine and traditional medicine (Country Health, n.d.). The Westernized system is based on the germ theory of disease and has mirrored the U.S. healthcare system since the American occupation in 1898 (Spangler, 1992). The traditional approach assumes that illness has supernatural causes, such as heat, cold, air, and bewitchment (Spangler, 1992). As in many Asian countries, it is not atypical for someone to seek help through both treatment approaches (Chu & Wallis, 2007; Lim, Sadarangani, Chan, & Heng, 2005). Home remedies and alternative treatments are common. Although medical care has improved and healthcare services have expanded, the persistent lack of economic wealth, as well as restricted access to family planning, has diminished the overall health of Filipinos. Healthcare agencies in the Philippines have struggled with limited success against heavy odds to expend scarce financial resources to provide their people with better healthcare (WHO, Philippines, 2005).

Factors leading to the inadequate health care system in the Philippines and its failure to deliver adequate health outcomes to the public include: (a) poor healthcare financing; (b) an improper health service delivery system, including an insufficient system for providing public health; (c) a brain drain of health professionals to developed countries; (d) excessively high prices of medicines, leading to high out-of-pocket costs; (e) inadequate enforcement of regulatory mechanisms; and (f) inadequate efforts to prevent and control new diseases, particularly non-communicable diseases (WHO, Philippines, 2005). As the lead agency for healthcare, the Department of Health sustains specialty hospitals, regional hospitals, and medical centers. People from rural areas and isolated communities have experienced a lower quality of care and fewer health services because of limited access to health care compared to residents of urban areas. The mass migration of doctors and nurses from both the public and private health

sectors has made the rural areas even more susceptible to human resource shortages (WHO, Philippines, 2005).

The most common source of funds (43%) for healthcare in the Philippines today is still out-of-pocket payments (WHO, Philippines, 2005). However, there has been remarkable progress in increasing public access to healthcare services. For instance, the National Health Insurance Program (NHIP) covers 81% of the country's population. The NHIP has been successful in targeting indigents through its indigent program, whereby national and local governments jointly subsidize annual premiums for indigents in each community. Additionally, social health insurance through the Philippine Health Insurance Corporation (PhilHealth) also makes an effort to provide quality primary, secondary and tertiary care services and make these more accessible to underserved rural and urban communities. Also, to improve the well-being of Filipinos in general, efforts have been made in HIV/AIDS prevention, maternal care and family planning, malaria control, immunization improvements, and tuberculosis management (WHO, Philippines, 2005).

In summary, the population in the Philippines has more than doubled since 1965, with the majority of the population being young adults. The causes of death in the Philippines are quite different to those in the U.S. Filipino causes of death are predominantly infectious whereas in the U.S., most cause relate to chronic diseases. Westernized medicine and traditional medicine are the two major healthcare systems used in the Philippines; many Filipinos utilize both systems. Many Filipinos do not have health insurance. Numerous factors have contributed to the inadequate capability of the Philippines' health care system to deliver better health outcomes to the public. The Philippines government has been struggling, with limited success, to provide services to its people. In addition to uneven healthcare services, the migration of Filipino nurses to the West may have created a further burden for the Philippine government. In this section, the PI aimed to understand how Filipino nurses' previous historical and cultural experience might

influence their current perceptions as they transition to a new country as a RN and how that might affect their role performance.

THE NURSING EDUCATION SYSTEM IN THE PHILIPPINES

The education of nurses in the Philippines began around 1906 (Spangler, 1992). Some Filipino nurse graduates in the 1900s took the scholarship offered by the Philippine government and were sent to the U.S. to earn a baccalaureate or master's degree. They then returned to the Philippines and assumed leadership or scholarly positions. In fact, most of the early nurse leaders were either Americans or Filipino nurse graduates educated in the U.S. (Spangler, 1992). This created the root of Filipino nursing education in the Philippines.

The Philippines began offering bachelor degrees in nursing in the 1940s. The number of nursing programs in the Philippines increased from 17 in 1950, 132 in 1989 (Brush, 1995), 233 in 2003 (Perrin, Hagopian, Sales, & Huang, 2007), 370 in 2005 (Overland, 2005), and 460 in 2006 (Lorenzo et al., 2007). This increase was partly due to encouragement from the government to facilitate educating, training, and placing Filipino nurses worldwide (Gamble, 2002). The increasing number of nursing programs provided more nursing graduates. However, the passing rate for the board exam in the Philippines dropped from 80% to less than 40% in ten years (Overland, 2005). The passing rate for nursing and midwifery from 2000 to 2006 was less than 50% (Romulo, 2007). The quality of these new nursing education programs was problematic. In fact, in 2004, 23 of these nursing programs were forced to close down due to the low quality of their programs (Overland, 2004).

Nursing education programs in the Philippines provide both theory and related learning experiences, aimed at preparing nurses with critical thinking skills and beginning professional competencies (de Guzman et al., 2007). Many of the hospital training schools were managed by U.S.-trained chief nurses and followed an Americanized nursing curriculum (Brush, 1995; Ordonez & Gandeza, 2004). In addition to the Americanized educational system, the FNA

stepped in to take care of problems such as the lack of communication and training consistency among nursing school systems.

The ‘brain drain’ has been widely discussed by scholars and clinicians, although whether ‘brain drain,’ ‘brain gain,’ or ‘brain circulation’ is the most appropriate term to describe the phenomena of Filipino healthcare workers going abroad is arguable (Ball, 2004; Ordonez & Gandeza, 2004). Brain drain, a term broadly discussed since the 1960s, refers to the immigration of professionals to other countries, causing a shortfall in that profession. For example, the University of the Philippines-Philippine General Hospital, the largest hospital in the country, loses 300 to 500 nurses from the workforce every year (WHO, Philippines, 2005). In the mid-1990s, females became the majority of those emigrating (close to 50%) from the Philippines; 14% of these were nurses (Ball, 2004).

The nursing board exam in the Philippines is called the Philippine Nursing Licensure Exam (NLE), and includes five areas of concentration: medical and surgical nursing, psychiatric nursing, community health nursing, fundamental nursing, and maternal and pediatric nursing. To qualify, the applicant must meet the following criteria:

> (a) be a citizen of the Philippines, or a citizen or a subject of a country which permits Filipino nurses to practice within its territorial limits on the same basis of the subject or citizen of such country, provided that the requirements for the registration or licensing or nurses in said country are substantially the same as those prescribed in this RA 9173; (b) Be of good moral character; and (c) Degree in Nursing from a college or university that complies with the standards of nursing education duly recognized by the proper government agency (Professional Regulation Commission, 2003).

The NLE is a multiple-choice exam that tests basic nursing level competency, which considers the objectives of the nursing curriculum, broad areas of nursing, and other related disciplines and competencies. The NLE is administered by the Professional Regulations Commission (PRC) every June and December in various public schools throughout the Philippines (PRC, 2003). The NLE tests nurses’ general knowledge; however, it is not clear whether it is comparable to the NCLEX-RN in the U.S.

In summary, nursing education in the Philippines is rooted in the U.S. nursing education system. In fact, many nursing schools in the Philippines offer a Westernized educational program because they are managed by U.S.-trained chief nurses. Westernized nursing education in the Philippines may help Filipino nurses adjust to the U.S. healthcare system more easily than those who are educated in a non-Westernized educational system. A growing number of nursing schools in the Philippines has created more nursing graduates; however, the quality of these graduates is a concern for the Philippine government and hiring countries such as the U.S. Overall, research indicates that RNs from the Philippines may be socialized to Westernized health care systems because they were trained by Filipino chief nurses educated in the U.S., which may influence their perceptions of their ability to perform RN roles in the U.S. However, this hypothesis has not been investigated thoroughly and deserves further exploration as concerns increase about the quality of Filipino educational programs and its effect on the care that Filipino nurses provide to the U.S. population.

FILIPINO NURSES' EXPERIENCE IN WESTERN COUNTRIES

Immigrating to a foreign country is challenging and may lead to many problems, such as social isolation, emotional distress, and health problems (Shin & Shin, 1999). Filipino nurses have immigrated to many Western countries to work as nurses or other health related positions to care for patients overseas. While adjusting to foreign healthcare systems and cultures, FNGs might choose to suffer through to the end of their often-inferior contracts, which may lead to discrimination or marginalization (Yu, 2007). Hence, it is essential to understand the phenomenon of Filipino nurse migration to help them avoid unethical treatment and successfully cope with life in a new country and culture. The following section of this proposal is a literature review, including a review of what is known about the characteristics of Filipino nurses, their reasons for emigration, their expectations and experiences of working in the West, cultural adjustment, common problems, and ethical issues. Although the focus of this review is on the

experiences of FNGs from the Philippines, I have pulled literature from the experiences of FNGs from other Asian countries as well, because little research has been done on the experiences of Filipino nurses.

Characteristics of Filipino Nurses

Filipino nurses may have the following characteristics that would positively affect the quality of care they provide. The first trait is "obligation to care" as a core value, which is supported by expressing seriousness and dedication to work, being attentive to patients' physical needs, and presenting respect and patience as a caring model (Spangler, 1992). The second trait is an outstanding work ethic, as evidenced by the high value they place on work, their low absence rate at work, and their low number of complaints (Ordonez & Gandeza, 2004). They tend to avoid confrontation or arguments and are afraid to disagree with authority, such as nurse managers or directors. This could potentially have negative effects on the image of Filipino nurses. They may be perceived as not interacting with patients or others around them because of their avoidance.

According to the literature, Asian nurses who work overseas are usually female, married, fulltime workers, and between the ages of 23 and 40, which means that they are likely to also be mobile and physically capable (Berg, Rodriguez, Kading, & de Guzman, 2004; Perrin et al., 2007; Withers & Snowball, 2003). Furthermore, in their study on Asian American nurses, Berg et al. (2004) found that Asian nurses who work in the U.S. usually held bachelor's degrees in nursing (78%), worked fulltime (82.9%), and would choose to become nurses again (80%). These characteristics may also hold true for Filipino nurses. Filipino nurses also value the usefulness and importance of providing physical care to their patients (Spangler, 1992), and potentially providing comfort to patients and their families through positive rapport and emotional support, which is often lacking because of modern technology. Other characteristics of Filipino nurses are summarized in Table 2.

Reasons to Come to the West

The reasons that Asians leave their countries of origin can be separated into two major categories: push factors and pull factors (International Council of Nurses, 2007; Kline, 2003; Lorenzo et al., 2007). Push factors are conditions in the FNGs' countries that encourage them to emigrate. On the other hand, pull factors are circumstances in the receiving countries that motivate the FNGs to go abroad and seek employment opportunities. The major push factors include a poor economic situation, high job stress, and socio-political instability in the country of origin. Lorenzo et al. (2007) argued that there are not enough jobs available in the Philippines, as evidenced by the 12% unemployment rate in 2003; in fact, 84.75% of employed Filipino nurses are working abroad. Consequently, the Philippines has been one of the major exporters of nurses to Australia, Canada, Ireland, the UK, and the U.S. (Kline, 2003).

The major pull factors are better economic conditions or financial compensation, better work environments, opportunities for professional development, educational opportunities, adventure travel, and socio-political stability in the receiving countries (Daniel et al., 2001; Kline, 2003; Mejia, Pizurki, & Royston, 1979; Withers & Snowball, 2003). Several researchers have documented that Asian nurses sought employment opportunities in the UK for better career prospects and financial security (Daniel et al., 2001; Gonagle, Halloran, & O'Reilly, 2004). Nurses from the Philippines believed that the UK had better opportunities for career advancement than the Philippines. Filipino nurses intending on working in the UK said that sending money home was one of the major incentives for going abroad to work (Gonagle et al., 2004). Asian nurses, including those from the Philippines, may have similar reasons for entering the U.S. In the Philippines, government policies that support nurse emigration may cause Filipino nurses to perceive that seeking jobs abroad is a great opportunity for professional growth and economic prospects.

Expectations and Experiences in the West

Nurses from different countries may have varying views and expectations of their jobs. Work environment, nursing roles, and the organization of work were identified as important factors when considering work expectations in a hospital in the UK (Daniel et al., 2001; Gonagle et al., 2004). In their study of Asian nurses, Withers and Snowball (2003) concluded that nurses' expectations about earnings, living conditions, and professional enhancement have not been met and might lead to their dissatisfaction. Nurses' attitudes and behaviors might also be affected by these unmet expectations, which might lead to their resignations from their jobs.

Because Asian nurses are from very different cultures than nurses from Western countries, their level of satisfaction may be different. Nurses from Germany, the U.S., and Canada reported that there were not enough nurses to get the work done properly and to provide quality care (Aiken et al., 2001). In this same study, nurses reported that they were required to perform many non-professional tasks that led them to leave professional work undone, such as teaching patients and families. Similarly, this may be a problem for other international nurses working in Western countries. Job satisfaction among Filipino nurses is related to acculturation (Ea et al., 2008). In a descriptive correlational study, Ea et al. administered a Short Acculturation Scale for Filipino Americans and Part B of the Index of Work Satisfaction Scale to 96 Filipino RNs gathered from convenience sampling. Although the non-randomized design of this study limited the generalizability of the findings, the authors were able to fill the knowledge gap for this population by using these two scales to explain the level of Filipino nurses' job satisfaction and how it relates to their level of acculturation. They found that participants' job satisfaction had a moderately positive correlation to the level of acculturation.

FNGs in Gonagle et al.'s (2004) study appeared to have little knowledge about health insurance, their own healthcare, housing, and transportation, which may cause surprises and confusion to the FNGs. Despite the increasing number of Asian nurses working overseas, nurses

in this sample seldom receive information about common working conditions, pay, or the resources that might be accessible in the country of employment.

Nurses from the Philippines may have trouble adapting to a new culture, both at work and in the general environment, especially when they are recruited to work in unfamiliar cultures with which they do not share common values (Gonagle et al., 2004). In this phenomenology study, a focus group discussion was used to follow seven individual interviews. Five themes were discovered in the thematic analysis: infrastructure, expectation versus experience, understanding of intellectual disability, education, and the role of the family. Nurses in their study expected hospitals in the UK to be more high-tech and more organized. They also expected the nurse-patient ratio to be higher and workload lower. Their experience and expectations, however, often did not match.

Because of Filipino culture, Filipino nurses may assume that families in the UK will take care of the basic needs of hospitalized patients (Gonagle et al., 2004). The functions of the extended family in healthcare are different in the Philippines and the UK (Gonagle et al., 2004). In the Philippines, the family takes responsibility for caring for their vulnerable family member, which is not common in the UK. Using a focus group interview approach, Daniel et al. (2001) interviewed two groups of Filipino nurses who were working in UK. The two groups differed in the length of time they had been on the job. One group had already experienced working on wards, whereas the second group was still on their 2-week hospital orientation. They also expressed their study results in a chronological sequence, going from ‘reasons for deciding to work in the UK’ to ‘expectations of working in the UK’ to ‘actual experiences,’ which helps the audience understand the experiences of recent immigrant Filipino nurses at a London hospital. In this study, the family or relatives of patients in the UK rarely took care of their personal needs, such as hygiene and feeding. This created a greater workload for the Filipino nurses than they expected. They also experienced differences in the nursing roles, such as nursing routines,

specialization of nurses, shift rotation, use of verbal orders rather than written ones, use of medical jargon, abbreviations, medication names, staff-patient ratios, lifting and handling, and the status of elders. For instance, nurses rotated shifts more frequently in the UK than in the Philippines. These differences may have created additional stress on FNGs if job expectations are not clearly described to them before their arrival.

Common Problems

Asian nurses experienced the following problems adjusting to the U.S. healthcare system: language barriers, cultural variations, variations in social skills, diverse standards of care, different concepts about nursing responsibilities, initial deficiencies in technical skills such as computer charting, supervision of nurse aides, and a lack of recognition from others (Lopez, 1990; Mullen, 2003; Parry & Lipp, 2006; Yi & Jezewski, 2000). Additionally, internationally educated nurses who are already working in the U.S. reported competence in English, clinical skills, and medication administration as the top priorities when first entering U.S. nursing practice (Edward & Davis, 2006).

The common difficulties experienced by FNGs were cultural differences, language and communication barriers, and problems with social interactions (Allan et al., 2004; Daniel et al., 2001; DiCicco-Bloom, 2004; Kinderman, 2006). Although foreign-born nurses may experience many different kinds of difficulties in a diverse setting, it is important to keep the obstacles in mind when recruiting nurses from overseas. Additionally, poor working conditions, low pay, and being used as a care assistant rather than a nurse, were common disadvantages that overseas-trained nurses experienced in the UK (Smith & Mackintosh, 2007).

Xu (2007) presented a meta-synthesis of 14 qualitative research studies with a detailed summary of immigrant Asian nurses' working experiences in Western countries. She used a methodology called Meta-ethnography proposed by Noblit and Hare (1988). The major themes identified by Xu included: "(a) communication as a daunting challenge; (b) differences in

nursing practice; (c) marginalization, discrimination, and exploitation; and (d) cultural differences" (Xu, 2007, p. 246). Examples of 'communication as a daunting challenge' included lack of skill with accents and use of informal language, such as slang and jargon; difficulties in telecommunications, such as receiving telephone orders; the domino effect of communication deficiency, such as avoiding speaking; and accent and communication deficiencies, as grounds for discrimination. The differences in nursing practice were identified as scope of practice, the technological and legal environment, and the role of the nurse.

Communication may be a problem for nurses from the Philippines because of language barriers and cultural differences (Daniel et al., 2001; Gonagle et al., 2004; Spangler, 1992; Yahes & Dunn, 1996). Asian nurses may also experience difficulties communicating with others because of different accents, slang, and pronunciations (Ordonez & Gandeza, 2004), as well as different types of medical terminologies and jargon (Daniel et al., 2001). They may also feel embarrassed to talk or are afraid to ask questions because of they are having difficulties communicating.

According to both published and unpublished sources, FNGs perceive they have been discriminated against, have experienced racism, or have encountered major challenges working overseas (Allan, Larsen, Bryan, & Smith, 2004; Ball, 2004; Smith & Mackintosh, 2007; Xu, 2007). Examples of major changes include communication difficulties and cultural displacement. Racism or discrimination may result in frustration and anger in FNGs, which may then negatively affect the quality of care they provide and their quality of life. One of the sub-themes in Xu's (2007) study was 'marginalization, discrimination, and exploitation,' which included nursing as a gendered profession, unfair treatment, and a lack of equal opportunity, bullying, and sexual harassment, and having to prove themselves. Feelings of 'otherness or lack of belonging' were commonly experienced by Asian nurses in Xu's study. They were also often passed over

for promotions or raises. They perceived that doubt was present in their patients' and in their American peers' minds until they proved themselves.

Asian nurses commonly experienced unfair assignments, undesired shifts, and additional holiday shifts. For instance, DiCicco-Bloom (2004) highlighted that 'marginalization as female nurses of color,' 'the challenges of living between two cultures and countries,' and 'the racism experience' were common statements by immigrant nurses from Kerala, India. The researcher intended to describe the experiences of a group of 10 immigrant women nurses from India by conducting semi-structured in-depth interviews. The themes that emerged from this study were "cultural displacement," "racial experiences/alienation in the workplace and at home," and "marginalization as female nurses of color." Some examples expressed by the participants were lack of promotion, unfair assignments, and lack of reimbursement. Other commonly reported issues were employment as a nurse's aide, assignment to a less-desired position, and failure to receive wages comparable to U.S. domestic nurses (Kline, 2003). Other difficulties experienced by Filipino nurses, as identified by Kinderman (2006), included cultural or lifestyle differences and a lack of respect from others.

Ethical Issues

Common ethical issues among FNGs may be categorized into three levels: global, institutional, and individual (Carney, 2005). Appropriate and effective recruitment should benefit nurse recruits, the receiving and donating countries, the employing organizations, and colleagues in clinical settings (Carney, 2005). A common issue is the ethics of recruiting overseas nurses as the first temporary solution for developed countries such as the UK. Foreign nurse migration was often viewed as negatively affecting the donating country, such as the Philippines, and depleting their experienced healthcare workers, which might compromise their general quality of care (Gamble, 2002; Lorenzo et al., 2007; Perrin et al., 2007). In fact, the home countries of these nurse recruits may also have a nursing shortage (Haddad, 2002). The results of Filipino nurses

immigrating to other countries may create some negative effects on that country, such as high turnover rates and vacancies, despite the positive consequences that improve the economy of the country (Ortin, 1990).

In their self-administered survey, Perrin et al. (2007) found that it is more and more difficult for hospitals to recruit experienced nurses from the Philippines because a large portion of them have already gone abroad to seek jobs. Using information from 86 surveys that were returned by Filipino hospital chiefs of nurses, the authors found that it was difficult to recruit nurses with more than a year of working experience, especially to private hospitals. In short, hiring these nurses may worsen an existing shortage in their own countries. The impact on some developing countries like the Philippines may be severe. Consequences may include losing scarce resources, lowering quality of care, and losing future leaders in the profession (Buchan, 2001). The recruitment of skilled health professionals to a developing country is dangerous because the resulting brain drain could potentially damage the existing healthcare services in that country (Kassaye, 2006). Highly educated professionals may be employed in jobs that are unrelated to their expertise or below their level of knowledge, or they may spend much of their time serving as consultants for recruiting companies rather than teaching students (Kassaye, 2006).

Filipino nurses might encounter problems such as unlawful agencies during the process of seeking a job overseas. The Sentosa Nurses' Case was one example of Filipino nurses being mistreated by "unmet promises and contract violations with regard to their places of employment, assignments, wages and benefits, overtime pay, living accommodations, and reimbursement for expenses" (Keepnews, 2007, p. 80). In response to these types of problems, the ICN established guidelines to ensure good faith contracting, access to grievance procedures, effective orientation, mentoring, supervising, and regulation of recruitment (ICN, 2001, 2007).

By following these guidelines, recruiting agencies, recruiting facilities, and foreign nurses may be protected, and therefore, less likely to encounter the issues mentioned above.

Cultural Adjustment

Culture is a powerful construct that refers to the learned and shared knowledge of values, beliefs, and life ways of a particular group that are normally passed on from generation to generation (Leininger & McFarland, 1995; Spector, 2004). Xu (2007) found that RNs from the Philippines believed that their kindness and tendency to accommodate was taken advantage of and even abused by people they worked with or cared for. Culture influences ways people communicate, behave, believe, and act. Culture is a meta-system made up from a set of beliefs, practices, habits, likes, dislikes, norms, and rituals where each part and aspect is related to one another (Spector, 2004). The clash of Filipino nurses' culture and the local culture often creates conflicts and makes it necessary to adjust and find ways to cope.

Cultural adjustment refers to the adaptation to a new culture. Adjustment is defined as "a change in a person's behavior or thinking" (Collins Database, 1987, p. 18). Adjustment is an on-going process required by one situation followed by another. Cultural changes can occur over time in various ways in each setting or country. To avoid misunderstanding from their patients, nurses should learn to adjust and meet the needs that are perceived by their patients (Spector, 2004). Nurses should learn and understand the values, beliefs, and major features of the culture of a foreign country before going to work there to avoid cultural stresses (Leininger & McFarland, 1995). For instance, a newly employed nurse usually feels uncertainty and confusion about the organizational culture of the institution where she works (Khoza, 2005). Nurses must learn the specific culture over time and decide whether to follow along or rebel against that culture.

One of the biggest challenges in working overseas is adjusting to the new environment and cultural landscape. Cultural adjustment is important in the process of hiring foreign nurses,

which may influence Asian nurses, the hospital, managers, and coworkers (Daniel et al., 2001; Gonagle et al., 2004). Factors that affect Filipino nurses' adaptation include equal opportunities with respect to training and promotion and the use of culturally sensitive orientation programs (Daniel et al., 2001). It is essential to pay attention to the cultural backgrounds of the FNGs to meet their needs and promote their assimilation into the practice of American nursing (Dijkhuizen, 1995; Kinderman, 2006). For instance, hospital administrators can incorporate cultural training into the new employee orientation, as well as provide educational opportunities on backgrounds of FNGs for hospital staff.

Filipino nurses, as well as many other Asian nurses, have a strong family orientation (McLaughlin & Braun, 1998) and treat other Asian nurses as family when they are overseas. Ordonez and Gandeza's (2004) summary of the healthcare beliefs, behaviors, and practices of Filipino nurses in the U.S. presents general ideas about how these nurses socialize. They ate and socialized primarily with each other, which placed them in an isolated situation where only Filipinos mingled with each other without their Western colleagues' cultural influences (Ordonez & Gandeza, 2004). This lack of interaction with the native population could negatively influence their cultural adjustment.

Cultural adjustment can be discussed in various ways. One example was presented by Withers and Snowball (2003), who adopted Pilette's (1989) phases of acculturation in a descriptive study of 45 Filipino nurses' experiences working in the UK. Of those participants, eight Filipino nurses participated in a semi-structured interview. Using both survey questionnaires and qualitative interviews to collect data helped the authors explore Filipino nurses' expectations and experiences at the Oxford Radcliffe Hospitals in the UK. Withers and Snowball (2003) found that in the acquaintance phase, Filipino nurses experienced a high level of anxiety before arriving in the West because of language barriers and cultural differences. Despite feelings of unfamiliarity with Western cultures and healthcare systems, they enjoyed the

autonomy of nurses in the West. Participants in their study stated that culturally sensitive training and an emphasis on medical terminology were helpful, but their unmet expectations were disappointing. Unanticipated nursing roles, staff shortages, and a heavy workload were listed as adversely affecting Filipino nurses' adjustment during the indignation phase. Mentors or preceptors were provided to advise and support the Filipino nurses, which they viewed as beneficial. Filipino nurses finally reached the phase of conflict resolution when they decided to adjust to the new culture and take action when discriminated against. These phases are helpful in mapping out the stages of adjustment in the nurses. Filipino nurses, like other Asian nurses, are acculturated to Western healthcare systems when they move to the West; however, their traditional values and culture still affect their daily practices, beliefs, and behaviors (Ordonez & Gandeza, 2004). Although this may create some conflicts when caring for patients, it is beneficial because it heightens their sensitivity to the culture and beliefs of others.

In conclusion, the reasons that Asian nurses leave their countries to work abroad can be separated into two major categories: push factors and pull factors. Filipino nurses' experiences in the U.S. or in other developed countries varied. Nurses from different countries may have varying views and expectations of their jobs. Common adjustment problems for FNGs included language barriers, cultural differences, differences in social skills, diverse standards of care, different concepts about nursing responsibilities, initial deficiency in technical skills such as computer charting, supervision of nurse aides, and a lack of recognition from others. Filipino nurses may experience similar problems. Common ethical issues can be categorized into three levels: global, institutional, and individual. Filipino nurses' experiences in the U.S. are complex, yet it is essential that these experiences be explored because of the increasing number of Filipino nurses working in the U.S. and because there are few existing empirical studies.

Existing studies suggest that Filipino nurses, like other FNGs, experience challenges and struggles for personal and professional identity and justice. Cultural differences, the diverse

scope of nursing practice, and the different communication styles of domestic nurses and FNGs are commonly mentioned in the literature. Nonetheless, Filipino nurses' perception of role performance, as well as how they transition and adapt their role in the U.S., are still understudied.

NURSES' ROLES IN THE U.S.

A role is defined in terms of functions or duties a person carries; however, the role of a nurse should be viewed more broadly (Doheny et al., 1997). Usually the regulation agencies, professional agencies, and the facilities where nurses work specify functions that they need to perform. Nurses' roles are directed by the activity or behavior that is expected and acceptable in a particular setting. As mentioned by Doheny et al. (1997), various expectations are usually in place where nurses work, which make the interpretation of a nurse's role even more complex. For instance, physicians may expect nurses to carry out their prescribed orders correctly and social workers may expect nurses to make timely and appropriate referrals (Doherty, 2003). The complex definition of nurses' roles and diverse expectations make the interaction between nurses and others a construct that needs further exploration.

The nurse's role varies in different settings or positions (Kerfoot, 1997). The nurse's role can be described in five categories: patient caregiver, client advocate, counselor or educator, coordinator or collaborator, and consultant (Doheny et al., 1997). The examples of functional activities in nurses' roles are summarized in Table 3. Moore-Higgs et al. (2003) asserted that nurses' also play the role of administrator. Other commonly identified functions of nurses include risk manager, researcher, mentor, and case manager. It is often understood that a nurse fulfills these roles whenever appropriate to properly care for his or her client. The roles of nurses are described in detail in the following sections.

Caregiver

Caregiver is the most commonly referred to role associated with nurses. Nurses assess their client's physical, emotional, cultural, psychological, and spiritual needs. Nurses also care for their clients based on their assessment, and evaluate their care after interventions. The role of caregiver may involve performing a physical assessment, administering medication, changing a wound dressing, inserting an intravenous line, obtaining vital signs, assessing skin integrity, advancing diet as appropriate, orienting the client to the environment, and giving emotional supports. The dimensions of practice for nurses include managing pain, performing nursing procedures, prioritizing the plan of care, taking care of patients with different problems or conditions, and using necessary technologies (Edward & Davis, 2006; Funtera, 2003). Nurses are also responsible for using critical thinking skills about findings in their assessments and then to take appropriate action.

Client Advocate

As a client advocate, nurses assist the client and family in understanding medically related information to help them make informed decisions about surgical procedures or research studies. Nurses also become involved in defending and protecting their client's rights (Doheny et al., 1997). Nurses are required to assure that patients receive appropriate information in an understandable language before consenting to treatment or procedures involving participation in a research study. Nurses can help clients regain power by giving them choices, when appropriate, such as the timing and types of pain relievers they receive. Nurses should know their responsibilities well because they are the ones who can best protect the clients. They are legally responsible for their actions or inactions involving their clients. In fact, if physician malpractice occurs, nurses are held partly accountable if they fail to take appropriate action. For example, when a nurse fails to take action for prolonged bleeding in a patient receiving a Heparin drip, the consequence may be death of the patient, for which the nurse is indeed accountable (Bhalodia,

2007). In addition, nurses should actively seek physician's orders to correct an oversight. Nurses are the patients' advocate, which means that they are responsible for catching the doctor's mistakes. If they fail to do so, they will carry part of the responsibility and accountability (Xu, 2007). They should break the chain of command if the physician neglects an existing problem. The nurse can also contact family members to visit the client who is hospitalized. Nurses are accountable for their action or inaction at any given time and situation while providing nursing care (ICN, 2004).

Educator

Teaching patients is an essential part of the nurse's role (Barrass, 1992). Nurses may serve as an educator to the client, the family, and others who may be involved with the patient's care (Doheny et al., 1997). Educational functions include instructing patients, families, communities, and staff on different occasions on various topics. Nurses provide knowledge to clients or their families to promote health, manage disease, and solve problems through behavioral and attitude changes. Nurses recognize teaching needs by interacting with their clients. Nurses may discover the educational needs of a client by questioning them or observing them directly. Nurses can educate clients on lifestyle changes, diet, and exercise for diabetic patients and their families. Nurses can also obtain advanced training to become specialized educators, such as a diabetes educator or a wound care specialist. Nurses should continue advancing their knowledge to provide quality education to their clients (Magson-Roberts, 2007). Barrass (1992) emphasized that for a patient to be an effective learner, the nurse and the patient must work together as partners. Such partnerships require effective communication and interaction between patient and nurse educator. In this way, the nurse can comprehensively assess the patient's readiness and previous experiences before proceeding. Nurses play a major role in patient education, for example, teaching deep breathing exercises or providing discharge planning/implementation.

Coordinator and Collaborator

Nurses are also required to have strong coordinating skills with and around the interdisciplinary healthcare team. Nurses should feel comfortable initiating direct referrals to specialists or other professionals when necessary, to assure their client receives quality treatment and care. For instance, when a staff nurse cares for a patient with a complicated wound, it is their responsibility to seek consultation from a wound specialist. Playing the role of a coordinator, nurses plan and organize the healthcare team so that coordinated care is delivered to the client (Doheny et al., 1997). For instance, nurses may contact the radiology department and find out when a computerized tomography will take place. Nurses may contact the dietary department and place an order for a meal for a client. A rehab nurse may facilitate communication among the members of a healthcare team by attending a team conference. Coordinators are expected to arrange patients' plans of care and to function as a bridge among patients, families, and healthcare team members (Neal, Brown, & Rojjanasrirat, 1999). This role requires effort to communicate with physicians, physician assistants, practitioners, therapists, managers, assistants, and even housekeepers or kitchen staff.

The role of collaborator is similar to that of coordinator. The nurse collaborates with the client, the family, and other professionals, to develop a plan that best fits the client's needs (Doheny et al., 1997). For instance, nurses may share their assessment findings of their clients with the physician, dietitian, and speech therapist to modify the client's diet accordingly. This role often overlaps with that of case managers and requires strong communication skills to coordinate and communicate patients' needs (Johnson & Schubring, 1999). Some functions related to this role include serving as a liaison between family and patient, facilitating ongoing assessment of patient care, and integrating patient and family concerns into the plan of care (Johnson & Schubring, 1999).

Consultant

Nurses should actively seek and provide information to clarify clients' goals and the means to reach their goals (Doheny et al., 1997). They also serve as recourses to other healthcare professionals. For instance, a nurse at a rehabilitation unit who is receiving a transferred patient may consult the primary nurse about the patient's needs and priority of care. Experienced nurses may serve as consultants or a resource to junior nurses (Doherty, 2003). Their role as a leader or role model is important to maintaining standards and quality of care. A consultant nurse takes on several functions, including expert practice, leadership, education, research, and development of practice (Currie, 2007; Manley, 1997). Nurses can improve the quality of patient care by strengthening these functions.

Administrator

Administrative functions include the delegation and supervision of clinical staff, as well as policy and protocol development or change. Nurses often work with unlicensed personnel and must delegate tasks to them, but nurses are legally liable for patient care. Thus, they are responsible for ensuring that the delegated tasks are completed correctly. Nurses are also responsible for assuring that staff members comply with rules and regulations (Tolle, 2006). Tasks for this role may include writing policies and procedures, assessing program effectiveness, evaluating staff job performance, ordering medical supplies, attending required meetings, and monitoring the functioning of medical equipment.

All of these roles are interrelated and may be required in different settings or situations (Doheny et al., 1997). The various roles played by nurses may occur singly or simultaneously depending on need. These elements help define the role of a nurse in patient care; however, the nurse's role is still restricted, which could be related to overlapping functions with other healthcare professionals. Members of a healthcare team are expected to function differently

based on their roles in a specific setting. Consequently, it is essential to involve interaction and interpersonal aspects when assessing and evaluating nurses' role and functionalities.

Many nursing functions overlap with that of other health care professionals, such as physical therapists, occupational therapists, case managers, social workers, and dieticians. RNs in general medical surgical units in the U.S. usually do not perform tasks such as venipuncture, wound vacuum changes, or arterial blood gases, which are done by laboratory technicians, physical therapists, and respiratory therapists, respectively. As roles were differentiated out of nursing over the years, the increased complexity and overlap with others created difficulties for nurses trying to define their roles clearly. In addition to the complexity of trying to distinguish nursing from other professions, nursing itself has become more diverse, as has the level of educational preparation for nurses. Licensed practical nurses or vocational nurses (LPN or LVN) are commonly hired by employers to help with staffing due to the shortages of RNs. The educational levels of RNs varied from diploma/associates degrees to doctorates.

The major differences between U.S. domestic nurses and FNGs, as identified by Xu (2007), include their roles, scope of practice, and the technological and legal environment. Nurses in the U.S. are viewed as functioning much more independently compared to nurses in other countries (Xu, 2007). However, U.S. nurses also take part in assisting in activities of daily living, which creates extra burden on the nursing staff. Nurses are responsible for completing legal and institutional paperwork, which takes time away from performing bedside care. Delegation is a major part of nurses' roles in the U.S., because basic nursing tasks, such as checking vital signs and feeding, are assigned to clinical assistants. Nurses are legally responsible for ensuring that these tasks are properly carried out by assistants (Xu, 2007).

In summary, a nurse's role varies depending on the setting or position held, which may be grouped into five categories: patient care, education, administration, and consultation. The scope of practice for nurses ranges from performing tasks to managing care. Nurse's roles often

overlap with that of other members of the healthcare team, which makes the definition of nurses' roles complex. Nurses in the U.S. are viewed as more independent than those from Asia. Given the complicated definitions of the nurse's roles in the U.S., nurses from Asian countries face many challenges to adjusting to the U.S. healthcare system and to functioning independently within the healthcare team.

THEORETICAL BACKGROUND

Symbolic interactionism was used as the philosophical foundation for this study, because of the nature and purpose of this research study. Symbolic interactionism is a theoretical perspective that specifies a connection and interaction between society and individuals that creates meanings in their lives (Schreiber, 2001). The foundations of symbolic interactionism were rooted in the early 1900s and were formulated by George Herbert Mead who was a social psychologist (Blumer, 1969). Symbolic interactionism was later defined by sociologist Herbert Blumer as a distinct research approach. Symbolic interactionism is based on the following roots: the nature of human society, social interaction, objects, the human being as an actor, human action, and the interconnection of the lines of action (Blumer, 1969). The fundamental concepts of symbolic interactionism are the human self, the world, and social actions.

Symbolic interactionism is considered the theoretical basis of grounded theory (Morse, 2001). According to Blumer (1969), a researcher must actively interact with the participants of a research study to understand the phenomenon derived from the participants' actions and interactions. In doing so, the researcher can view the experience through the participants' eyes. This approach assists researchers in identifying concepts and propositions that connect the concepts and in exploring the worldviews and social relationships of the participants (Crooks, 2001). Therefore, it was advantageous to use symbolic interactionism as the philosophical foundations in this study of Filipino nurses' role performance and its related concepts.

Symbolic interactionism has been the philosophical basis for a variety of grounded theory research studies involving various populations, including the homeless (Morris & Strong, 2004), women with HIV/AIDS (Klunklin & Greenwood, 2006), nephrology nurses (Bonner & Walker, 2004), and mothers of critically ill children (Noyes, 1999). Although the populations and settings differed in these studies, symbolic interactionism guided them all. Symbolic interactionism can be applied in a variety of settings or populations when first-hand observation is required. Symbolic interactionism requires that the researcher be familiar with the social lives of the participants before making interpretations. It also requires the researcher to ensure that their interpretation is grounded in empirical reality. Because symbolic interactionism is the conceptual basis of grounded theory, it was used to guide this study. To properly use this philosophical framework to guide a study, the researcher conceptualized the data and carefully examined the data for evidence of empirical occurrences.

SUMMARY

Foreign nurse recruitment has been used as a staffing strategy since the 1940s by many healthcare facilities because of the cyclical nursing shortages in a number of developed countries. The history of Filipino nurses' migration to the U.S. provided a background of Filipino nurses and allowed a better understanding of their intentions and reasons for working abroad. The overview of the healthcare system in the Philippines allowed a better understanding of Filipino nurses' beliefs and behaviors. In addition, the nursing education system in the Philippines, although based on the U.S. system, has many differences from the U.S. system. Although the growing number of nursing schools in the Philippines may produce more graduates to mitigate the shortages of nurses, the quality of the graduates is of concern. Several studies have begun to address the issues in recruiting FNGs, both in the receiving country and the sending country. Of all the FNGs recruited, the Philippines has remained one of the major sending countries. Nurses from other countries, like those from the Philippines, may experience

difficulties because of cultural differences, language barriers, differences in practice, and differences in social norms. Because of these differences and potential barriers, they might not be treated with the respect and dignity they might expect. It is the hiring facilities, as well as the receiving and sending countries, responsibility to ensure that appropriate actions are taken before hiring them to protect these nurses, their colleagues, and the hiring countries.

Generally, nurses' roles, which include patient care, education, administration, research, and consultation, are different based on the positions they hold in various settings. These roles often overlap with those of other health care professionals, which makes the definition of nurses' roles even more complex. Given the multifaceted definition of nurses' roles in the U.S., it is challenging for nurses from the Philippines to adjust to the U.S. healthcare system.

Symbolic interactionism has been used as the philosophical underpinning for many research studies employing grounded theory as the methodology. Symbolic interactionism was useful for this study because it emphasized human actions and interactions. Because Filipino nurses' role performance was related to nurses' interactions with others and the healthcare system, symbolic interactionism further guided the researcher to understand the phenomenon. This chapter synthesized the existing knowledge about Filipino nurses' migration history and experience. However, it was unknown how nurses from the Philippines perceive their work environment in the U.S. and what impact these perceptions may have on their role performance in the U.S. This gap in the literature needs further exploration. Therefore, this study explored Filipino nurses' perceived role performance in the U.S. using in-depth interviews; thus, filling gaps in the existing knowledge.

CHAPTER 3: METHODS

Grounded theory methodology (Strauss & Corbin, 1990) was used for collecting, sampling, and analyzing the data to develop a substantive theory to explain Filipino nurses' transition from nursing practice in the Philippines to nursing practice in the U.S. The theory that evolved was based on 31 female Filipino RNs' descriptions of their perceptions and experiences of adapting to their roles as nurses in the U.S. All names and cities used in this dissertation were changed to a different name to protect participants' identity. This chapter presents the research design, sampling methods, data collection procedures and sequence, data management, and data analysis.

DEFINITIONS

Categorizing

Categorizing is the analytic step in grounded theory of choosing specific codes that have prime significance, or of locating regular patterns in multiple codes and forming an analytical concept (Bryant & Charmaz, 2007). A category is a taxonomy of concepts that is derived from data analysis in grounded theory (Strauss & Corbin, 1990).

Coding

Coding is the procedure of identifying and characterizing data (Bryant & Charmaz, 2007). Coding breaks data down into segments and then names the segments that are identified (Schwandt, 2001). Grounded theorists generate qualitative codes by defining what they see in the data collected. Simply stated, it is the process of analyzing the data.

Constant Comparative Method

The constant comparative method, developed by Glaser and Strauss (1967), is a way of analyzing qualitative data (Schwandt, 2001). This analysis technique creates more abstracted concepts and theories through the "inductive process of comparing data with data, data with

category, category with category, and category to concept" (Bryant & Charmaz, 2007). Possible sources of data include field notes, observations, and interviews. The collected information is coded inductively and then these segments pieces are compared with one another (Schwandt, 2001).

Grounded Theory

Grounded theory is a methodology designed for conducting a qualitative research study that focuses on constructing conceptual frameworks or theories by performing inductive analysis of the data (Bryant & Charmaz, 2007). It is a rigorous procedure for generating a formal, substantive theory of social phenomena (Schwandt, 2001). A grounded theory is revealed, built, and conditionally confirmed through systematic data collection, as well as through the analysis of data related to the phenomenon (Strauss & Corbin, 1990).

Memo-writing

In grounded theory, memo-writing is the crucial transitional step between collecting data and writing papers. Memo-writing helps researchers investigate their data and place their codes into categories early in the research process (Bryant & Charmaz, 2007). Memos are the result of memo-writing; they are written records of the analysis related to the formulation of theory (Strauss & Corbin, 1990). Memo-writing is used for elucidating or elaborating coded categories (Schwandt, 2001). The final analysis is derived from incorporation and analysis of memos that the researcher generated during the analysis.

Theoretical Sampling

Theoretical sampling is a type of sampling in grounded theory in which the investigator aims to build the properties of the emerging categories or theories by selectively recruiting participants. Because the purpose of this type of sampling is to develop theoretical categories by seeking specific types of participants, performing theoretical sampling may take the investigator

across substantive areas (Bryant & Charmaz, 2007). In other words, it leads the researcher to build on meaningful constructs of the theory by sampling in a specific way. It permits the researcher to take a new path when new tentative and emerging, but incomplete, ideas appear (Charmaz, 2006). Sampling of additional incidents, events, activities, and populations are directed by the evolving theory (Schwandt, 2001). Concepts that have established theoretical connections to the developing theory are focuses of this type of sampling (Strauss & Corbin, 1990).

Theoretical Saturation

Theoretical saturation is the point at which gathering more data about a theoretical category reveals no new properties, and yields no further theoretical insights about the emerging grounded theory (Bryant & Charmaz, 2007; Strauss & Corbin, 1990). When theoretical saturation is reached, the theory is deemed conceptually solid and grounded in the data.

RESEARCH DESIGN

The specific aims of this study were to: (1) explore Filipino nurses' perceived role performance in the U.S., and (2) generate a theory describing the factors that contribute to Filipino RNs' role performance in the U.S. healthcare system. The research design was qualitative; more specifically, grounded theory was used as the methodology for this study, using symbolic interactionism (Blumer, 1969) as the philosophical underpinning.

Methodology

Grounded theory was the methodology used for the inductive development of theory using qualitative techniques. Glaser and Strauss (1967) originally developed grounded theory for generating theories by connecting empirically derived data using systematic procedures of coding and hypothesis testing. It is a methodology used to explain socio-psychological and socio-structural processes (Stern & Govan, 2001). A progression of repeatedly analyzing,

coding, and categorizing is used to discover the core variables or categories for a theory. In recent years, Strauss and Glaser developed two major approaches to conducting grounded theory (Melia, 1996; Stern, 1994). The methodology became popular quickly, partly because of Glaser and Strauss's transmission of ideas to their students (Stern & Govan, 2001).

Grounded theory is rooted in the philosophy of pragmatism and symbolic interactionism (Morse, 2001). Symbolic interactionism is a theoretical perspective that indicates a connection between society, individual human interaction with society, and other relationships that create meanings in their lives (Schreiber, 2001). Symbolic interactionism is based on the following roots: the nature of human society, social interaction, objects, the human being as an actor, human action, and the interconnection of the lines of action (Blumer, 1969). People select, perceive, interpret, and reject lines of actions, and their behavior is influenced by these interactions. This is the root of grounded theory development and must be addressed throughout the process of constructing a grounded theory. Using constant comparison, and both inductive and deductive reasoning, grounded theorists interact with the data, the participants, and other sources of input to form the emerging grounded theory (Milliken & Schreiber, 2001). Consequently, symbolic interactionism served as the background influence and theoretical infrastructure that guided this study as a whole. The focus on social interaction provided fertile ground for this study.

Grounded theory is best used to answer questions that focus on participants' experiences over time or responses analyzed over the course of an event. It is also useful for studying how people deal with their lives over time in changing circumstances; for instance, caregivers' experiences in taking care of a dying person. It can also help researchers study new phenomena, discover new perspectives, and determine the gaps in existing knowledge. The characteristics of a grounded theory were summarized by Morse (2001) as follows:

> (a) grounded theory focuses on a process and trajectory, resulting in identifiable stages and phases; (b) it uses gerunds (Glaser, 1978, 1998) indicating action and changes; (c) it

> has a core variable or category (Strauss & Corbin, 1998) that ties stages and phases of the theory together; and (d) grounded theory is abstract (as is all theory), but it is unique in that it makes the synthesis of descriptive data readily apparent through its concepts and relational statements (Morse, 2001, p. 2).

Grounded theory has been utilized in different disciplines, especially in the social sciences, since Glaser and Strauss (1967) developed this methodology. O'Connor, Netting, and Thomas (2008) found that more than 200 dissertations since 1994 have used grounded theory as a methodology or design. It has been employed as a methodology in diverse settings and with diverse populations, including nurses (Tabari-Khomeiran et al., 2007), family caregivers (de la Cuesta, 2005), and college students (Thompson, 2008). Grounded theory is valuable for enhancing the understanding of a process in the actions and interactions among people as the process unfolds.

In this study, Strauss and Corbin's (1990, 1998) strategy was used. The PI followed their analysis steps (open coding, axial coding, and selective coding) to examine data using the constant comparison method. A constant comparison method enabled a comparison of the codes and categories to search for similarities and relationships that might exist. The direction of data collection was modified concurrently with data collection to fit the identified linkages between the categories and the emergent theory. The specific design choices and methods used within this grounded theory are outlined below.

Interview Setting

The location for the interviews was based on each participant's preference. Potential interview locations included the participant's home, a quiet restaurant, a coffee shop, a school, or a library. Participants decided when to meet at their convenience. The actual locations where interviews were conducted included a coffee shop, a hospital cafeteria, participants' homes, and a hospital lobby. For the interview, the PI used two audio recorders, extra batteries, tapes, a notebook, and study flyers. Participants choose where they preferred to sit in the room where the interview took place. After the participant signed the informed consent form, the PI placed both

tape recorders between the participant and herself. The PI ensured that participants had access to the controls of the tape recorder in the event they wanted to share information without it being recorded.

Inclusion and Exclusion Criteria

English-speaking Filipino RNs practicing in the United States were selected to participate in this study. The inclusion criteria were Filipino RNs who: (a) received basic nursing training in the Philippines, (b) spoke fluent English, (c) practiced as an RN and provided direct patient care in any setting in Texas for a minimum of 3 months, (d) worked at least 20 hours weekly, and (e) were female. Given that the majority (87%) of CGFNS participants in the U.S. are female (CGFNS, 2002), only females were included in this study to represent homogeneity of experience. The exclusion criteria were Filipino RNs who: (a) were not fluent in English, (b) obtained basic training in a country other than the Philippines, (c) currently worked less than 20 hours weekly, (d) worked in a state other than Texas, or (e) were male.

SAMPLING

Sampling in grounded theory is a process aimed at enriching data. As suggested by Strauss and Corbin (1990), the PI utilized convenience sampling at the beginning of the study to start building the theory. Initially, participants were selected if they self-reported that they were licensed Filipino RNs and were currently employed in Texas for at least 20 hours per week.

To refine the connection of the developing theory, the PI began using theoretical sampling once the framework of the theory was built. The PI made the decision about transitioning from selective or open sampling to theoretical sampling. Theoretical sampling is a process of coding, analyzing, and collecting data concurrently, which makes it complex and emerging (Schreiber, 2001). In grounded theory methodology, the path of data collection is directed by the emergent theory instead of pre-determined criteria (Strauss & Corbin, 1990;

Charmaz, 2006). Theoretical sampling is used to fill the gaps in the emergent theory. In other words, the direction of sampling is controlled by the emerging theory (Glaser & Strauss, 1967).

The PI used theoretical sampling to reach theoretical saturation. The purpose of theoretical sampling is to establish the researcher's emerging theoretical categories (Charmaz, 2006). It helps the researcher decide what path to follow in collecting data after developing some tentative categories. Theoretical sampling is a strategic, specific, and systematic approach for obtaining data (Charmaz, 2006). It is relevant to the conceptual and theoretical development of a phenomenon instead of the representation of a population. It can strengthen and explicate the categories by filling the unknown or questionable areas of a tentative theory. It also helps to discover differences in data and categories throughout the process of data analysis in grounded theory.

Saturation in grounded theory means, "to sample until theoretical saturation of each category is reached" (Glaser & Strauss, 1967, pp. 61-62, 111-112). The researcher reaches saturation by collecting additional relevant data in the field. The researcher then diagrams the categories to amalgamate the emerging theory of the phenomena of interest (Strauss & Corbin, 1990). Theoretical saturation was reached when the PI found no new theoretical insight or when no new properties emerged in the developing categories or post-incident comparisons (Charmaz, 2006; Glaser, 1978). In other words, no new data emerged in the categories or the theoretical framework, the developed category itself was solid, and the relationships between categories were entrenched. Before research began, the PI anticipated that at least 25 participants would be needed to reach theoretical saturation using grounded theory (Charmaz, 2006). In the completed study, the PI decided to stop collecting data after 31 participants were interviewed because theoretical saturation had been reached.

Recruitment

As noted above, the study began with convenience sampling, which then evolved into theoretical sampling. During the first phase of sampling, two separate recruitment strategies were used. First, the PI recruited potential participants through word-of-mouth. RNs from the Philippines known to the PI or other community liaisons were contacted and informed about the study. If they indicated interest in the study, more information was then provided. Second, the RNs from the Philippines were given a choice to contact the investigator after reading about the study on a recruitment flyer. Recruitment flyers were given to RNs known to the PI who might have contact with nurses from the Philippines currently working in Texas. The PI also sent out flyers to the president of the Philippines Nurses Association in San Antonio, TX. All participants were recruited through word-of-mouth; no participants were recruited through the flyer.

The PI started utilizing theoretical sampling to refine the proposed theory after the initial core categories and concepts were established. For theoretical sampling, the PI selected participants who maximized the potential to explore as many dimensions and conditions relevant to the phenomenon as possible, as suggested by Strauss and Corbin (1998). To saturate the theory, the PI selected participants who may have facilitated the generation of the theory by examining the findings gained during convenience sampling. The PI contacted Filipino nurses whom she knew to recruit potential participants who fit the criteria of theoretical sampling. For instance, the PI discovered that Filipino nurses began to pay attention to adjust their relationships with others and to deal with others' mistreatment as well as racism after they had been in the U.S. for some time. In response, the PI purposely began recruiting nurses who had just arrived in the U.S. in the last six months and through contacts with another Filipino nurse known to the PI, verified this finding. The PI also asked different questions to fill the gaps in the emerging theory.

DATA COLLECTION PROCEDURES

The goal of data collection was to meet two specific aims. The first aim was to explore how Filipino RNs perceived their role performance in the U.S. healthcare system. The second aim was to generate a theory describing factors that contributed to Filipino RNs' role performance in the U.S. Demographic data forms, interviews, field notes, and memos were methods used to collect data to meet these aims; these are summarized below.

Demographic Data

The demographic questionnaire consisted of questions about education and work experiences (Appendix A). Demographic information was collected to gain a general idea about the participants' characteristics and backgrounds. Data were collected after the participants completed the informed consent process. The data were useful in developing the theory.

Interviews

One in-depth, open-ended interview was conducted with each participant. Each interview was audio-taped. The PI interviewed the participants about their work experience in the Philippines and in the U.S. Each participant was informed about the purposes of the study. The interview focused on how the participant has adapted to their work roles in the U.S. and how they perceived their role as a nurse, both in the Philippines and in the U.S. Interviews began by asking or stating the following:

1. Tell me about your work experience in your country.
2. How does a nurse perform their job in the Philippines?
3. What do you think about being a nurse in the U.S.?

Later interviews were adapted to fit the needs of the emerging theory. Interviewers are discouraged from using an interview guide to develop grounded theory because the researcher might miss some important information by using a structured format (Schwandt, 2001). Thus, the PI followed this flexible design and allowed participants to tell their own stories first, which

enriched the data collected. The PI ended the interview by asking participants to share additional information freely to briefly assess if any information was missing and to take appropriate actions to fill the gaps, if necessary. The PI asked participants specific questions to clarify any vague areas or points. In other words, the PI used the interview guide as a reference, rather than as a 'script,' to avoid a restricted interview. Therefore, the interviews were conducted such that the participant could share information freely.

Field Notes

Field notes are written notes about thoughts, impressions, or hypotheses recorded by the researcher during and after an interview. "Field notes are written accounts that filter members' experiences and concerns through the person and perspectives of the ethnographer" (Emerson, Fretz, & Shaw, 1995, p. 13). They provide evidence of interpretation of meaning that one encounters during fieldwork. The PI wrote field notes as soon as possible after each interview to capture any impressions and thoughts. The field notes were included in the data analysis to refine the proposed theory.

Memos

Memo-writing is the process of recording emergent meanings while conducting a grounded theory study. Most researchers find it helpful to write memos about ideas, impressions, and decision-making that arises from the research process. It helps a researcher think, question, and sort ideas at the beginning of data analysis. It may also help a researcher answer questions in the later stage of data analysis. Memo-writing assisted the PI in identifying the gaps, and theoretical sampling helped fill the gaps and the missing properties that were discovered. The PI documented ideas and thoughts each time she interacted with the data. She also recorded any decisions made throughout the data analysis process.

Memo-writing is an important tool used in the process of developing a grounded theory (Charmaz, 2006). It takes place in data collection, coding, writing, and theorizing and can

accelerate the work. It keeps a researcher organized and involved in conceptualizing the data and enhances the levels of abstraction in the ideas. It also helps a researcher connect and compare thoughts in addition to formulating questions and directions about the tentative theory that they might have developed (Charmaz, 2006). Memos can also be used to describe non-verbal cues from the participants, such as their body language, the setting, and atmosphere. Researchers start sorting memos and other related data as soon as an idea about the main categories in their research concept appeared, focusing on the core variable.

SEQUENCE OF DATA COLLECTION

Data collection proceeded in an integrated, continuous fashion. The data collected included audio-taped interviews, interview transcripts, demographic information, field notes, and memos. The process of collecting data is outlined below. After a RN from the Philippines contacted the PI and expressed an interest in the study, the PI explained the study in detail. If the RN continued to express interest or willingness to participate, a mutually agreeable time and place for an interview were established. Each RN was informed that he or she would receive a $20.00 Wal-Mart gift certificate after completing the interview. One interview was conducted with each participant. All interviews, which were conducted in English, were tape recorded and transcribed verbatim. The PI only began tape recording the interviews with the consent of the participant. Interviews and notes were transcribed within one week of the interview, which was necessary for the on-going constant comparative analysis.

The PI made field notes after each interview. The PI remained sensitive to the environment and the situation where the interview took place. Locations where the PI recorded field notes included her car and house, where she could think and write without interruptions. To keep track of the important findings in the interview, she kept a log of the field notes made for each interview, including the date, time, and place.

The purposes of memo-writing are to make the researcher's pre-existing assumptions clear; to record rationales of the decision-making process; and to hypothesize and analyze the data (Schreiber, 2001). Memo-writing should begin at the planning stage of a research study and continue throughout its entirety. Following this guidance, the PI began memo-writing at the planning stage of this study and continued memo-writing throughout the entire study; memos were dated, filed, and titled as soon as possible to keep track of the emerging categories and theory. To avoid forgetting emerging ideas, researchers should record ideas as soon as they appear without interruption. In addition, diagramming is another important tool that facilitates the organization of and reflection on data and assists the researcher in identifying the gaps. The PI used diagramming to facilitate theory development throughout data collection.

The exact sequence in which demographic data were collected, interviews were conducted, and field notes and memos were written is outlined below. Participants were made aware that they had the right to continue or stop participation in the study at any time in the interview process.

Demographic Data

Demographic data were collected after obtaining the informed consent form from each participant. The PI explained to each participant the reason for collecting the demographic information, as well as how confidentiality would be ensured. All participants chose to complete the demographic data form. Demographic information was entered into an Excel spreadsheet as soon as possible after it was collected.

Interviews

The PI transcribed each interview verbatim within one week of the interview. Each transcript was compared to the audiotape to ensure accuracy of the transcription. Glaser and Strauss (1967) recommended that researchers finish their analysis of data that has been collected before moving on to the next interview to adapt the direction of data collection. This researcher

intended to analyze each transcription before meeting with the next informant. However, several participants clearly stated that they preferred to have the interview at their residence when they were having a "get-together" event. The PI made a decision to bend the rules of completing each analysis on the collected data before the next interview to fit these participants' needs; thus interviews were conducted with these participants one at a time on the same day. The PI remained sensitive throughout the process of interviewing and decided to remain flexible because qualitative interviews should be conducted in fluid way to facilitate participants sharing information more freely, thus enriching the resultant data.

Field Notes and Memos

Field notes included information such as the environment and atmosphere during the interviews as well as how each participant was dressed. The PI continued to write field notes and memos throughout data collection and recorded a memo any time she had a thought or idea about the study.

DATA MANAGEMENT

Data management is the steps taken to organize and handle qualitative data, including transcription and data storage.

Data Transcription

The transcript of each interview was typed into a MS Word document by the PI within one week of the interview for the first 18 interviews. A transcriptionist transcribed verbatim the remaining 13 interviews. All of the transcripts were formatted with large margins to facilitate line-by-line hand-coding. First, the transcribed interview was read to obtain a general idea of its implications. The PI then listened to the tape a second time to compare the audio recording with the typed transcription. The PI also typed the field notes and memos into a MS Word document for later analysis and comparison.

Data Storage

All data, including field notes, memos, demographic data, and audiotapes, were stored in a locked cabinet. The PI was the only person with access to the data. All data were labeled using a pseudonym for the interviewee with only a coded link to the consent form and the demographic form. The memos and field notes were dated and kept in a separate file. In addition, the consent forms were separated from the interview data to avoid potential disclosure of the participants' identities. When the results of this study are published or presented, the participants' identities and confidential personal information will not be disclosed.

Reducing Bias

To understand her preconceptions before analyzing the participants' perceptions about foreign nurses' adaptation to work and life in the U.S., the PI made an effort to reduce bias by bracketing her views about the experiences of foreign nurses in the U.S. One of the common pitfalls in research is the danger of the researcher imposing their personal preconceptions on the data, which might mislead the concept of the phenomena (Charmaz, 2006). A researcher must be cautious when interpreting data to avoid imposing their viewpoint or understanding. The PI kept a record of all decision-making processes to keep track of her thought processes for future reference. Memo-writing was also used to keep a record of any ideas that appeared during the study. The PI verified her memos with her graduate advisor, who acted as a cautious auditor for this study. Memos were also made available to other members of the dissertation committee if needed. The PI contacted her graduate adviser once a month and as needed to verify the quality of data transcription and analysis.

DATA ANALYSIS AND INTERPRETATION

The PI began data analysis as soon as the first interview was conducted and continued until the theory was developed. Constant comparative methods were applied throughout data analysis to establish an analytical view of the data collected (Glaser & Strauss, 1967). The goals

of constant comparison are to raise questions and discover properties and dimensions in the data (Tabari-Khomeiran et al., 2007) by analyzing and comparing all units of the data (O'Connor et al., 2008). This technique was applied at all times by the PI when analyzing the data until there were no new relationships discovered between categories.

After each interview, the interviews were transcribed verbatim using a word processor. Then, the PI analyzed the verbatim transcripts, as well as the field notes. Data were analyzed as it was collected, while continuing to conduct interviews based on the ongoing data analysis until data saturation was reached. In other words, interviews and data collection occurred concurrently with data analysis, to ensure that the analysis was grounded in the data collected.

Because the focus of a grounded theory is to discover and build a substantive theory, it is important to follow a systematic coding process. The best way to initiate data analysis is to first determine "what is happening" and then move on to analyzing the data (Charmaz, 2006). The PI first examined the data briefly to grasp the general ideas. Then, she followed a systematic process of coding. Constant comparison ensured that the data were analyzed and understood completely.

Coding in grounded theory is an essential step in the process of developing the theory. Making comparisons and asking questions are the two analytical procedures of the coding process. Coding helps a researcher to understand and make sense of repeated data, and build a link to the data collected from the participants. Through active interaction with the data from various angles, the researcher becomes immersed in the data and finally builds a theory that is grounded in the data. The coding process builds the analytical frame of the data for a grounded theory (Strauss & Corbin, 1990).

Open Coding. As recommended by Strauss and Corbin (1990), the data analysis included open coding, axial coding, and selective coding. First, in the process of open coding, the data were broken down and categorized. Using line-by-line analysis helped the PI build the first set of

codes, and conceptualize the phenomena. Charmaz (2006) stated that there are two major phases of coding in open coding in grounded theory: the initial phase and the selective phase. Initial coding aims to gather a representative segment of data to get a general idea about the data collected and how it relates to the study. Initial coding helps the researcher pursue additional data collection by forming analytical ideas. During initial coding, the PI stayed as close to the original data as possible to accurately capture participants' perspectives. In other words, the data were summarized in concise terms, but it was not abstracted during initial coding. The goal was to remain open-minded to all potential theoretical directions based on the data. The PI also remained open to new ideas in hopes that she could discover gaps in the data that needed further investigation. Each transcript was read and re-read carefully in a systematic manner. There are several approaches to initiate open coding, including word-by-word coding, line-by-line coding, and incident-to-incident coding. Line-by-line coding is the most commonly used approach for many grounded theorists (Charmaz, 2006). Thus, the PI utilized the line-by-line coding during open coding.

Axial coding reunites data after they are separated into distinct codes in the initial coding phase (Charmaz, 2006; Strauss & Corbin, 1998). After completing the open coding, the PI began axial coding, by making connections between categories and subcategories. This type of coding involves diagramming, integrating, and elaborating categories and their relevance with the substantive theory (Strauss & Corbin, 1998). The PI searched for relationships and differences among categories to discover and validate these relationships. Axial coding was used to emphasize the dimensions of the initial codes and categories. This helped create connections among causal conditions, context, and consequences. Moving back and forth between proposing new categories and verifying them also helped to keep the theory "grounded."

Selective coding is a process of relating categories and integrating them into a theory (Glaser, 1978, 1998) to refine the relationships and make the analysis clearer and more concise

(Strauss & Corbin, 1998). In selective coding, the PI related the categories with the core variable (Strauss & Corbin, 1998). The purpose was to verify the emerging theory and discover categories that have not yet been uncovered. Obtaining data from a new participant, reviewing a previously conducted interview, observing a participant, and reviewing the literature are all part of theoretical sampling to develop a grounded theory. Theoretical coding is used to maximize the process of uncovering various dimensions and conditions related to the phenomenon of interest (Strauss & Corbin, 1998). Categories and hypotheses generated from the process are tested and compared continuously to achieve an interpretive understanding.

During selective coding, the PI focused on the core categories to make sense of their relationship with other categories and the original data. Selective coding indicated the general relationships between categories and included validating and polishing the relationships among these categories. “Discriminate sampling is associated with selective coding. Its aim is to maximize opportunities for verifying the story line, relationships between categories, and filling in poorly developed categories” (Strauss & Corbin, 1990, p. 176). During this stage, the PI refined, integrated, and systematically organized all categories to generate a theory that delineates the Filipino RNs’ role performance in the U.S.

Demographic Data

Data collected on the demographic questionnaires were entered into an Excel spreadsheet and transferred to a Word document. Frequency distributions were used to describe the characteristics of the participants. A total of 31 participants were in this study, including three participants from a pilot study completed prior to this study. The male participant from the pilot study did not fit the selection criteria for this dissertation study; therefore, he was not included in this analysis. The PI included the three interviews from the pilot study in the analysis to enhance the emergent theory. Only 14 of the participants indicated their age (ranged 28-58), with the majority (n = 9) between 31 and 40 years of age at the time of data collection. All participants

who indicated the number of hours they worked per week (*n* = 25) worked full time for current employers at a local hospital in the U.S. Each participant interviewed was working as a staff nurse and providing direct patient care. They had been working in the U.S. for 6 months to 35 years. Facilities they worked for included two for-profit hospitals in central Texas (*n* = 13), a non-for-profit facility in central Texas (*n* = 3), a veteran hospital in central Texas (n = 1), a general hospital in east Texas (n = 5), a rehabilitation hospital in central Texas (n= 1), and a general hospital in south Texas (*n* = 8). Many of them (*n* = 20) worked as a volunteer before they were hired to work as a staff nurse and some of them worked as a clinical instructor in the Philippines (*n* = 6). Two of the participants stated that they did not work as a nurse in the Philippines, but served as a volunteer nurse. Some of them (*n* = 9) had experiences in other countries such as Saudi Arabia, Italy, Libya, and Sultanate Oman. The majority of participants held permanent residency (*n* = 18) and others held citizenship (*n* = 11) as their work permit. The majority of the participants (*n* = 29) held a BSN; two held the MSN, and one held a PhD in education in addition to her BSN. Only two participants held an associate's degree in nursing. Other characteristics of the participants in this study are summarized in Appendix D.

Field Notes

The PI analyzed the field notes line-by-line to conceptualize the interview data. In addition to line-by-line coding, incident-to-incident coding was also used to conceptualize codes, categories, and their relationship with the concept. During incident-to-incident coding, the researcher compared an incident with incidents conceptualized in earlier codes (Charmaz, 2006). The incident-to-incident coding was useful in analyzing field notes, depending on the nature of the data, by assisting the PI in discerning patterns and contrasts within the data (Charmaz, 2006).

Memos

The PI used memos to keep track of her thoughts and any decision-making processes. The PI analyzed and categorized the memos using a line-by-line approach. As suggested by

Glaser (1978), a line-by-line approach forces the researcher to verify categories, which minimizes the possibility of missing important findings. In this way, the codes and categories generated from analyzing the memos facilitated the development of the emerging theory.

RIGOR IN THEORY DEVELOPMENT

Grounded theory is a powerful and valid methodology because of the rigorous process required to conduct it. Differences are needed for a good grounded theory, in addition to theoretical saturation. In fact, grounded theorists should actively seek differences while remaining focused on the core concept. Many researchers and scholars have discussed the criteria for rigor in grounded theory (Charmaz, 2006; Chiovitti & Piran, 2003; Hall & Callery, 2001; Milne & Oberle, 2005). The criteria discussed in these references include authenticity, credibility, resonance, criticality, integrity, generalizability, plausibility, reflexivity, and rationality. These criteria are useful in improving rigor of a grounded theory study in general. Nonetheless, to keep consistency in study approach, the PI followed the criteria suggested by Strauss and Corbin (1990) as summarized in Table 4. The PI began formulating the conceptual framework based on the collected data. She ended data collection when data saturation was reached and the conceptual framework was complete. The PI kept these criteria in mind and took action, as needed, during the entire course of developing the theory to ensure rigor in this grounded theory study.

SUMMARY

The purpose of this study was to explore Filipino nurses' role performance in the U.S. and generate a theory by conducting interviews with participants. Grounded theory served as the methodology and symbolic interactionism was utilized as the theoretical foundation that guided this study. Strauss and Corbin's (1990, 1998) strategy was employed in this study. To analyze the data using the constant comparison method, the PI followed Strauss and Corbin's analyzing steps, which include open coding, axial coding, and selective coding. Demographic data sheets,

interviews, field notes, and memos were used to collect data. The PI recruited potential participants using snowball sampling in the beginning, and then utilized theoretical sampling once the initial framework was in place. Confidentiality and human subject protection were in place throughout this study. The PI collected data and analyzed it concurrently to ensure that the theory developed is grounded in the data. Bias by the PI was minimized by memo- writing under the supervision of her advisor. The PI followed the criteria of theory forming suggested by Strauss and Corbin through its entirety to ensure rigor in this grounded theory study.

CHAPTER 4: FINDINGS AND PRESENTATION OF THE THEORY

INTRODUCTION

This chapter presents a substantive theory developed from analysis of the collected data. The process of Filipino nurses' transition and adaptation to U.S. nursing practices is summarized in Figure 1. The core variable that emerged from this analysis was 'transitioning from Filipino to U.S. nursing practice.' In addition, relational categories connected to this core variable emerged during data collection and analysis. Overall, it was evident that Filipino nurses' adapted to U.S. nursing practices by learning and adjusting to American culture, adapting to the U.S. healthcare system, and overcoming obstacles in order to function and survival in the U.S. healthcare culture. Obstacles included facing barriers to communication and mistreatment, dealing with stress, and handling racism. They overcame these obstacles by learning to be assertive and vocal when providing patient care, which enabled them to become more independent. After Filipino nurses adjusted to the culture and work of nursing in the U.S., and learned to overcome obstacles, they felt more comfortable and competent practicing as nurses in the United States. This substantive theory explains the process of how Filipino nurses come to adjust to their roles as nurses in the U.S. The model in Figure 1 illustrates the relational categories and their ties to the core concept of "transitioning from Filipino to U.S. nursing practice."

Filipino nurses' experiences and educational backgrounds in the Philippines are the basis for the process of role adaptation in the U.S. In other words, Filipino nurses used their education and experiences acquired in the Philippines as the foundation upon which to interpret the roles of nurses in the U.S. Filipino nurses felt that they were competent about their nursing knowledge and skills because of their experiences and education in the Philippines. Filipino nurses utilized their experiences in the Philippines as the foundation to help them adapt to their role as a nurse practicing in the U.S. healthcare system. Filipino nurses in this study stated that they were educated based on an American structure. Many of their nursing instructors acquired their advanced nursing education in the U.S., which increased Filipino nurses' exposure to American

nursing. As a result, Filipino nurses felt that they were more familiar with American nursing practices compared to those who did not have such prior exposures, such as Chinese nurses. This perceived familiarity led to their concepts and specific expectations about U.S. nursing practices.

Initially, Filipino nurses conceptualized their meanings of U.S. nursing from the assumptions they formed while obtaining their experiences and acquiring their education in the Philippines. As female nurses who were educated, trained, and experienced nursing practices in the Philippines, they became unique people who carried specific cultural and gender-based perceptions. They learned to interact with others in a way that was distinctive to the Filipino culture. They interacted with others in a way that was socially and culturally acceptable in the Philippines. They believed, before their arrival to the U.S., that they were supposed to interact with individuals of different genders, ethnicities, and cultural backgrounds in life and at work in ways consistent with these prior frameworks and perspectives. An example of interactive behaviors could be not confronting the authoritative persons, such as their supervisors or physicians. Coming to the U.S., a westernized country, created turbulence in their cultural and gendered beliefs and values. This eventually led to reconstruction of the meanings they had for culture and gender. They developed new ways of understanding their experiences as a nurse in the U.S. based on these reconstructed meanings. These reconstructed meanings were incorporated with their beliefs based upon both cultures that influence their actions and interactions with others. This is the root of Filipino nurses' role adaptation processes in the U.S. nursing practice. Healthcare in the Philippines was perceived as different from the U.S. system, according to the participants interviewed. Participants characterized healthcare in the Philippines as having medical supply shortages, poor quality of care, staff shortages, and few employment opportunities. This affected how they perceived the U.S. healthcare system. The decision to migrate to the U.S. also illustrated how Filipino nurses transitioned from Filipino to U.S. nursing practice. Filipino nurses' conceptions of U.S. nursing influenced how they adjusted to U.S. nursing practice. The relational categories and related subcategories of the theory are shown in Table 5.

THEORY OVERVIEW

The core variable identified was "transitioning from Filipino to U.S. nursing practice." The nine relational categories identified in the analysis included: (1) acquiring nursing knowledge and skills, (2) the decision to migrate to the U.S., (3) settling into life in the U.S., (4) adapting to new work environments, (5) adjusting to cultural differences between the Philippines and U.S., (6) overcoming communication barriers, (7) becoming accustomed to the U.S. healthcare system, (8) adapting interpersonal relationships, and (9) overcoming other obstacles. These factors interacted and affected how Filipino nurses' perceived their roles as nurses and how they adapted to U.S. nursing practice.

The process of adaptation is divided into four stages: prior to arrival, arrival to orientation, early adaptation period, and late adaptation period. First, 'prior to arrival' refers to the process of Filipino nurses acquiring their nursing knowledge and skills in the Philippines as well as their decision to migrate to the U.S. Second, 'after arrival to orientation' begins with their time of arrival in the U.S. and ends when they were finished with their job orientation at the hiring facility or shortly thereafter. This stage includes adapting to life in the U.S. and their new work environments. Third, 'early adaptation period' falls between post-orientation in the first year, which includes adjusting to cultural differences, overcoming communication barriers, and becoming accustomed to the U.S. healthcare system. Lastly, the 'late adaptation period' is one year after their arrival to the U.S. and thereafter. In this period, Filipino nurses focused more on adapting to Americanized interpersonal relations and overcoming other obstacles, such as racism and mistreatment.

PRIOR TO ARRIVAL

Prior to their arrival to the U.S., Filipino nurses needed to acquire the knowledge and skills to function as a nurse in the Philippines. They accomplished this by obtaining their education and practicing as a volunteer nurse or staff nurse in the Philippines. They learned and practiced the socially and culturally desirable behaviors of a female nurse in the Philippines.

They learned about U.S. nursing by interacting with others and other sources such as media in the Philippines and started to conceptualize, as well as create meanings and expectations, about nursing practice in America. This is an important point of the process of deciding whether to migrate to the U.S. If they decided to move forward to come to the U.S., they then contacted and interacted with a recruiting agent who idealized the recruiting process and influenced their expectations and meanings of U.S. nursing. After they finalized their decision and decided to come to the U.S. and practice as a nurse, they completed all required exams and immigration paperwork and applied for a job in the U.S. Most of the Filipino nurses used a recruiting agency to find and apply for jobs in the U.S. They were required to pass several mandatory tests and complete all the required paperwork to get either a work permit (H visa) or permanent residency. The next section presents how Filipino nurses acquired nursing skills as nurses in the Philippines and how they made the decision to come to the U.S. This helped explain their perceptions and expectations about U.S. nursing and how their prior skills affected their processes of transitioning to U.S. nursing practice.

Acquiring Nursing Skills and Knowledge

Filipino nurses in this study obtained their nursing education and training in the Philippines upon which they built the foundation of their nursing knowledge and capability. Then, they either found a job as a staff nurse, or more than likely, as a volunteer nurse, because there were more nurses graduated each year than there were jobs available. In the process of obtaining their nursing training, they interacted with people who had knowledge of or experience with U.S. nursing practice. They started forming their own perceptions, expectations, and meanings about U.S. nursing. This later affected how they transitioned into their role as a nurse in the U.S. The following sections discuss Filipino nurses' education, work experiences, and perceptions of healthcare in the Philippines.

Nursing Education in the Philippines

Because many nursing instructors and principals received their graduate nursing education in the U.S., most nursing schools used English textbooks and English as the language of instruction, as stated by the participants. English was taught in the Philippines when they were in grade school, which increased their exposure to the English language. "…when I went to nursing school, all our instructors came from States, and they have few years because they, before they have this exchange visa…. And our principal came from States—well, Philippines, and then States experience, and went back…. So pretty much, we are using all English books when we were in nursing school, and they are teaching the same thing that they are teaching here in States…. You know, it's really helpful with us to understand, and adapting the American way." "…we pick up easy because our learning experience is in English, the same books we use, fundamental nursing, OR nursing, and all this other stuff…. First grade, second grade, you got your native language, but the third grade you learn English as you go along. It helps!" Thus, Filipino nurses in this study did not realize that American nursing was foreign to them, because of their exposure to U.S.-educated nursing faculty members and other professionals in the Philippines. In other words, Filipino nurses felt that they had a foundation of knowledge about American nursing before arriving in the U.S. Having had nursing instructors who had obtained extra training in the U.S. and had been exposed to English at a young age led Filipino nurses to perceive themselves as having greater ability to adapt to U.S. nursing practice than those who did not have the same experiences. In other words, they believed they were more prepared than other FNGs from other countries, such as Korea, China, or Thailand.

Work Experience in the Philippines

Because there were more nurse graduates available than actual jobs, many Filipino nurse graduates served first as volunteer nurses before they became staff nurses at hospitals or before they immigrated to other countries. Because this study is about Filipino nurses' adaptations to nursing in the U.S., and because only a few of them had experiences in other countries, these

experiences in other countries are not included in this analysis. This section presents Filipino nurses' descriptions of their work experiences as a nurse and/or volunteer nurse. It had been 6 months to up to 35 years since the participants had practiced in the Philippines. This speaks to the shifting nature of culture in the context of still memories.

Most of the participants worked as volunteer nurses in the Philippines as a way of being hired as a full time worker at a hospital. When working as a volunteer nurse, they functioned as a regular staff nurse under a staff nurses' supervision. Volunteer service lasted from two months to two years while they waited for a regular position to become available. Many of them worked without pay or some even had to pay to obtain volunteer nursing experience. One of the participants stated, "We have to be a volunteer to get some experience, we are not paid for that, actually, sometimes, we are the one who pays the hospital, just to get the experience…. I did pay, when I took the volunteer training." Even if they were paid as a volunteer nurse, the pay was usually a small amount. "We get like, of course is very cheap, like let's see 300 Peso a month, so it's just enough for fare."

Filipino nurses stated that as staff nurses, they were responsible for administering medication, managing patient care, and teaching patients and their families. Basic nursing care tasks were usually performed by patients' families or companions. Depending on the level of the facility, their involvement in patient care varied. For instance, nurses who worked at rural hospitals or functioned as private duty nurses were involved in taking care of critical patients. "He was receiving IV fluid you know [so] I took care of IVs also at home. So the family just goes to this hospital pharmacy to get the IV fluid antibiotics so I took care of that. And this patient died. I did the CPR you know we brought him to the ER." On the other hand, a nurse who worked at a teaching hospital was responsible for managing patient treatment instead of performing invasive procedures, such as inserting an IV. Nurses in the Philippines cared for patients with ventilators on a regular hospital floor as part of their job. In contrast, American nurses, as the participants mentioned, do not care for ventilated patients on a medical-surgical unit. "And there, we took care of patients who just had you know surgeries; they are still

intubated and just did the suction. I was just surprise[d] when I came here we don't for [go to] the medical surgical floors we don't take care of the patient, I thought we are going to. But we are not." Their experiences as volunteer nurses or staff nurses in the Philippines formed the foundation of their general nursing knowledge and skills. They perceived themselves as capable of practicing as nurses in the U.S. because of their experiences in the Philippines. "Oh, it doesn't take much, really. It doesn't take much because I've had a lot of experience already in the Philippines. It's just that I am adjusting to the people, to the environment, but not to my nursing, no, because you already have that." Their previous work experiences helped them develop the ability to perform nursing tasks. They understood how to take care of a sick patient in the ways they practiced in the Philippines. However, how they practiced differed from how nurses practiced in the U.S. These differences created some conflicts when they were adjusting to U.S. nursing practices. For instance, the nurses in this study stated that their patients in the Philippines did not complain of pain as much as American patients do. This may be due to the fact that these nurses did not focus on pain management while they were practicing in the Philippines. They had to adjust to the way pain management is handled in the U.S. when they shifted their nursing practice from the Philippines to the states.

Healthcare in the Philippines

This section presents Filipino nurses' views about their experiences with or opinions about healthcare practices in the Philippines. The problematic areas they identified were shortages of medical supplies, poor quality of care, and shortages of nursing staff, which are discussed below.

Medical supplies in Filipino hospitals were commonly mentioned by the participants as scarce, especially those who worked at government hospitals. As one of the participants mentioned, "Back in the Philippines, you have to get used to you only have like this, especially if you work government hospital, they are short, short, you know, all the tapes, you know, syringes. Here you can throw everything away, there you have to really minimize everything that we

use…don't even have wipes there. So you get used to all the modern technologies here [in the U.S.] that when you go home it's very difficult probably, you know, to adjust of how they the things they used in the hospital, it's very, very different." Because of the lack of supplies, nurses become resourceful and creative in order to perform their nursing jobs. They recycled and reused medical supplies, such as gloves and syringes. "Gloves we recycled. We washed the gloves after the surgeon and everybody else finished…. then you hang them and let them dry…. you powder the gloves and then shake it, and then you fold it up in the glove holder or something. If there is a hole in there, then you throw it away. We boil the needle…. we boil the disposable needles and syringes… because sometimes we have some poor people who can't afford it. We have to save all the supplies because if we run out, the patients will have to buy their own."

Quality of care was poor due to the shortage of medical resources, as mentioned by the participants. Some patients did not receive the prescribed medicine, blood transfusion, or other necessary procedures because they were uninsured and they did not have money to pay for them. Filipino nurses had to be inventive and use what they had available to provide care when they did not have enough medical resources. For instance, one of the participants mentioned that "….Medicines, if the patients don't have the money to pay for it, we just skip the dose, and the nurse would write…. like dose skipped or something…. Sometimes we save medicines from the patients who are discharged we keep them and give them to the indigent people…. " One participant told of instances in which patients had to decide between immediate death and possibly receiving contaminated blood. The participant shared the sadness of poor people facing this life decision:

> The blood transfusion, say the patient needs blood, but no money to buy the blood. They needs to look into their resources, like the social worker, you know, try to find the ways to get the blood. Like if you want, they might ask you, 'well, how much money you have?' Let's say, 25 dollars, or something like that. Well, if you go to jail, the county jail, you ask for a volunteer, from the prisoner, you pay the prisoner 25 bucks. And then you get your blood for your, say your mom. So, we did that too. We ask it from the prisoner. They just give you the blood, and after they donate it. They get the money, after that they go back to jail. If they ask the prisoner, 'do you have hepatitis?' The prisoner could say 'Oh, no!' Because the screening like for HIV are not very particular, I don't know now.

> You know how we screen the blood here. But they don't screen like that. If you ask the prisoner, they will say, no, because they want your money.

Two participants mentioned their experiences with two patients having to share one hospital bed because there were no more beds or openings at a government hospital. As one of them stated, "You know how government hospitals are run, they don't have much funding. Imagine, day shifts, there are two patients in one bed and this is the shock of my life!" The other participant stated, "So they're doubled in one bed. You can't picture that, but there's two moms in one bed. The moms not really lying down…. The moms are sitting in the chairs, and the babies are in the bed—yeah, plus the family members that are under the bed. That's how sad it is." One participant shared her experience of having two patients share an oxygen meter because there were not enough meters available. "I don't know how we manage it, but we have this little rubber tubings that are Y, so we stick them and put them all together, and so they're Y and connected so these other patients—we're not sure if we're supposed to put them on 2 liters. Okay, let's put 4 liters so they can share two and two." Sometimes, a decision had to be made for the patient in need of a ventilator that could not afford it—they either extubated the dying patient or hired someone to bag them. "So if you're poor, you cannot afford 450 for a day of ventilator. You either extubate your patient and they die, or you can hire a bagger, and a bagger bags the patient, and they get paid 50 pesos a day, which is $1.00 a day."

Staffing shortages were another common occurrence at hospitals in the Philippines, especially at government hospitals. "Like 40 patients and there is only 2 of you nurses…. Sometimes it's been how many days already and the doctor's orders are not carried out yet. That's how worse, that's how worse working in the government hospital there." Due to the shortage of nursing staff, the workload of nurses was extremely heavy. "So there is no code team, yeah. Sometimes there is a code running at one end and the other one is about to code, gee, this happened to me one time. There is short of staff, there is no help, you give your drugs, you start the IV, you chart."

Depending on the place of employment, nurses in the Philippines cared for 10 to 60 patients at a time. Nurses cared for fewer patients at privately owned hospitals compared to government hospitals. At a government hospital, one nurse cared for as many as 60 patients. As one participant described—being a nurse in the Philippines was "physically demanding" because she had to "take care of the whole floor." Filipino nurses were scared, exhausted, and frustrated because of the heavy workload and patients' conditions. As one nurse stated, "And it's just so scary sometimes when everything has a problem, and everyone is sick…. there, if you have 60, and everyone is sick, it's just so crazy. You just don't know, and it's a medical-surgical, so everything – You just expect anything that comes in, and the turnover is very rapid. It's acute hospital, so there's a rapid turnover, like discharge, admission. I don't know how did I, did that – how - with a 60 census oh God, I did it; and I've been working there for quite some time." "Sometimes I couldn't even take a break. How could you take a break; and it's so exhausting also…. you have to just do it routinely because you cannot really do a very special record for each of the patient if you have that load that's much – so much!" Even though participants agreed that there was a shortage of staff at hospitals, they did not witness nursing shortages been raised as an issue in the Philippines. Perhaps they were accustomed to staff shortages and a lack of resources being the norm, especially in government hospitals. "…so if there are budgets for nurses they won't go for all of the nurses, they will cut it back and then just settle for other—maybe their pocket—I don't know. Maybe I already have that of those notions because that's what we – the system works. It's just too bad!"

Healthcare practices in the Philippines were perceived by the Filipino nurses as difficult because of shortages of medical supplies, poor quality of care, and shortages of nursing staff. While they all strived to provide care to their patients, Filipino nurses learned to be creative and resourceful with the limited medical supplies and shortages of staff they had. Although the quality of care was poor, especially at government hospitals, they accepted it as the way it was, given what they had in the Philippines. Since they could not change what was happening in the Philippines, they could imagine that working overseas, such as working in the U.S., was the way

out. Their practice of and reflections on healthcare in the Philippines led these nurses to move forward to the final decision of coming to the U.S. Aside from forming the foundation for their practice in the U.S., their strong motivation to migrate also made them more prone to discrimination in pay because they were desperate to leave the Philippines and thus were scared to go back to the Philippines and start over. This provided them the motivation to put their best effort into adapting to U.S. nursing practice in order to keep their jobs and stay in the U.S.

THE DECISION TO MIGRATE TO THE U.S.

Filipino nurses obtained their education and gained work experience in the Philippines. They also went through several decisive steps before coming to the U.S. Most of the participants in this study desired or were encouraged by other Filipinos to come to the U.S. Most of them applied for jobs through a recruiting agency, although a few of them went a different route, such as through a friend who had been working in the U.S. This section explains the Filipino nurses' decisions to migrate to the U.S., which included conceptualizing U.S. nursing, idealizing the recruiting process, reconstructing the meanings of U.S. nursing, and finalizing the decision to migrate to the U.S.

Conceptualizing U.S. Nursing

Filipino nurses conceptualized their meanings of American nursing based on their interactions with others and their experiences in the Philippines. After Filipino nurses interacted with others in the Philippines, they began to derive their meanings and expectations about U.S. nursing. Their concept about American nursing continued to evolve while they were acquiring their nursing education. They interacted with their nursing instructors who had obtained their advanced nursing training in the U.S. and thus conceived their ideas about U.S. nursing. In addition to their exposure to their nursing instructors, they also received information about U.S. nursing from others in the Philippines. After they formulated their perceptions about U.S. nursing, they began the process of deciding whether to migrate to the U.S.

Filipino nurses' experiences as nurses and their views of healthcare in the Philippines was also a major influence in their decision to migrate to the U.S. Their reasons for migrating were two-fold. They preferred to leave the Philippines because of the less desirable conditions, including poor economic and social conditions, poor working conditions, and few job opportunities. Filipino nurses worked with inadequate medical resources and personnel in the Philippines. They viewed their workload as very high because they had to take care of so many patients, especially at government hospitals. Their working conditions and the quality of care were poor and challenging. Additionally, it was common in the Philippines to find few employment opportunities for nurses, especially for those newly graduated. Participants mentioned that most new graduate nurses could not find a job right after graduation and had to work in a non-nursing job, such as in retail positions. Because of the many new graduates coming from nursing schools each year, it was difficult for new graduate nurses to find a job without first obtaining volunteer nursing experience or knowing someone with a connection. As one participant described, "…considering how many graduates in the Philippines, nurses every year, there is a lot, a lot, lots." Another participant stated the necessity that she first served as a volunteer nurse to be potentially hired by the hospital. "I started as a volunteer nurse, because at that time, the work there is like not enough work for the new graduate nurses…. I volunteered just to get my foot in." "All of us there are BSN graduates, but the thing is that there's no available hospital or whatever."

They were inspired to come to the U.S. because of their perceptions and imagination about American life and work. These motivators included advancing one's nursing career, improving family life, receiving better pay, witnessing other Filipinos migrating, and looking for better opportunities. Many participants mentioned that one of their reasons for coming to the U.S. was to advance their nursing knowledge and career. Advanced education was not encouraged by healthcare facilities in the Philippines and rotating shifts were usually required. Consequently, it became difficult for nurses in the Philippines to obtain advanced nursing education or take continuous education courses. Hearing others discuss the opportunities in

advancing one's nursing career became appealing to the Filipino nurses, which motivated them to come to the U.S.

Better income and helping family were other main reasons Filipino nurses decided to migrate. "…it's hard to find a good paying job in the Philippines. You feel that way, you just want to get out of the country and to earn good money, so you can, you know improve your life or you help your family back home…. I don't want to go back home and start from zero." They spoke of many nurses who had Master's degrees and even doctors who were had upper-level administrative positions desired to migrate to other countries like the U.S. to receive better pay. "Yes, just to think that even if you have Master's degree, even doctors you know, they are already chiefs of the hospital, they still want to come over here you know and apply as a nurse, just because of the salary." Filipino nurses thought that there was a shortage of experienced nurses and doctors in the Philippines because of these migrations. "Maybe shortage, in terms of experienced nurses…. It's like they called like a brain-drained, brain-drain that you know all the experienced, all the better ones, all the smarter ones go out of the Philippines…even the doctors now, we have doctors now come here [to the U.S.]" One participant shared that her reason for coming to the U.S. was to get better opportunities for herself and her family. "Well it's a lot of better opportunities, and I want my family to be here for the immigration, too. Better experience; you see a lot of advancement in what you do in the field. That's pretty much it—better opportunity." Also, "We want all the best for our kids, just like you're just anybody else. We're doing this for our kids, and that's why I said, oh, I have to be…moving forward." Filipino nurses figured out a way to come to the U.S. to make more money so that they could then send it home to help their families. They used all their resources to help one family member become a nurse, who eventually moved to the U.S. These nurses saved money to either send periodically to help their families or they filed petitions to bring other family members to the U.S.

Idealizing the Recruiting Process and Reconstructing the Meanings of U.S. Nursing

Once they made the decision to move forward in the migration process, Filipino nurses started to interact with others to gather information about immigration. They talked to their friends and relatives who had knowledge of U.S. nursing. They also contacted the hiring facility or agency. After interacting with a recruiting agent, Filipino nurses formed their ideas about the recruiting process and revised their idea about U.S. nursing. Their contacts with recruiting agents were positive or negative, or mixed. These interactions then led to the reconstruction of their meanings and expectations about U.S. nursing, as well as their ideas about the recruiting process.

Finalizing the Decision to Migrate to the U.S.

After they went through the process of constructing and reconstructing their meanings and expectations about U.S. nursing, Filipino nurses made their decisions based upon those meanings produced during this process. They rationalized their reasons for migrating to the U.S. and took action based on those decisions. Filipino nurses decided to come to the U.S. because they desired to leave the country or were motivated to come to the U.S. for a different life, as mentioned in the previous section. Regardless of the reasons they made their decision to migrate to the U.S., these reasons gave them the motivation to jump over the necessary hurdles, including extensive preparation of paperwork and mandatory tests to obtain a job in the U.S.

The exams required for Filipino nurses, like many other foreign nurses, to come to the U.S. included the CGFNS exam, NCLEX-RN, Test of Spoken English (TSE), Test of English as a Foreign Language (TOEFL), and a written English test. Some nurses had to spend money out-of-pocket to take the required tests, which created an additional burden for them. “I have to spend a lot of money; I spent about 3 or 5 thousand Pesos. You know if you convert it to dollar, it’s like nothing, but it’s a lot [in the Philippines]. I had to fly a lot of times, a lot, a lot!” Many mentioned that the TSE was the most difficult exam of all the required tests. “…there is a lot of nurses who can’t come, especially with the test of spoken English, it’s very difficult because they told me; I took it twice before I passed it. They said in the test of spoken English, I think is like

senior people, who you know, middle age, who check the exam, I don't know, if that's true, if they check it, they can't really understand what you are saying…we have different accent, that's the problem why they can't understand us." Another participant stated, "It was difficult, so most of the nurses there, failed test of spoken English." Some participants also mentioned the requirement of passing the competency check-off for critical thinking and dealing with emergency situations before the facility would accept them to practice in the U.S. This could have created additional stress for them.

Recruiting Process

After Filipino nurses passed the required tests, they also had to complete the required paperwork to allow them to legally practice in the U.S. Depending on when they were recruited, the fees for their application and the preparatory exams could fall on either the hiring facilities or the Filipino nurses. It created additional financial burdens for the Filipino nurses when they were required to pay for the recruiting fees. In addition, some nurses believed that the recruiting agencies did not treat them by given false promises. One of the participants shared her disappointment with the recruiting agency:

> But they say, ok, you just pay the exams and tests, and we just refund you when you come over to the United States. Unfortunately, when I came over here, they did not give me even a single cent. I believe we were three nurses here who are on the same agency. And those Filipino nurses who are not been paid, so, you know, when you think about the refund, oh, I wish I could have the refund. But…. it would be a long process, I believe. It would be like a, emotionally and mental involvement. So, my friend's advice is like, just leave it to Jesus, like leave it up to him, and then, any way, you can earn that money.

One participant stated that some of the recruiters were not doing their part, which might have created additional frustration for the recruited nurses. "…the recruiter resigned from the company and they didn't even tell me. It was like a year of waiting for me. So I waited and waited, then I found out that that recruiter already left that company. And nobody processed my papers actually. So it is very frustrating."

During recessions, the U.S. usually stops hiring foreign nurses. Filipino nurses, like other foreign nurses from around the world, must then wait for the government to re-open the hiring

process. Some participants waited up to 3 years for their paperwork to be processed. As one of the participants stated, “Then, it took me three years before I was able to come here.” These Filipino nurses felt frustrated during the process of preparing their immigration paperwork because they perceived that the process was lengthy or “time consuming,” and tedious. Several of them stated that it took three years to completely process their immigration paperwork and they had to travel to the capital city, Manila, several times during that process. They also had to pass all the required tests to be accepted by the hiring agencies or facilities for a nursing position. They overcame all of the obstacles, despite the exploitation or problems they experienced. This showed their determination to migrate to the U.S.

ARRIVAL TO ORIENTATION

After they arrived in the U.S., they first needed to get their life settled, including obtaining housing, transportation, and basic living needs. Some recruiting agencies or facilities helped nurses during their initial move by offering assistance. Some nurses had to figure out things on their own, which was very frustrating for them. These interactions and actual incidents created changes in their perceptions and meanings about U.S. nursing and the recruiting process. If their expectations and experiences did not match, they became confused and frustrated. This then hindered their adjustment to living and working in the U.S. Regardless of their experiences during their initial arrival in the U.S., they adjusted after some time passed, usually within the first month. After they became settled, they started the process of adapting to their new work environments, including learning from others and learning advanced technology.

Settling into Life in the U.S.

Adjusting to life in the U.S. was very challenging for these Filipino nurses for different reasons, such as cultural differences and language barriers. Participants used many different approaches to cope. Support from the hiring facilities or agencies, friends, and families were mentioned as useful. One participant mentioned her appreciation for her children and her husband’s support during her orientation stage.

> But for me, I believe it was my family, especially my husband. My husband's support, you know, that make me really, really strong, you know, really, really tough for my orientation…. It helped a lot! He is the one cooking, when I go home, the dinner is cooked, everything is you know. I am not worrying with anything except my orientation, except start here…without my husband's support during that time, I might end up frustrated…. My kids and my husband would do all the chores; I did not have to pick up anything. That was during the whole time I was orienting not accomplish those things that I've accomplished before.

Some hiring facilities helped Filipino nurses with housing, transportation, and basic needs for living so that the only thing they needed to worry about during their orientation period was adjusting to their work. "Everything; they're very nice about it. That's what I'm thankful about because I've heard so many different things…. They paid for one month of our apartment. They already did, so we're already assigned what apartment, so I didn't have problems with that, and you don't have—we don't have a ride at the time, to begin with, so they assigned somebody to pick us up."

Conversely, if participants had to adjust to U.S. life on their own without the assistance of the hiring facility or other Filipinos, it was very frustrating and scary. One participant described her difficult experience in adjusting to life when she first arrived to the U.S. "I came here with my family, but it was difficult because we were the one who looks for an apartment. And the hospital did not assist me in looking for an apartment…. I also did the social security application. I started to look for an apartment by myself, without assistance. So, I called them, what type of transportation do you have here? Do you have a train; do you have, or just a bus or. I see some taxi or cabs. And they say, I am sorry, I don't know the bus routes, or I was just kind of like, Ok, let's buy some maps…. I went to south side by myself. I was so scared, because I didn't even know how to pay the bus…. So, I was scared, I even got lost. So, I say, no, I am going back to the apartment. So, I was just walking, and walking, and people are looking at me, you know, because I am the only one walking down the street. … It was difficult. Very, very difficult, when I came here, we don't have friends, you don't know anybody."

Filipino nurses who received support from hiring facilities or had other Filipinos to assist them during their initial settlement had a smoother and more pleasant experience when they first

arrived. They were less worried about some of the things others had to deal with during the settling-in period because they had someone available to assist or advise them; therefore, they were able to focus more on adjusting to their new work environments.

Adjusting to New Work Environments

These Filipino nurses started to adjust to their new work environment as soon as they started the orientation process. They also had to adjust to working in English language; however, it was not their priority during the initial 2-3 months settlement period. Regardless of their adjustment to everyday life, they still had to adjust to their new jobs as nurses in the U.S. During their orientation period, they had to adjust to people at work, the advanced technology, and the types of patients. Working in a specialty with which the participant was unfamiliar made the adjustment even harder. Filipino nurses' open-minded attitudes to adjusting enforced their adaptation to the American ways of life and work. "I just forget whatever I—I know it's something different at home, but I just keep quiet and say okay. Do it the way you do it because if that's the thing here, then I got to embrace the thing so I could be—I could learn how the way you do it here because I'm here now. I think you always compare, it's going to hurt you the most, and it's going to—you'll never learn." Filipino nurses perceived that their work and educational backgrounds in the Philippines helped them adjust to the U.S. working environment and their new working conditions faster. Filipino nurses adjusted by learning from others, especially from their preceptors or mentors. It helped them tremendously to have a Filipino preceptor because of the cultural and language similarities. With help from other Filipinos and preceptors, Filipino nurses were able to adjust to their new work environment; for example, it made learning the new technology much easier.

Learning from Others during Orientation

The length of orientations varied from 2 weeks to 3 months. Some were short and superficial, while others were detailed and complete. Because much adjustment was needed during the settling-in period, a three-month orientation was preferred and suggested by many of

the participants. “The best orientation I’ve ever been with is with S. Hospital. The orientation was really rich, was really detailed, it was a good orientation.”

Preceptors played a critical role in the orientation process. The participants believed that when their preceptors failed to understand their struggles during this adjustment period, their orientation became more difficult than it had to be. During the initial adjusting period, Filipino nurses might not be aware of the local culture and how to interact with people they encountered. As a result, they might perceive that their preceptors were not supportive or understanding, which may change overtime once they became aware and accustomed to the local culture. “And it was not enough, my preceptor was not good. The thing is that they don’t understand that I came from the Philippines and it’s very different from, you know, compared to them.” The participants believed that some preceptors had misconceptions about Filipino nurses and had unrealistic expectations for them. “Preceptor, yeah, she thought that if you are a nurse already, you came over here, you know how to do it…. It’s better now, but she did not understand that we need more time and that’s different.” Not having a designated preceptor, who only oriented newly hired nurses, prolonged their job orientation process. “There are other hospital they really have preceptors, you know certified preceptors, you know, and they don’t have, like the person who gave me orientation also had six to seven patients and teach me, if she will teach me everything, she is going to you know, she is going to be very behind.” Not having a good preceptor intimidated the newly hired Filipino nurse and interfered with her learning and performance. “Because if it’s someone who’s not going to teach me or who’s very strict or very obsessive-compulsive, I would be scared. I wouldn’t be able to ask question. I’ll be like, ‘Oh!’ Yeah, I wouldn’t be able to perform, you know.”

On the other hand, a participant believed that her preceptor helped with her adjustment during her orientation. “…especially my preceptor before, her name is Sophie. She is an African and she is very nice. She helps because she is also a foreign nurse. She work here. She work before in Africa and then she came here to work. Yeah, she understands how we feel, you known Filipinos, we are been treated like, you know.” Another participant mentioned how she learned

from her preceptor and how the preceptor guided her as a mentor: “I started Step 1, baby steps, and my mentor was good, too, because she taught me baby steps, too. So I was like a baby nurse when I came in here, so I forget all about at home. That’s the thing—that’s the best thing about it when I started here. I had a good preceptor; a good mentor, and everybody’s good around the unit, and I started baby steps, and I didn’t complain.”

Filipino nurses felt more comfortable having a Filipino preceptor or mentor. They tended to stay with other Filipinos or try to work with fellow Filipinos. When Filipino nurses are abroad, they usually help each other by offering help, such as transportation. One participant shared her appreciation of a fellow Filipino nurse who gave her a ride home after work. “But then at night you don’t have any more [buses], so some of the Filipinos at work, they’ll bring me home.” Another participant voiced her desire to stay with other Filipinos to feel safer. “That’s why—I was not supposed to be here, but because of the fear that I felt on that time, I decided to be with my friends. Wherever they went, I decided to be with them, so that’s why I landed here.” By seeking out other Filipino nurses, they felt more at ease to share their thoughts and less scared to be in a foreign land. Observing other Filipino nurses’ settlements also encouraged Filipino nurses to be more confident in their ability to adapt to U.S. nursing practices.

Learning Advanced Technology at Work

Medical technology was perceived as more advanced in the U.S. compared to what was available in the Philippines. Some Filipino nurses felt that it was hard to adjust to the advanced technology because modern medical equipment was not commonly used in the Philippines. “I think the machines because at home, we don’t have – we have an IVAC, or the IV pumps, but usually we don’t usually use pumps.” In addition, many Filipino nurses mentioned the need to learn how to deal with medical equipment and computer technology. “….here I have to deal with different technology also. I have to learn it. That’s part, also, of my adjustment when I came over here.” One participant shared her fear of losing patients’ trust not knowing how to handle medical equipment. “….with the equipment. It would be nice, if you know, during orientation,

although some of them already have that, you get to play with the machines, you know, with the IV pump. Even myself, the first time I've seen this kind of brand and all that, you know, you will be, at least you don't have to start it on the floor when you are in front of the patients, this nurse doesn't know how to do this. You know, they lose trust, can I trust her to provide care? So, that would be helpful to be able to play with the machines." Filipino nurses needed to feel capable of dealing with medical equipment and other technology to feel competent as a nurse practicing in the U.S. Receiving a constructive orientation by supportive mentors facilitated Filipino nurses' learning about modern medical equipment.

Filipino nurses perceived that advanced medical technology helps them provide quality care to their patients. However, it was stressful for Filipino nurses, who were not yet familiar with the equipment used in the U.S. Having a good orientation and preceptor helped ease their stress and frustration, as mentioned by one of the participants. "When I first came here, probably the machines…it's not that difficult, because I had a very good preceptor, she helped me, teach me all the time, just do this and then do that…and she is always with me." If they perceived themselves as incapable of using relatively advanced technology found in Western healthcare systems, then the Filipino nurses felt incompetent as nurses in the U.S.

THE EARLY ADAPTATION STAGE

After they passed the initial orientation stage, they then moved on to the early adaptation stage, which included adjusting to cultural differences, overcoming communication barriers, and becoming accustomed to the U.S. healthcare system. Participants revealed that one year was usually the time needed to feel settled and secure at work. "I think it took me like a year before I feel more confident."

Adjusting to the Cultural Differences in the Philippines and the U.S.

Filipino nurses had to adjust to the cultural differences between the Philippines and the U.S. to perceive themselves as competent to practice American nursing. Because of the cultural differences between the U.S. and the Philippines perceived by these nurses, it affected how they

perceived their roles as nurses in the U.S. Nursing principles were viewed as similar in the two countries; although, nursing practices were carried out in diverse ways. This section discusses the sub-categories discovered in the analysis under 'adjusting to cultural differences between the Philippines and the U.S.', which included: (1) overcoming natural shyness, (2) adjusting to life as a Filipino American, and (3) accepting the U.S. practice of patient-centered care.

Filipino nurses first learned to overcome their natural shyness and then became accustomed to living as a Filipino American by adjusting to the cultural differences between the two countries. After they became less shy and more accustomed to living as a Filipino American, they began to learn the so-called practice of 'patient-centered care.' By learning about patient-centered care in the U.S., Filipino nurses learned how U.S. families involved themselves with patient care, how patient confidentiality and privacy were treated, and how pain management was carried out in the U.S.

Overcoming Natural Shyness

Several participants stated that they were 'shy' and did not feel comfortable speaking up in the presence of doctors or patients. They tended to merely agree with what others said without questioning them, especially when communicating with doctors. This was partly due to the way they were treated in the Philippines; namely, they were accustomed to just following doctors' orders without asking the rationale behind such orders. One of the participants stated, "Communication with the doctors was very important because we were used to just following and saying, yes okay…so of course we were very shy—or I was very shy, where whatever they say, yeah, go ahead, okay because you said so."

Filipino nurses learned to overcome their shyness during their first year of employment, especially right after their orientation period. My field notes indicated how one Filipino nurse, who had only been in the U.S. for six months, expressed herself, "She had just started her job at the hospital 6 month ago. I think she is shy or it could be that she is not used to expressing herself yet. She always said things in a simple way or used short sentences. I felt like I had to

encourage her a lot in order to bring her to talk." They needed to overcome the propensity to be easily intimidated, to avoid feeling threatened by others. "But now I have learned to…so it's just a matter of, or maybe it's just a matter of intimidation when you first got here." Similar to being assertive, Filipino nurses had to overcome their shyness to be more vocal and expressive so that they could be more effective in communicating with other healthcare providers, including doctors. By doing so, they felt more Americanized and competent to practice as a nurse in the U.S.

Becoming a Filipino American

'Culture shock' was mentioned by several participants as one of the difficulties they experienced. They felt that they were either 'nobody' or 'did not belong,' especially during the first year after their arrival in the U.S. As a foreigner, it was tough to ask Americans to perform duties for them, such as delegating nursing tasks to nurses' aides. One participant said, "Oh God, it's hard for you. You're just merely coming from the Philippines, and you're just like a nobody, and then, you come to their country, and then, you tell them what to do, and it's hard." Another participant stated, "When I first came here, especially when I came out of the airport, you cannot see all of those Asian faces anymore; they're white, black, and everything. You have a culture shock, and it's like that – you feel like everyone is looking at you, and you feel like oh my God you don't belong here. You're—you feel so small, and when you go to a workplace, especially if you're new, they feel—you feel so small and everybody's intimidating [to] you."

However, after they became familiar with life as a Filipino American, everything began to get easier for them. To survive in America as a Filipino, they had to learn to be assertive and to boost their confidence, because they were not instructed or encouraged to speak up for themselves or for their patients in the Philippines. "It's like you feel like you're—Nobody is listening to you at first, but then, after you regain your—confidence and you know how to treat. You'll know how their personalities are, but then—to just go with the flow or else." Another participant described how she learned to fight back and deal with her emotions to be treated

right. “But when you fight back, my God they’re the ones who’s going to …. But, we have our own moods and everything. I’ve gone through all of that. I was able to fight—not confront, and after that it’s okay…because if not you are the loser…. You have to be assertive; here you have to be assertive, especially if you know that you are right. You need to assert—because if you won’t—you’ll feel bad inside.” Filipino nurses learned that they needed to be assertive at work and be confident about themselves to be able to adapt their practice to the American way.

Accepting Patient-centered Care in the U.S.

Nurses in this study perceived that customer satisfaction is emphasized in the U.S. healthcare system as part of patient care, which makes nurses responsible for keeping their clients satisfied by providing care and services. Customer satisfaction was not a focus of nursing care and practice in the Philippines. As one of the participants said “…here, you’re patient focused…[the] patient is always number one…. You have to please the patient. You have to—I guess it’s more patient-focused, like I said.” Even though it was uncomfortable for them, Filipino nurses had to learn to accept the fact that patients were the center of U.S. nursing, and thus, their rights were emphasized and respected “…you’re very customer-oriented, like you have to please them, you know, even if it is detrimental to their health, I guess. If they refuse – they can. You know, the thing is they can refuse.”

Filipino nurses also learned to face dissatisfied patients or families, and to accept the fact that at times, no matter what they have done or how hard they have tried to please them, patients or their families could remain dissatisfied. As one participant mentioned, “…there are days that you’re going to have rough patients, but you cannot satisfy [the patient] whatever you do…there are really some patients that you cannot meet their expectations, and that’s the hardest thing to do. That’s the big challenge in the nursing field that everyone is facing. And not all our patients appreciate what we do, even how much we do…. And that’s really frustrating.” Because these nurses had a higher social status than their patients and their patients’ families when they practiced in the Philippines, it took them a great deal of effort to adjust to the culture of patient-

centered care. They were able to practice and accept that cultural differences existed, as perceived by these Filipino nurses, only after they became accustomed to patient-centered care in the U.S. In the U.S., the participants perceived little family involvement with patient care, more nursing focus on patient privacy and confidentiality, and more nursing emphasis on pain management than in the Philippines.

First, the participants had to adjust to less family involvement in patient care in the U.S. They felt frustrated about what they perceived as U.S. families' apparent lack of attention to providing basic needs and care to patients and the families' high demands on nurses. Since the participants recalled that families in the Philippines were very involved with patient care, especially in providing basic needs to patients such as feeding and cleaning, the lack of or decreased family involvement with patient care was perceived as strange to the Filipino nurses. Family's participation with patient care eased nurses' workloads in the Philippines, because families were taking care of patients' basic needs. "Like here, you have to do it yourselves. You can't wait for the tech because he has other patients, so here you have to do it by yourself. It's more like its physical and mental labor at the same time. So we weren't used to that. We were always tired. We were like, "Oh my God, what did we get into?" That was the first time you go to sleep and you snore and you're so tired. Yeah, we don't – you don't eat any more. You just go to sleep straight; you take a shower and go to sleep, that's it, then you wake up the next day, have to go to work again. Yeah. So I mean its hard work. We weren't used to it; I wasn't used to it, so that kind of shocked me, yeah, the physical aspect. Filipino nurses perceived Filipino families as being more involved in patient care compared to American families. In the Philippines, families actually stayed with patients in their rooms and took the responsibility for bedside care, including cleaning, toileting, and feeding. "…there are family members who stay with the patients." In contrast, families in the U.S. usually do not get involved with patient care. "…. But families here, they are not helping, they will leave it up to the nurses. They don't help…they just dump their patients here, and then, if they are here, then all they do is like ask questions and complain." Filipino nurses had to become familiar with family involvement in

patient care to perceive that they have adjusted to American culture. They were able to reconcile or 'fit-in' with the American society and accepted the fact that American families are less involved with patient care. Although participants in this study perceived that they had become accustomed to the American culture, they might not fully integrate or understand it.

Second, patient privacy in the Philippines was not emphasized to the same degree as it is in U.S. hospitals and similar medical facilities. For example, private rooms were not common in the Philippines, especially in government hospitals. Patients were in large wards without any privacy devices like curtains to separate them and provided some level of privacy. "There's not even a—no, there's not a curtain. So they talk to each other…." Filipino nurses also need to learn not to discuss patients' conditions with others, even family members, without a patient's permission, according to the HIPAA. Since patient privacy was not forcefully addressed in the Philippines, it took some time for them to familiarize with it here in the U.S. "Yeah, that's the thing. I'm afraid of getting into trouble, and—so I just have to say, I already say hey, would you mind if you just come here in the morning and talk with the doctor. I think he can give the best explanation about what's going on. Right now, he's stable, and that's all I can say. I'll give you a call whenever this changes. That's just being—because I know they have their law about the HIPAA thing. At home, we don't have that. I know there's confidentiality, but not really to—that's not a big deal compared [to] here because it's really a law." Until they became accustomed to the way of dealing with patient confidentiality and privacy issues, they did not feel adjusted to U.S. culture.

Third, Filipino nurses perceived that American patients viewed pain management in a different way than those in the Philippines. Filipino nurses experienced that it was encouraged in the Philippines for patients to hide their pain unless the pain was intolerable. However, pain control is emphasized in the U.S., and patients are encouraged to take pain medication, as well as to ask for it. Filipino nurses felt it was strange to offer patients pain medication when patients did not ask for it or stated that the pain was tolerable. They also had to adjust to the greater amount of pain medicines that U.S. patients take. One participant stated, "Another thing that's

different—pain management is so much—they give so much importance to pain management here. A little bit of pain, you give them whatever for pain medicine. Back home we try to give them the minimal…minimum of pain medication. Over here, I see a lot of patients take so much pain medication for so – it seems like so little. Well, to my perception – maybe just a little bit of pain, but maybe to them it's a big pain." Another participant said, "For example, in Philippines, a little pain is okay; but here, most of the time, you have to get something for pain. A little pain usually they encourage you to give something for pain. So at first I thought a little pain is okay. I don't have to worry about it. Then they come to you—you have to ask. You have to give something to relieve those pains." Filipino nurses had to adjust to the American way of managing pain to be perceived as caring and knowledgeable nurses.

Overcoming Communication Barriers

Language was viewed as one of the major areas Filipino nurses needed to adjust, especially during the first year after their arrival in the U.S. Language barriers made adjustment harder for Filipino nurses. "It's more language, I think; it's still our main thing." Language barriers were a great obstacle for Filipino nurses trying to adjust to new working environments. "A lot of time, I got lock out, I don't know how to express myself too." In other words, Filipino nurses had trouble expressing themselves due to communication barriers. Having communication difficulties negatively influenced Filipino nurses' ability to adapt to U.S. nursing practices. Nonetheless, when they became fluent in English, their level of confidence, in general, improved. A field note that I wrote provided the evidence, "My first impression about her is that her English is very good. And she is very confident about herself and nursing skills." The sub-categories identified under this category included: (1) becoming familiarized with different accents, (2) becoming skilled at telecommunication, and (3) learning medical terminology and U.S. pronunciation.

Becoming Familiarized with Accents

Regional and other foreign accents were one of the most difficult aspects of American life to adjust to, as mentioned by the participants. People from other countries spoke different languages, but also have different regional accents, as do Americans from different regions of the U.S. Filipino nurses used what they had learned from a book in school, initially. "The most difficult thing, language, as far as their accent, because I can understand English very well but with different accent, like the way we speak English is different than the way they speak here…. it's like we have the Philippine accent." "And even, I know, I am sure you've experienced things like that, they don't understand…the accents are different, because we are from another country." Not only did Filipinos need to ensure that others understand what they said, they also needed to adjust to peoples' accents from all over the world, which increased their frustration in adjusting to the English language. "…a lot of doctors are from different countries…they are hard to understand, especially over the phone…there's one particular doctor that's really complaining, but anyhow, he's not an American. He's not white or something. He's also—something like from—where is that somewhere—the Caribbean."

Becoming Skilled at Telecommunications

Telecommunications were difficult for Filipino nurses because it blocked the advantage of having body language to facilitate communication. The participants stated that having obliging and sympathetic coworkers helped Filipino nurses learn to adapt to communicating with physicians over the phone. Many stated that communicating with others over the phone was incredibly tough and it created additional stress for them. This is especially true when they were calling doctors or receiving telephone orders from doctors. "…but that's not the language that we talk at home, so it's a little harder, too. That's another thing to adjust to. So when you [are] calling the doctor, they don't understand us right away, and they keep complaining, why are the new Filipino nurses—you know what I mean—and they have slang words here." One participant

used her friend's experience as an example of how stressful it was to communicate with doctors over the phone:

> I remember France, my friend, had a problem with a doctor over the phone. Like, he was ordering a CT scan of the chest or something, and he said something about CT of the chest. 'Get the CT of the chest.' And she repeated the order, and she said the same way; the way she said it is the same way. She said, 'Oh, okay, you want a CT of the chest?' and then the doctor said, 'I said get a CT of the chest.' So she was repeating what he was saying, but I guess because of her accent he wasn't getting it. And then later on the doctor said, 'Oh, can you get me another nurse who can speak English?' So that was—yeah, she told me about that, 'Well, he told me to call an English-speaking nurse, and I'm an English-speaking [nurse]!

Avoiding phone calls altogether was one of the methods nurses used when they were afraid to answer the phone. "When the phone rings, I didn't want to answer the phone. I mean, I have like a language barrier, I was afraid like I won't understand what they say on the phone. Like, the doctor will have an accent or they won't understand my accent or something like that. I was so afraid to pick up that phone. I try not to be too close to the nursing station so I won't have to answer the phone when I was on the hall way" "My God! The phone just keeps on ringing, and I don't understand what the other line is talking, you know, and if it's a doctor, what can I do? As much as I could just run away. I'd just ignore it. I pretend I'm doing something, but after a while, you get used to talking to the people, the nurses, the patients, and everybody, and then, you tend to learn." Filipino nurses perceived themselves as less competent as nurses in the U.S. because they were unable to converse with other healthcare providers over the phone.

Learning Medical Terminology and U.S. Pronunciations

The use of medical terminology was also very different in the U.S. and the Philippines. For example, equipment was often named for their brand names, such as 'Foley' instead of catheter, which was very confusing for the Filipino nurses when they first arrived. One of the participants shared her experience, "So, it is very difficult. When I first started, there is always a problem. Like different terminology. Like they say H & H, we say hemoglobin and hematocrit. I mean they are just very different."

In addition, medications were pronounced differently in the Philippines than in the U.S. For instance, one of the participants stated, “Like Ro'cephin, back home is like 'Rocephin. So it doesn’t click right away, it takes time to process.” They needed more time to think about what others were trying to tell them, instead of understanding it right away. “Like the 'Bacitricin, we pronounce differently…. Like Pe'nicillin in the Philippines, but here they [say] 'Penicillin, we say Pe'nicillin. They say ‘Tetanus, imaging that!” Filipino nurses felt inadequate because they were unable to pronounce the medical terms in the ‘American way,’ which hindered their adaptation to U.S. nursing practices. Even though they perceived that the English language was not foreign to them because of their exposure to English in grade school, not understanding what Americans said surprised them. They did not expect conversing in English to be such a big adjustment in becoming an American nurse.

Becoming Accustomed to the U.S. Healthcare System

The participants conveyed that a positive working environment keeps nurses happier and increases their intention to remain in their current position. As one of the participants stated, “I am please where I am right now. I wish that I can retire there, since I am very happy and satisfied where I am at…. It’s nothing compared to working at a private hospital [in the U.S.]. Doctors are very nice; the residents are in training…. So, they are not grumpy or yelling at you.” Filipino nurses became accustomed to the U.S. healthcare system over time, which helped them adapt to their role as a nurse practicing in the U.S. There were several themes mentioned by the participants in this study that centered on their adjustment to the U.S. healthcare system. The sub-categories identified were: (1) being aware of legal aspects of practicing nursing; specifically, the danger of lawsuits; (2) accepting that documentation must be detailed; (3) learning to think critically; (4) being willing to act independently at work; and (4) relearning their roles as nurses.

Being Aware of Legal Aspects: The Risk of Lawsuits

Legal liability was another major area to which the participants had to adjust because they were not familiar with it in the Philippines. These Filipino nurses felt that nurses in the U.S. have more legal responsibilities than nurses have in the Philippines and face potential consequences for their actions, or inaction, in the U.S. One participant mentioned her views on the legal consequences in the U.S. "Legal wise, maybe because people here are more, more conscious about legal things, your responsibility are still a little…need to do some more…maybe it's this foreign planet, we have to think about the consequences." Another participant said that families might sue nurses for minor things. "…everybody is covering for themselves, if you don't, family might sue you for a minor thing…little things like that." Thus, Filipino nurses had to learn to be conscious of the legal aspects of working in the U.S. As one participant stated, "It's just like the environment, I guess, because here always litigation-conscious. You know how people will sue you if you don't do this or you don't do that." After they learned to be aware of legal issues, they became less scared about potential lawsuits, and thus, many perceived themselves as better adapted to U.S. nursing practices.

Conversely, nurses did not have to worry about legal issues when practicing in the Philippines because families were less likely to take legal action, especially for minor incidents. "I'm very comfortable over there because you're not scared—because just hearing here, over there; they have lawsuits or something like that. Over there, no, because it's not really a practice." According to the participants, lawsuits filed against medical personnel or healthcare facilities were not very common in the Philippines. Families in the Philippines usually forgave medical personnel for minor mistakes. "In the Philippines it's nothing…. little things like that they will forgive you" "…but the beauty of it is that the people do not have to like going to court, just like Americans…they don't have money. That's one thing for sure because they are at the government hospital." Based on their experiences in the Philippines, they were not legally oriented. Therefore, they had to force themselves to become aware of the legal aspects of practicing nursing in the U.S., including the risks of potential lawsuits. Some of the actions

included being extra cautious in their practice regularly, as well as accepting and practicing detailed documentation.

Accepting the Need for Detailed Documentation in the U.S.

Detailed medical and patient documentation is important in U.S. nursing practice. The participants stated they were not accustomed to the detailed documentation requirements of the U.S. because it was not a common practice in the Philippines. This may be because of the lack of time for such documentation and lawsuits filed against medical personnel were not common in the Philippines. Therefore, nurses were not encouraged to document thoroughly to avoid legal trouble. Over time, they learned to practice detailed documentation to steer away from potential legal consequences. One of the participants described in detail the nuances of ensuring accurate and detailed nursing documentation:

> Oh, it's much different because it's very stressful. You have to be very careful. It's just that you have to—other than patient safety first, you have to protect your license, too, because that's the only thing that holds you here—well, for everyone. So in every step you make you have to be careful, documented everything and you just have to be sincere…be careful because of those. You have to document everything. You have to cover your butt. It's just they're—every patient here, if they're not satisfied, "Oh, I'm going to the next level." That's what they're coming on their mouth all the time. So cover your butt every time. I have to make sure to document everything, and especially—I don't know, but if they have foreign nurses, especially—there are lots of patients here. You can see who are educated and not. Those educated people are just so, so quiet like that, but those uneducated—the ones so loud, keep on complaining, whatever. So those are the ones that are prone to lawsuits like that.

Learning Critical Thinking

Critical thinking was not a skill that was required to function as a nurse in the Philippines, perhaps due to in part that there had always been a doctor physically present in Filipino hospitals. Filipino nurses had to adjust to the need for learning and critical thinking skills in their patient care on a regular basis. One participant shared her astonishment when she discovered that there would be no resident stationed at the hospital at all times and that she would be the one expected to think critically and take the necessary action. "I have to do it on my

own. I was like, ‘For real?’ And our manager’s like, ‘Oh Karla, do you know—how do you work over there?’…. And she’s like, ‘Oh, it’s different here; because you’re the one who’s going to calling the doctor.’ I was like, ‘What? Me? Why? There’s no resident?’ No, I was only two weeks, and then we were just needing paperwork—yeah, we don’t have residents here. It’s the consultants. It’s the doctor. During the night—because you work nights—or even the day, there’s no—so you mean there’s no doctor in the unit? No. Who’s going to see my patient? Oh, they only see it once in the morning, or whatever, and then during the night you have to call them if there’s any problem. Oh, you mean I’m going to think about—you know what I mean? That was hard!”

Filipino nurses had to learn how to make the decision to call the doctor and to communicate to on-call doctors or consultants the status of their patients. Because they were not trained to give on-call physicians a concise and constructive report about their patients, it was difficult for them. They also had to become accustomed to recognizing patients’ problems and determining the significance of such problems to decide if calling the doctor at a given time was the correct decision. “Critical thinking about what’s going on. Yeah, and you have to find it, or you have to see it, because you’ll, we will be the one to call the…. [To make the decision] Yeah, prepared—what’s going on? Why do you need me to call to wake me up at this time? Is something wrong? Is it really wrong? Yeah, something like that. And you have to see it” They also had to learn to be ready to make suggestions about their patient’s problems to the doctor, as well as to know what doctor or consultant to call based on the problem, which was not a practice in the Philippines. As one participant described, “Here you have a lot of, you know. There’s like three different types of doctors to call. You have to call MedLink, MedExchange, or ADC, and you’re like, ‘Okay, what is it now?’ What problem, you have to decide which one, is it the pulmonologist, the cardiologist?”

Being More Independent at Work

In addition to learning critical thinking skills, nurses also had to learn how to think and act independently. They perceived that they were expected to initiate non-invasive or sometimes even invasive treatments; for example, giving certain medications without a doctor present. It was a scary for them because they were not accustomed to acting independently in the Philippines. “But, it’s a little scary here because the only—like I said, being independent nurse, that you have to watch them…just that because at home now we have resident. You can just call, sir can you watch this one? Can you look at this patient? What’s going on? Oh, this one—but here you have to decide. That’s just the thing—major, major!” They might also become overwhelmed by how much they have to learn and to do. “…it’s just that you could not have that time management yet. You’re just like a chicken without a head; just going around like crazy, like that.”

Once the nurses learned critical thinking skills and adjusted to the work environment, they believed they enjoyed the independence and autonomy that came with being a nurse in the U.S. “…but I like it here, though, because we’ve learned to be independent. That’s the thing about it I like about here because you just have to think about and—oh you can start anything you want, as long as you know there’s a protocol, or something like that; over there, no. We have to wait where the doctor will say hey, what do you—and then the resident—and if there’s any problem, the resident—then the resident will be the one to talk to the consultant, and then after they talk they say—they will tell us hey, do this, do that. Here you have to be independent, and we just call, sir I already started a dopamine; okay.” Being an independent nurse able to think critically and being legally conscientious about nursing practice, they felt that they were becoming accustomed to the U.S. healthcare system. The next step was to re-learn their roles as a nurse and to re-construct their meanings of American nursing.

Learning the Roles of Nurses in the U.S.

Filipino nurses had to adjust to their new roles as American nurses by interacting with and learning from others. Their critical thinking skills and independence as a nurse affected their perceptions of nurses' roles and their meanings of U.S. nursing. Some participants stated that they perceived nurses as having more authority and were more respected by patients and families in the Philippines than in the U.S. These nurses perceived that they were viewed as 'helpers' instead of as a professional in the U.S. This perception was derived in part from their involvement with basic care of their patients in the U.S. "If you are in the Philippines and you are a nurse the patient themselves or the family are you know like I said they have high regards for you that they are, may be ashamed...to ask to do something not really important" Others viewed nursing as less professional in the Philippines. "As far as Philippines experience goes, it's totally different. Because nurses there just you know, are just like pill pushing, you know, give you medications, it's so superficial." Another participant described the duties of a nurse in the Philippines as merely an 'assistant's' role, "But pretty much, the nurses there just give medications, start IV, and assist the doctors for treatment, like minor suturing, and like if they have to do casts, you have to assist the doctors, like assisting the doctors when they have all this treatment." This is an interesting point because everyone views the nursing profession differently, even nurses from the same country.

Nursing principles were viewed as similar in the Philippines and the U.S. by many of the participants in this study. However, the differences were perceived as primarily due to various regulations, legal liabilities, and cultural differences. Existing regulations related to patient care in the U.S., such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), led Filipino nurses' to perceive that the work environment was more stressful in the U.S. Other sources of stress included additional responsibilities for patients, managing nurses' aides, and legal issues.

Filipino nurses had to learn different levels of responsibilities that they had as a nurse in the U.S. Nurses in this study perceived that as nurses in the U.S., they were responsible for

managing patient care, delegation, patient education, and being a patient advocate. “I do everything, direct patient care, take vitals, and call the doctor, being in charge of your own self.” They felt that they were in charge of doing complete health histories and assessment on their patients, which was not strictly required in the Philippines. Nurses in the Philippines only did simple assessments and history-taking because they were too busy doing other tasks such as giving medications to many patients. “It’s like during admission, after your assessment—there’s no thorough assessment. It’s usually the doctor who does the assessment and history, but here, the nurse does that one. We do the assessment and the history taking [at] the same time. I just learned that history taking thoroughly when I became a clinical instructor because we’re teaching that work to the student, but I’m not able to practice that during my hospital experience as a nurse because it’s like a routine job. We just work as we get—during admission we receive the patient. We also need a history, but it’s like not thorough history.” On the other hand, Filipino nurses perceived that they were expected to perform a complete assessment and be proactive about patient care. “…we are assessing patients from head to toe. And then if you see any abnormalities then we will call the doctor’s attention, call the doctor the doctor will believe me, you know, and the doctor will even ask [for] any suggestions.”

There were usually interns and residents physically present in Filipino hospitals. They notified the doctors if they discovered any abnormalities with their patients, but the doctors made the decisions on what to do next. “The thing is, we have lots of doctors over there; like interns, and doctors, and PGIs are those who are like IM [Internal medicine doctors] and the residents. In our unit, we have residents in the unit, so we don’t deal with the consultants. I don’t deal with them. The only thing that I deal with them—the only time—is when they’re making the rounds, and I’m there, and then there’s no resident because the resident is in the other cubicle with another consultant. So there’s this time that I have to answer their questions. Anyhow, if I have problems during the night I have to call the residents, and the resident is just at the back.”

Delegation was another skill that the participants perceived they had to learn when they started working in the U.S. Part of delegation was ensuring that tasks delegated to assistants were

completed accurately because Filipino nurses were the ones who were legally liable for the patients. “Our techs, they complain a lot. ‘Why do I have all this critical patients?’ My question is ‘why are you so worried?’ You just have to check the Accu check. You’re not going to do anything. Is the nurse’s responsibilities, you know the patient’s low blood sugar. She has to call the doctor; she has to do this and to be prepared for the call or whatever. And he is not doing for anything, what’s making them busy about.”

Because lawsuits were perceived as more common in the U.S. than in the Philippines, the stress of supervising others was a constant battle for nurses working in the U.S. The participants perceived that other nurses were not familiar with delegation either, which made the participants anxious about their nursing roles. The participants stated that when the patient care technicians (PCTs) failed to complete jobs or tasks that were delegated to them, it was the primary nurses’ responsibility to either complete the tasks themselves or mandate that the PCTs complete them. Many Filipino nurses decided they would complete these tasks themselves, especially when they were not familiar with how to delegate or the local cultures. “But these other PCTs they don’t care how many hours they have been lying there, they won’t bother to turn them you know. I think they know they should be turned every two hours but they just don’t…you have to tell them or to remind them.”

Nurses in this study felt that they did a lot of ‘invisible work’ that was hard to explain to others, even to the PCTs who worked closely with them. “But they won’t understand that. They don’t. They don’t’ know we are dealing with this the doctor, patient, the chart, all the orders, they don’t know that…it’s all the techs they mostly they think that we are just giving medications. You know, we are just uh, checking chart…. They think that’s the only job that we are doing…so they don’t realize that we are you know responsible for a lot of things…. That’s challenging for me.”

Filipino nurses had to become skilled as a patient educator because they were not used to teaching patients on a regular basis in the Philippines. They had to get used to the patients’ desires and demands for information on their illnesses, treatments, and medications. “As far as

nursing wise, here in the United Sates, patients are very out front, if they don't like you; or, they are very knowledgeable. You don't just. I mean not all of them, but most of them, like when you give them medicine, they don't just take it, they ask you what is for, and they want to know it, because they are knowledgeable." Filipino nurses also had to adjust to always involving patient teaching in their care, which was also not commonly done in the Philippines. "They value education in the U.S. Before—during admission, you give education to your patient, and before the patients will be discharged, they give education. We're not doing that in the Philippines."

They perceived that nurses in the U.S. play an important role as patients' advocates. Filipino nurses had to learn that as a nurse practicing in the U.S., they are responsible for informing doctors about patients' conditions as needed, such as critical laboratory values. This was not required as part of nurses' responsibilities in the Philippines. "It's like the lab, we will get the results there, and the doctor will review it. We see the critical labs if we have time, yeah, we will call the doctor. But that is not our priority. We just did not have time to do that." Nurses had to grow accustomed to respecting patients' wishes as part of 'patient-centered care,' even if it meant respecting a patient's right to refuse treatment or medications. "You're supposed to be an advocate of them taking the medication, but if they don't want it, what do you do? You can't force somebody."

Nurses felt that they were expected to speak up for their patients in the U.S. A participant stated her perceptions about nurses as patients' advocates:

> And there were times when we really have to stand up for the patient, and you really have to tell them what you think because you are the ones that are in contact with them…. I think here you're more of—you can really be patient advocates here. I think you can actually talk to a patient about her medical problems and you can actually give advice and they actually seek your opinion too. Yeah, and like back home they just listen to the doctors, I think…. But here you're more of—you have more freedom to actually talk to a patient about their diagnosis, help them decide what to do next, you know, give them opinion of what you think matters most. Especially in ICU—we get all these patients who are critically ill who's been there for a long time with no changes in status, and I think the best role a nurse can have is to kind of talk to the family…. Is this what you want? Or is this what he wanted when he was alive? Or when he was still, you know, healthy? Would he want to be in this position for a long time?... Nurses can see how they suffer. They don't see how the patients suffer because they don't see them in pain. They're not there

> 24 hours a day. We see them; we see how the family's always there and spending time with the patient and getting disappointed each time because they don't see any improvement. And then they talk to the doctor and the doctors keep saying, "Oh, let's do this, let's do that. Maybe this will work." I mean a lot of tests, a lot of things that they wanted to do, but it's not helping the patient. I guess here you have more—more, yeah, more flexibility and more like authority also.

THE LATE ADAPTATION PERIOD

In the later stages of adapting to the U.S. nursing practice, Filipino nurses learned different ways to relate with others at work. After Filipino nurses were adjusted to their new living conditions, new work environments, communication, techniques, cultural differences, and the healthcare system, they then moved on to the late adaptation stage. This stage took place after Filipino nurses had been in the U.S. for at least one year. They started to pay more attention to their interpersonal relations, as well as ways to deal with other obstacles, such as stress, mistreatment, and racism. This phase is characterized by a more subtle, nuanced understanding of U.S. social and organizational culture and the ways in which nurses negotiate relationships.

Interpersonal Relationships

As foreign nurses, Filipino nurses had to adjust and adapt their interpersonal relationships with doctors, patients and their families, and colleagues. They initially merely reacted to others in the early stages of adaptation. In this late stage, they started to interact.

Adjusting the Doctor/Nurse Relationship

Filipino nurses gained power from the doctors in the U.S. and learned to communicate with them as a professional on equal footing. They also came to realize that they shared in the U.S. doctors' responsibilities because they served as doctors' bedside monitors for their patients and were responsible for reporting significant changes accurately to doctors in a timely fashion using the 'right approach.' It was challenging for them to decide when to call a doctor for a patient's problem during the nightshift because there was no set standards or guidelines to determine the appropriateness of calling a doctor. Nurses had to learn each doctor's likes and dislikes, which caused them additional stress. "…But now I am also having a hard time,

especially when patients have V-Tach [ventricular tachycardia], when its V-Tach, you need to call them it's like…more than ten beats or it's more than how many seconds. If not, don't call them if you think the patient is ok, don't call them so that. It affects me sometimes because do you think I need to call?"

These nurses perceived these doctors as difficult. "It's very difficult I think that the most difficult person to work with in the hospital is also, one of the most difficult is also the doctors." It took time for these nurses to build confidence in discussing with doctors on their patients' behalf. "And what's hard for me was talking to the doctors. I was so afraid to talk to the doctors before because I was—I thought that every word that I say is wrong, but now my God, oh I need this order, period. Oh, doctor—it's just—it's so different now when you find confidence in yourself that you know what you're doing."

The Filipino nurses viewed nurses' relationships with doctors in the U.S. and in the Philippines differently. Doctors were viewed as having more power and control over patient treatment in the Philippines. Doctors in the Philippines did not value nurses' opinions regarding patients' treatment options. Nurses were supposed to simply carry out doctors' orders without questioning them. "…especially in the Philippines, doctors there are like untouchable. Their words is their words!" Over time, they learned to confidently and effectively approach doctors.

Adapting Ways of Interacting with Patients and their Families

In the U.S., Filipino nurses lost the authority to tell patients and their families what to do, which they did as nurses in the Philippines. In the U.S., they were the ones who had to meet patients' and families' needs in a timely manner and assure that they were satisfied. Patients were the center of everything that nurses did, unlike in the Philippines. This conflict created additional stress for the Filipino nurses; however, over time, they adapted to the American way. "…they look up to you. It's different. They look up to you. 'Oh, here comes a nurse.' But here, it's like, 'Oh, here's the nurse,' and then, you get to be here. 'Can you place the blah, blah, blah?' like you're just nothing. But in the Philippines, when they see you as a nurse, they tend to

look up to you like you're not as the level of a doctor, but at least it's a different thing than what they have here. But here, it's like, no, you're just the same person that works and takes care of their families or something…. Caretaker or just another lady that works just like in Wal-Mart. Like, 'hey, I need something.' So that's the other thing that really is hard."

Filipino nurses were aware that they were closer to their patients and their patients' families in the U.S., and even got attached to them, especially in the ICU. Filipino nurses took care of fewer patients in the U.S. and felt that they were able to be more personally involved with their patients and their patients' families. "Yeah, you'll see the difference because you're so much more focused on the patients and their families. You kind of—you can actually develop a rapport with the family because some patients have been there like what, a month or so. So you kind of know them already by their names, your family's names, their grandchildren, you know, someone who calls on the phone all the time…. So it's nice. It's nice in a way, but it gets depressing also sometimes…like you saw you've done everything and still…. The patient deteriorated, so it's kind of depressing at times too. Whenever we lose a patient, like patients who have been there for some time, that's when we really feel bad because you really get to know them." In this phase of adaptation, the participants mourned the loss of their status as a nurse in the Philippines but valued the new emotional connection they felt for their patients and their patients' families.

Discovering Effective Ways to Approach Co-workers

Another difficulty that the participant's experienced in the U.S. was negotiating and working with nurses' aides. In the Philippines, nurses supervised nurses' aides or were at least one level above them in the hierarchy. Thus, Filipino nurses were accustomed to giving orders to nurses' aides in the Philippines, and it was very difficult for them to delegate work to nurses' aides in the appropriate manner in the U.S. Nurses in the U.S. usually worked with their assistants as part of a team instead of working in a chain of command. Filipino nurses were frustrated with the rejection they received from aides when they first came to the U.S. and would

simply perform tasks usually done by aides. Managing other co-workers, like PCTs, was stressful, especially if they were not good 'team players.' "Most of the time, you know these PCTs like you say they just do vital signs…that's why I get frustrated, I get high blood pressure from how they respond. So I tell them you know can you stop that and come bring this patient down." Sometimes, they dealt with PCTs who refused to assist them, "I can tell them, 'Miss Janice, can you please empty that?' 'No!" "They don't help you. Probably it's because it's a big city. They're more aggressive than here in the rural areas, and they say, 'Why are you telling me what to do?' They close the door on you, and then they won't help you at all in here." Filipino nurses had to learn to handle these additional sources of stress to function as a U.S. nurse. Most of them learned over time that delegation was necessary and practical. Although it differed from their experiences in the Philippines, they adapted to it in order to complete their tasks. They were aware that doing everything themselves merely made them more frustrated. Learning to adapt to the American way of interacting with assistants was a turning point for these Filipino nurses.

Learning to develop good relationships with their coworkers eased Filipino nurses' work-related stress. "We have a very, very good relationship with each other. So, yeah we are function together, and team work is really very different" Having good relationships with others at work helped them function better in their jobs. "My friend at work, like this nurse, she helped me a lot. They can see like I am timid talk on the phone, they will do it for me. 'Do you want me to call the doctor? What do you want me to say?' 'Oh, you have to call the lab?' They will help me, my preceptor…she helped me a lot and I learned a lot from her…. If I did not have her, I would struggle." Understanding the importance of having good relationships with colleagues and fostering teamwork helped Filipino nurses more effectively interact and become acquainted with people at work. They changed the way they approached people to achieve this goal.

Overcoming Other Obstacles

In addition to changing the ways that they approached others, Filipino nurses also began to pay more attention to other obstacles and how to overcome them. This section presents how

Filipino nurses learned to conquer other obstacles, including managing work-related stress, facing mistreatment and intimidation from others, and conquering racism.

Managing Stress at Work

Many participants perceived a higher stress level in the U.S. "It's a lot of more stressful here." Sources of stress at work that they experienced included patients' conditions and a heavy workload. Dealing with types of patients that they were not familiar with was very stressful for them. "When I first work over here, and they floated me to 4th floor, you know, I felt scared, you know, working with renal patients, I am not comfortable anymore because it's been a long time. You know, taking care of renal patients. Especially, I always hear code, what's that Dr. Leo, 4th floor, room 499, oh, my God!" In addition, handling heavier patients was stress for them. Compared to patients in the Philippines, U.S. patients were physically heavier on average "…although sometimes it's just doing this medical/surgical and orthopedics is really—we are all overworked. The cases we do is heavy patients."

The heavy workload also increased Filipino nurses' stress levels. Taking care of more than five patients on a regular floor was overwhelming for them. Filipino nurses learned that they were responsible for all aspects of patient care because families in the U.S. usually did not stay with patients in their rooms or help with their basic needs. Taking care of patients' basic care, such as toileting, feeding, and cleaning took away from the time available to provide advanced nursing care such as patient teaching. Filipino nurses had to become accustomed to these additional responsibilities in the U.S. to perceive themselves as fully adapted to U.S. nursing practices. "So, I worked there, I didn't enjoy working there because first of all, they are trying to, because we are under staff." Another participant stated, "This patient has medications is delayed because there [were] other things that you have to do. When somebody calls us, we can't go there right away, because we are cleaning up a patient or giving somebody juice."

Many Filipinos stated that they managed their stress by socializing with other Filipinos. One of the participants who had been in the U.S. for more than 10 years stated that her way of

managing her stress and not becoming overwhelmed was visiting her friends, as illustrated in a field note, “She likes to travel and visit her friends. That seem to be the way she deals with stress from work. She is the first Filipino I have met so far that does not work overtime to support lots of people back home, with Filipinos who were born here being the exception. She has her theory of taking care of herself and not killing herself by over working.” Other Filipinos dealt with stress by contacting their families back home. One participant stated how she felt more connected with her family in the Philippines by calling them daily, which made her fell less homesick. “Every day I’ve been talking to my mother, to my—everyone because I have—you know the Time Warner, this unlimited call everywhere, and I have to pay extra bucks for monthly, just to call them every day. So it feels like they’re here. So nothing much, it’s just that—just this morning I talked to my mother, and talked to everyone. I can talk to everyone I want to talk every day because of that connection, which is nice.”

Facing Mistreatment and Intimidation from Others

Filipino nurses in this study stated that they experienced mistreatment and intimidation from colleagues, supervisors, doctors, as well as from patients and their families. They encountered or perceived mistreatment throughout the processes of settlement; however, they only started to manage this issue during the later adaptation period. To perceive themselves part of the U.S. nursing team; they had to find ways to handle this mistreatment and intimidation. Without the proper ways of dealing with these difficult situations, they felt out of place and used avoidance behaviors like resignation to face their potential problems.

One participant shared her unpleasant experience with an American colleague who was her mentor when she was in orientation:

> Anyway, this white nurse, American she was not nice….She is mean, it was during my orientation, and she was my mentor that time. And I had this patient, dressing needs to be changed. And it was my first time to change a dressing and I don’t know how to change a dressing….So there are four dressing that needs to change. And she is not listening to me. And it supposed to be changed twice a day. So I ended up change it in the afternoon the patient was so pissed. You know I almost cried in front of this patient I keep on apologize and this nurse, White nurse, she didn’t care, and she didn’t care at all. I mean. She just

like oh, you know work for me in my point of view. She didn't understand that I am just an orientee.

Another participant expressed her feelings of intimidation from a male colleague:

I mean if I see him, you can't think that he is a normal person…. I can't even like passing say hi any more…. I can't even see myself working with him and to say hi…. I hope he will never be charge again. I cannot work with him. I don't think I want to work with him any more even if he is not the charge nurse, Julie. I don't feel comfortable…and I just feel so bad because I am not really good at computers really. That's why I stay late most of the time and he is just like banging everything whenever he passed you and sometimes I just I forgot to you know the EMAR to plug the computer. And he just pulls the computer when I am there and just plug it, you know.

The participants felt that nurses' opinions were usually not valued as much as those of patients or doctors in the U.S. "The doctors can be very disrespectful and the administration is so focused on satisfying the doctor because in a small hospital, there's not many doctors wanting to work there because it's a small town, so we have a very abusive behavior." Another participant shared her experience of her supervisor treating complaints from doctors and nurses differently. "They try to satisfied the patient, they don't' care about the nurses…. Same as doctors, if this doctor complains about these nurses, they listen to the doctors and they do something. But for the nurses, the nurses saying this doctor. The doctor is very rude their behavior is not right, they would say 'yeah, we will talk to them, talk to him' and the next day, same attitude, you know, just like they didn't do anything about it. So it's not very fair." Instances such as this made these Filipino nurses feel that supervisors were unfair in their treatment of them.

These Filipino nurses also did not perceive that they received fair treatment from their supervisors in regards to work assignments. One participant shared her friends' story of having been placed as a nurses' aides when she requested that her orientation be extended.

"I learn that…two Philippine nurses, you know, they are kind of slowly catching up, you know. I hate to say that maybe they are trying to be honest. They are just trying to extend the orientation, so they extended. You know what happen? They [the supervisors] let them like be a CNA, you know. Ok, you are going to be our tech for, instead of teaching them to be an RN…. It's not they didn't do it one time, ok? They did it several times. So,

> that's the problem. They asked for extension you know to be oriented as an RN. It's not right. So they are just trying to fill up, you know, the spot. Uh, the tech job doing that to be done by the nurses, it's not right."

Another participant shared her experience of being used by her facility as a nurses' aide and did not receive the proper orientation for nurses. "But my experience is uh, I had a different experience. They hired me as a nurse, right? But when I came here they let me be a tech…nursing assistance…it's make them cheaper I guess…it is cheating, you know. That's why we sue them."

The participants stated that they were contractually obligated to the hiring facility with which they initially signed a contract in order to petition their immigration paperwork. Some nurses in this study who experienced unfair treatment from supervisors or the hiring facilities had to sacrifice their rights to be treated fairly and the freedom to switch jobs in order to complete their contracts.

> "Oh, yeah, you can't complain, you know, because you are tie to them, they are the one who sponsor you, so you have sometimes just say yes…and then what happen is that because we have to leave, we left and we are out of status, because we left the employer cause we didn't like the employer…and, uh, at some point we are not employed, so we have to get another lawyer, we have to find another employer and the lawyer to help us with paper works again. Because at the time we are considerably illegal, just strictly speaking we are considered illegal if you break the contract and you are not working if you come here under their contract and you are not working, for the employers, you know."

As mentioned by the participants, they were generally responsible for paying for their remaining contract if they resigned from their position. Thus, most of them stayed in their positions despite the problems because they did not have the money to 'buy-out' their contracts. Most also choose not to complain because they were afraid of being deported or did not know what their options were. "I did not quit. I stayed; I sacrifice a lot. I suffered a lot. I cried. I

prayed, a lot, just to survive." Most of the Filipinos nurses did not complain because they needed their jobs to support their families back home. "To us, you know Asians or in the Philippines is ok, you know, I guess it's ok, because you know we have to earn, we have to have a job you know, so we try to accept that."

Some of the Filipino nurses in this study reportedly did not receive pay comparable to that of domestic nurses in the U.S. These nurses were either not aware of the pay differentials or were unsure about what to do about receiving unequal pay. Some were so desperate to keep their jobs that they were afraid to mention the lower pay.

> "But of course, being a foreigner, they don't really give you the same equal salary with the U.S. nurses…. At the time, maybe few cents, but at the time, few cents is more money comparing before and now…. And, so maybe now the comparison is maybe few dollars now than comparing 30 years ago…. One year later, we find out, but what can you do? We are lucky to be here anyway so…. Before, we are just—I think at that time, suing the employer is not, I don't know, I never even heard about. We are lucky that we are able to get the job, and they were able to accept us as foreign nurses. Of course, they give us training, too."

Many participants experienced mistreatment from doctors. "I said—do you want to do this, and he goes, why don't you go home and read your book—something like that. I thought—and I cried, and cried." Another participant shared an incident in which she was intimidated by a doctor.

> "It's very difficult. In the previous hospital that I work with, I got scared calling doctors; because we have experience that we get hung-up and we are suppose to carry out the doctors' orders…. And there was a time when I was calling the doctor, when I was still in Houston. I was calling the doctor, it was only like, I think it was like 9 or 10, but the patient's blood pressure is so high. And he was laughing at me and he is very rude, he is, he is probably trying to intimidate me, because he is asking me 'so what does it mean?'… 'So why are you calling me?'"

The participants stated that their relationships with doctors were challenging, especially when they were not yet familiar with how to communicate with them. “Well, in the first few months, it’s not really good [relationship with the doctors] because I don’t know what to do.” Some internalized or rationalized the mistreatment they received from doctors. “…actually, the, it’s not that, they are probably, one time I had, I did, I called one doctor, and probably he is tired, he said, I told him about that IV. It got infiltrated, so I took it out. So I just want a read back, you know, and he said, I told you to leave it out! But then after a while, he says hi, probably he is just tired.” However, as they became accustomed to communicating with doctors, they felt more comfortable and competent to talk to doctors.

Filipino nurses also encountered mistreatment from patients. One participant shared her frustration over an American patient’s unpleasant behavior, “And sometimes, they just—whoever the person that they see, the first thing they see is they throw everything on you, and they bark on you. It’s like, why me? Here I am trying to take care of you, and of course, you don’t tell them that, but within your heart and in your conscious, that’s how you feel.” Even though they understood that patients were sick and the family was appreciative, it was still hard to take verbal abuse from patients. “It strikes with your ego. It’s hard, but later on, you can understand. Although they appreciate you, as a family, but when the time it goes with a patient, the patients were going to do the verbal abuse for you. It’s hard to accept it at the same time, but that’s the only—well, it’s a challenging experience, too.”

Another participant shared her experience with a patient:

> Or one time I had to start IV—actually I had to Hep-Lock. Convert the IV fluid into a Hep-Lock, and I forgot to put the pressure at the site so the blood is coming out. So I said, “I’m sorry, I’m sorry.” And that patient was one of the employees there. She’s not a nurse…. Yeah. I said, “I’m sorry, I’m sorry.” I had to clean the site and she’s like, "I was fine until you came." Yeah, so that was, “Oh, yeah. I was fine until you came.” I will never forget that. I remember—and I think it’s a human nature that you remember the bad

> first rather than the good, do you see. So that kind of thing. She can give me smile in the hallway or whatever later on, I still remember…. What she said to me at that time…I didn't know what to say. I was speechless. And every time I go back into that room, I feel very—she doesn't want me there. So it was hard for me.

Conquering Racism

Feelings of alienation from the main stream culture were mentioned by the participants. They described the alienation as something they could feel, not all the time, but it was there. One participant described racism when she stated, "There are, there are, but not a whole lot. Not a whole lot, but there are. You could feel it." Other participants perceived racism in everyday life,

> You will encounter people that are racist. Because of the color of your skin, you are not an American, so really they, but there is just few of them, because your experience there, sometimes people were hurt, they just come out. But of course as an alien here in this country you have to get used to it. That's what we are telling our kids you know, you are brown, you are not an American, you have to get used to it. There will be racists, you know there will be, you know, it's horrible" "Because it's not, you're different—it's not your same color. The different attitude towards, you know?"

Some participants experienced either perceived or actual racism at work. "Like in New York, I mean, the Blacks will discriminate. Oh, if the Blacks will discriminate people, like Asian and stuff, but if it was the Black, the White, and the Asian, they'll go with the Asian. They don't want to go with the White at all. They don't want to take sides with them. So they'll take sides with us, but if the White will have to choose between the Black and the Asians, sometimes they'll take sides with us, but not a lot." Sometimes, they rationalized and accepted the fact that this was not their country, and they belonged to a different group. "It's just a feeling…. Yeah, like you're not in the group. What can you do? I said, 'Yeah, this is not our country. This is not—we weren't born here.' So I said, 'Okay, we're just sat back. That's it. It's their country. It's their nation, so, okay." Their feelings of alienation were stronger when they first arrived in

the U.S. and if they lived in an area populated primarily by Whites. My field notes demonstrated the surprise of one participant, “I was surprised that she had such a hard time when she first arrived due to language barrier and cultural differences. She worked at a small town as her first job where there were not many foreigners. She felt not welcomed been a foreigner, perhaps the people there felt like she and other Filipinos took jobs away from them. Patients get frustrated if they don’t understand nurses from other countries.” Filipino nurses learned to recognize racism as a problem and found ways to overcome it in their later stages of adjustment to their nursing roles. They handled it by using effective confrontation and networking with others. This helped lessen their feelings of alienation, and thus, helped them adjust to nursing practices in the U.S.

COMPOSITE EXEMPLAR CASE

The following exemplar case was constructed from a combination of all the participants’ stories to help explain the theory that evolved from this study. In 2000, Marian graduated from the University of Philippines in Manila. While she was obtaining her education, she spoke to her instructors who had obtained their Master’s or Doctoral degrees in nursing in the U.S. She also had two cousins who practiced as nurses in the U.S. and had told her about American nursing. In addition, she had heard that becoming a nurse in the U.S. was a dream of many in the Philippines. She wanted to go for an adventure in the U.S. to advance her nursing career and help her family financially. She believed that going to the U.S. would make her dreams come true. She was told by her cousins that recruiting agencies would not hire her without some experience in the Philippines.

Because she was so excited about being nurse and her desire to work as a nurse in the U.S., she started to look for a job in the Philippines right after graduation. Having had a hard time finding a staff nurse position in the Philippines, Marian decided to serve as a volunteer nurse to get her foot in the door at a government hospital. She thought that 6 months would be enough to earn her a full-time position; however, she served as a volunteer nurse for 2 years before she found work as a full time staff nurse. While serving as a volunteer nurse, she

witnessed how poor Filipinos were. They could not pay for their medicine, treatments, or even food, sometimes. The quality of care was very poor and orders were not carried out in a timely manner. She took care of 60 patients at a time under a staff nurse's supervision. She was always busy and did not have time to take breaks. The staff nurse who supervised her was not very nice to her. She realized that this was just the way it was there and did not complain.

Finally, Marian was able to practice as a staff nurse at the government hospital for which she volunteered. While serving as a staff nurse, she witnessed more incidents of the poor quality of care in the Philippines. She started to think, "Nursing must be better in America—at least that's what I have heard.'" She decided to go forward and look for a job in the U.S., as her cousins had. She gathered information from her cousins and found a recruiting agency that offered her a job. The agency told her that she had to pay for everything out-of-pocket and once she arrived in the U.S., she would be reimbursed by the facility. She thought, "Wow, what a nice offer! Coming to America must be worth it. They're actually going to pay for my exams and travel expenses!"

Marian quit her job at the government hospital after two years of service because she wanted to concentrate on preparing for her exams. She passed the CGFNS, the Test of English as a Foreign Language, the NCLEX-RN, and the writing in English exam. Unfortunately, she had difficulty passing her Test of Spoken English exam. She tried and tried, and was finally able to pass it the third time. She thought, "If it is this hard to go through all the steps to go to the America, it must be good. Why would people keep on going over there if it is not good?" She borrowed money from her parents and paid for all the fees for taking the required tests, as well as her airline ticket. She assumed that she would be reimbursed when she arrived in the U.S. because that was what she was told. She planned to pay her parents back after receiving her reimbursement.

Marian arrived in El Paso, Texas in the summer of 2005. She was told by the hiring agency that there was a group of Filipinos working in El Paso. However, when she arrived at the airport, not one Asian was there. She became scared and confused. "This is different! Where are

all the Filipinos?" The recruiting agency was supposed to arrange someone to be at the airport to give her a ride to the hotel where she would stay temporarily. She waited and waited, but no one showed up. She became more scared and decided to call her cousin who was working in Dallas at the time. Luckily, she was able to get a hold of her cousin, Joanna. Joanna finally arrived at the airport 12 hours later. Marian told Joanna what the agency promised her and how scared and confused she was at the time. Joanna helped her get settled and found an apartment for her.

Marian tried to get in touch with the contact person from the hiring agency, but he was nowhere to be found. Marian thought, "What about the promises you made? What about my reimbursement? This isn't fair!" Marian then contacted the agency in the Philippines, but they could not help her much since the agency was U.S.-based. Marian called Joanna and told her what had happened to her. Joanna advised her to forget about it because she would be wasting her energy, and adjusting to her new job should be her priority. Marian was not happy, but accepted that adjusting to her work should be her priority. Marian contacted the hiring facility and talked to the unit manager in charge of the unit for which she was hired to work.

Marian walked to work because she did not know how to drive. It was summertime and the temperature was 90-100 degrees. Marian had to walk 20 minutes to get to work. She thought, "All this would pay off once I become an American nurse and make lots of money." She did this for the first month. After five days of classroom orientations, she met with the unit manager and the manager introduced her to her preceptor, Michael. Michael was a Caucasian nurse who was born and raised in El Paso. On the first day of her orientation, Michael told her, "You will have rooms 1 to 5. Let's start by introducing yourself to the patients." Marian thought, "I don't know how to introduce myself, and I didn't do that in the Philippines. But I guess it shouldn't be too hard if he just told me to do it."

She went into the first room by herself, and started to speak to the patient, a 70-year-old Caucasian woman. After two sentences came out of her mouth, the patient said, "I do not understand a word you are saying! Are you speaking English? Are you going to be my nurse? I don't want you to take care of me because I don't understand you! Get me an English-speaking

nurse!" Marian was speechless. She felt insulted. A patient would not speak to her that way in the Philippines. She did not know what to do, so she went to her preceptor. Michael told her, "Oh, she is just like that, you will get used to her." Michael then said, "How about you go give Rocephin in room 3. It is due in 20 minutes." Marian had never been exposed to an IV pump before and she did not receive training on IV pumps during the classroom orientations—only in textbooks. She did not know how to operate an IV pump or understand the medicine to which Michael referred. She became extremely frustrated and started crying in the staff bathroom.

She then decided to talk to the unit manager about the difficulties she was having. The manager told her, "Oh, how about you start with being a nurse's aide. Then you will learn." She did not know how to respond and just agreed with the manager. While functioning as a nurses' aide, Marian had to ask for help from other aides because she did not know how to use a vital sign machine. She did not get much help, and was scolded by another aide, "No, I am busy, too. I thought you are a nurse in your country. Don't you know anything?" She was again speechless and remained silent. She started to think, "Maybe I should just give up. No, I have gone through so much. I must stay. What about the money I borrowed from my parents and spent?" She decided to stay and just work harder to prove herself to others. She was working as a nurses' aide for one month. She still did not know how to function as a nurse after one month of orientation because she was forced to work as a technician. Feeling helpless, she started to look around for other Filipino nurses. She found Mattie, who had just come back from out of town. Mattie had been a nurse in the U.S. for 5 years. Mattie offered to help Marian by giving her a ride and showing her around. She also talked to the manager for her and offered to be her preceptor.

Marian felt 100% better to receive orientation from Mattie rather than Michael. She learned a lot from Mattie and was able to operate medical equipment. She also slowly learned to overcome her shyness and become accustomed to living as a Filipino American. Mattie taught Marian how to 'please' American patients so that she was able to interact with her patients without being rejected. After another month of orientation, Marian was able to complete her nursing tasks on time. However, she was scared to answer the phone or call doctors. She would

always stay away from the nurses' station to avoid answering the phone. She was also uncomfortable giving recommendations for her patients to doctors. She was confused about why American families left their family members in the hospital and never helped with their basic needs because that was how it was done in the Philippines. She was also puzzled as to why American nurses always documented their activities.

She decided to talk to her preceptor, Mattie, to address her questions. She also learned how to communicate with her colleagues and doctors by observing Mattie. Mattie shared with her a story about a lawsuit in which she was involved because a patient developed a blister from a sequential compression devise after surgery. She also told Marian the importance of detailed documentation and critical thinking, as well as acting independently at work. After the conversation with Mattie, Marian was able to reinterpret her perceptions of nurses' roles in the U.S. The meaning of being a nurse in the U.S. evolved from her naïve interpretation built on stories told by her family while in the Philippines.

One and half years after Marian's arrival in the U.S., Marian perceived that she was finally competent as a nurse in the U.S. She was able to justify her approach of interacting with patients, coworkers, and doctors. She was able to overcome her initial perceptions that she was abused by others, and adjusted her reactions after learning the cultural differences and expectations. She was able to use assertiveness in an appropriate and effective manner after she learned how to interact with others successfully, instead of merely reacting to others' behavior and verbal content. Reflecting on her memory, Marian thought, "American nursing is different, although patient care was similar. I make more money here as a nurse, but I also deal with higher level of stress. If I have a choice to start over again, I am not sure that I would take the same route, knowing how many obstacles I had to overcome. Now that I am here, I don't know if I can ever go back. The Philippines is so poor and the quality of care is not good. I have gone through so much to be here. I am not going back to start from point zero. I will stay here and maybe I will help my sister to come to the U.S., too. However, I will make sure to find her a reliable agency so that she will not have to go through what I went through."

Marian's transition story provides a summary of the typical process a FNG goes through when first coming to the U.S. Her transition path would have been much easier if the hiring facility had helped her settle in and the agency had kept their promises. Her adjustment to work would have been much smoother if she had had a more understanding and supportive preceptor. Having Mattie as her preceptor helped her tremendously in adjusting to her new environment and to American culture because Mattie went through the same process she did.

SUMMARY

This chapter presents a substantive theory to explain the course of Filipino nurses' transition and adjustment to U.S. nursing practices. Relational categories linked to the core variable 'transitioning from Filipino to U.S. nursing practices' evolved as data were being collected and analyzed. Filipino nurses learned to adapt to U.S. nursing practices by learning to understand American culture, their new work environments, and the U.S. healthcare system, as well as overcoming other personal obstacles. They overcame these difficulties by learning to be assertive, which increased their confidence in living and working in the U.S. After Filipino nurses adjusted to U.S. culture and work, they perceived themselves as more comfortable and competent to practice nursing in the U.S. This substantive theory explains the social processes by which Filipino nurses came to adjust to their roles as nurses in the U.S. Filipino nurses' experiences and educational contexts in the Philippines was the root of their perceptions about nursing in the U.S. Their meanings of U.S. nursing practices evolved throughout the process of transitioning from their roles as nurses in the Philippines to their roles as nurses in the U.S. Their transitions were affected by the perceptions that they held in the Philippines about practicing nursing in the U.S. They used skills obtained in the Philippines as the foundation upon which to interpret problems they encountered and their reactions to others. In addition to previous experience, the decision to migrate to the U.S. was also part of the process of how Filipino nurses transitioned into U.S. nursing practice. Other relational categories included adjusting to life in the U.S., adjusting to their new work environments, adjusting to cultural differences,

breaking through communication barriers, becoming accustomed to the U.S. healthcare system, adapting to interpersonal relationships, and overcoming other obstacles. These factors were interrelated and shaped how Filipino nurses' viewed their roles as nurses and how they shifted their practices from their home country to the U.S. The exemplar case illustrated a typical scenario of how a Filipino nurse might became employed in the U.S. and then transition from her role as a nurse in the Philippines to her role as a nurse in the U.S.

CHAPTER 5: DISCUSSION

INTRODUCTION

The purpose of this study was to explore the social processes contributing to RN role performance in FNGs from the Philippines currently practicing in the U.S. Thirty-one Filipino nurses were interviewed for this study, including three in a previous pilot study. All participants had experience as either volunteer nurses and/or staff nurses in the Philippines and were currently practicing full time as staff nurses in U.S. hospitals at the time data were collected. Initially, participants who met the inclusion criteria were recruited and interviewed about their experiences, as well as their roles as nurses in the Philippines and in the U.S. After the PI formulated the initial substantive theoretical framework, theoretical sampling took place to locate individuals who had the potential to strengthen the relationships among relational categories, as well as the evolving theory. Specific questions were also asked in later interviews to fill the gaps in the emerging theory.

The initial research question was "how do Filipino nurses come to perceive their roles and adjust to roles as RNs in the U.S.?" and the initial specific aims of this study were "to explore Filipino nurses' perceived role performance in the U.S." and "to generate a theory describing factors that contributes to Filipino registered nurses' role performance in the U.S." After interacting with the participants, the PI revealed that the participants' description fit better with the re-stated specific aim "to explore how Filipino nurses perceived their role performance in the U.S." Although the PI initiated the study with the specific intent of discovering Filipino nurses' perceived role performance, participants shared what were perceived as important to them at the time of data collection, which focused on how they transitioned and adapted to their roles as a U.S. nurse.

The PI utilized memos, field notes, diagrams, and verbatim transcriptions in the analysis. She communicated with her advisor regularly in person and via e-mail to ensure the trustworthiness of the data analysis. After interacting with the data with a constant comparative method, the core category 'transitioning from Filipino to U.S. nursing practice' emerged. The substantive theory includes nine relational categories that explain the social processes by which Filipino nurses in this study came to adjust to nursing practice in the U.S.

The results of this study showed the difficulties that Filipino nurses faced adapting to their roles as nurses in the U.S., as well as some strategies they used to cope with these challenges. The results may help hospital administrators and nurse educators improve their orientation for newly hired Filipino nurses, as well as other FNGs from countries in Asia. FNGs may also find the results beneficial; they may benefit from learning of the experiences of others who have transitioned to successful nursing practices in the U.S. Additionally, the findings may enhance understanding of Filipino nurses by those who work with them to improve their interactions, relationships, and communications with Filipino nurses.

This chapter explores the connections between existing knowledge and the results of this study followed by a discussion of how the emergent theory ties to existing knowledge. The topics discussed include characteristics of Filipino nurses, nursing education in the Philippines, healthcare in the Philippines, the decision to migrate to the U.S., settling into life in the U.S., adjusting to new work environments, adjusting to cultural differences, overcoming communication barriers, becoming accustomed to the U.S. healthcare system, adapting interpersonal relationships, and overcoming other obstacles. Learning the nurse's roles in the U.S. is covered in detail because this study is about how Filipino nurses made their role transitions in becoming a nurse in the U.S.

CONNECTIONS BETWEEN THE THEORY AND THE LITERATURE

The literature review in chapter 2 presented what is currently known about Filipino nurses' migration to and experiences in the West. However, it was unclear how nurses from the Philippines perceived their work environment in the U.S. and what effects these perceptions may have had on their role performance in the U.S. Filipino nurses' perceptions and meanings about nursing in the U.S. were based on their interactions with others during the course of their migration was incorrect. In this chapter, the PI re-examined the literature in light of these interactions. The next section covers the core variable, 'transitioning from Filipino to U.S. nursing practice' and how it relates to existing studies.

Studies about the transitioning of nursing practice from one country to another were not identified in the literature reviewed, which was surprising given the importance of its role in explaining the social processes that contribute to role performance in FNGs. This lack of literature confirmed that there is a gap in the literature. According to the literature reviewed, nurses from other countries, like those from the Philippines, may encounter hardships associated with cultural dissimilarity, language barriers, diversities in nursing practice, and differences in social norms. For instance, Xu (2007) presented a meta-synthesis of 14 qualitative research studies with an in-depth summary of immigrant Asian nurses' working experiences in Western countries. The major themes identified included: "(a) communication as a daunting challenge; (b) differences in nursing practice; (c) marginalization, discrimination, and exploitation; and (d) cultural differences" (Xu, 2007, p. 246). Other challenges identified were: adapting to interpersonal relationships, uncertainties about differences in nurses' roles, and feelings of alienation (Daniel et al., 2001; Ea et al., 2008; Yu, 2007). Filipino nurses in this study also experienced these differences.

The substantive theory developed in this study includes nine relational categories: (1) acquiring nursing knowledge and skills, (2) deciding to migrate to the U.S., (3) settling into life in the U.S., (4) adjusting to new work environments in the U.S., (5) adjusting to the cultural differences between the Philippines and the U.S., (6) overcoming communication barriers, (7) becoming accustomed to the U.S. healthcare system, (8) adapting to interpersonal relationships, and (9) overcoming other obstacles. Similar to existing study findings, this study showed that cultural differences, communication barriers, interpersonal relationships, differences in healthcare systems and nurses' roles, as well as other obstacles, including racism, were challenges that Filipino nurses encountered during their adjustment to working in the U.S. This study also showed that how Filipino nurses acquired their skills, made their decisions to migrate, and handled their initial adjustment period were a part of the social processes that contributed to these nurses' role performances in the U.S.

Characteristics of Filipino Nurses

Asian nurses who work overseas are usually female, married, full-time workers, who are between the ages of 23 and 40 (Berg et al., 2004; Perrin et al., 2007; Withers & Snowball, 2003). The average age of the Filipino nurses in this study was 36 years, which was similar to the ages of participants in previous studies. Furthermore, in their study on Asian American nurses, Berg et al. (2004) found that Asian nurses who worked in the U.S. usually held Bachelor's degrees in nursing (78%), worked full-time (82.9%), and would choose to become nurses again (80%). The majority of the nurses in this study held a Bachelor's degree or higher (94%) and worked full-time (100%), both of which were higher than in the study by Berg et al. (2004). This may be due in part to the small sample size in this study (N = 31). Because grounded theory is a methodology that aims

to explain socio-psychological and socio-structural processes (Stern & Govan, 2001), the representation of a population is not relevant to the conceptual development of a phenomenon; therefore, it was not a concern of this PI.

The following sections present how the theory that evolved relates to existing studies, discussed in order, from becoming a nurse in the Philippines to their arrival in the U.S., and finally, becoming a nurse comfortably practicing in the U.S.. The sections are divided into the following: prior to arrival to the U.S., arrival to orientation, early adapting period, and later adapting period.

PRIOR TO ARRIVAL IN THE U.S.

Filipino nurses started to conceptualize their perceptions, meanings, and expectations about U.S. nursing, prior to their arrival in the U.S. while obtaining their nursing education or gaining work experience. After they interacted with others in the Philippines, they learned more about U.S. nursing. Next, they began the process of decision-making to migrate to the U.S. These nurses had very different views and expectations of their jobs as nurses than those who were educated and trained in the West because of their cultural backgrounds, previous experiences, or education. This context affected these nurses' perceptions and meanings about U.S. nursing, and as a result, influenced the transition of their practice from one country to the other. However, nurses' educational backgrounds or work experiences in their homeland and the subsequent influence these might have had on transitioning their nursing practice were not included in the existing empirical studies reviewed. The following section presents the existing literature and its connections within this context, which includes education in the Philippines, healthcare in the Philippines, characteristics of Filipino nurses, and reasons for coming to the U.S.

Nursing Education in the Philippines

Most hospital training schools in the Philippines were managed by U.S.-trained chief nurses, and followed an American-style nursing curriculum (Brush, 1995; Ordonez & Gandeza, 2004). In addition, many early nurse leaders and educators were either Americans or Filipino nurse graduates educated in the U.S. (Spangler, 1992), which formed the root of nursing education in the Philippines. This statement is supported by the participants interviewed in this study. In fact, as mentioned by many participants in this study, the nursing schools they attended used English textbooks and English as the medium of instruction. In addition, these nurses received English education that dated back to grade school, which increased their exposure to the English language. Prior research indicates that RNs from the Philippines may be socialized to Westernized healthcare systems because they were trained by Filipino chief nurses educated in the U.S., which may influence their perceptions of their ability to perform RN roles in the U.S. (Ordonez & Gandeza, 2004). Participants in this study showed their perceived ability to adjust to the U.S. healthcare system and nursing practice were influenced by their exposure to English and U.S. nursing practices. This also facilitated their motivation to migrate to the U.S. to work as a nurse.

Healthcare in the Philippines

The Philippines have struggled with partial success to provide their people with better healthcare against insufficient resources. Leading causes of inadequate health outcomes and quality of healthcare in the Philippines include: (a) poor healthcare financing; (b) an improper health service delivery system, including an insufficient system for providing public health; (c) a brain drain of health professionals to developed countries; (d) excessively high prices for medicines, leading to high out-of-pocket costs; (e) inadequate enforcement of regulatory mechanisms; and (f) inadequate efforts to

prevent and control new diseases, particularly non-communicable diseases (WHO, Philippines, 2005). The vivid stories shared by the participants in this study echoed some of the above causes. For instance, they identified problems with healthcare in the Philippines as shortages of medical supplies, poor quality of care, and shortages of nursing staff.

In addition to insufficient resources, the 'brain drain' made the existing shortages of nursing staff in the Philippines even worse. For instance, the University of the Philippines-Philippine General Hospital loses 300 to 500 nurses from the workforce every year (WHO, Philippines, 2005). Females were the majority of those emigrating from the Philippines in the mid-1990s, and 14% of them were nurses (Ball, 2004). Brain drain was mentioned by the participants in this study in the form of losing experienced nurses and nurse leaders. In fact, many of the participants in this study were nursing instructors in the Philippines, including one who had a doctoral degree and was a faculty member and researcher at a Filipino university. These losses may create an extra burden on educational institutions attempting to improve or even maintain their quality of nursing education, as well as healthcare agencies trying to provide quality care to the Filipino public.

The health problems in the Philippines are, to some extent, different from those in the U.S. The leading causes of death in the Philippines are related to acute infectious diseases (Department of Health, 2005), whereas the leading causes of death in the U.S. are the development of chronic diseases (CDC, 2005). These differences in the nature of disease and the nursing care related to such diseases or conditions may be so diversified that they require different approaches in planning and implementing care. For example, the nursing problems for acute, watery diarrhea would be very different from those for stroke. Without further orientation, Filipino nurses' experience with caring for patients

could be limited to what they were exposed to in the Philippines, which was primarily acute illnesses. They might need to learn how to take care of patients in the U.S. who have multiple chronic illnesses and health problems. One of the participants in this study actually stated her surprised in having to send an 80-year-old patient who had some underlying medical problems to surgery.

The Decision to Migrate to the U.S.

In previous studies, reasons that Asian nurses migrated to the West were presented as either 'push' or 'pull' factors (ICN, 2007; Kline, 2003; Lorenzo et al., 2007). Push factors are circumstances in the FNGs' countries that drive them to emigrate. The major push factors are as follows: poor economic conditions, high job stress, and socio-political instability in the country of origin. Thomas (2006) discovered the reasons that Indian nurses migrated to other countries, including a poor native economy, dissatisfaction with working conditions, and unhappiness with prevalent social attitudes towards nurses in India. This might also be true for Filipino nurses because the economic conditions were perceived to be poorer in the Philippines and working conditions as inferior to those in the U.S., according to the participants interviewed. Filipino nurses in this study went through several steps to make their final decisions to migrate to the U.S. after they acquired nursing knowledge and skills in the Philippines. The factors that pushed them to migrate to the U.S. were poor economic and social situations in the Philippines, poor working conditions, and few job opportunities, which were similar to previous studies.

On the other hand, pull factors are circumstances in the receiving countries that inspire FNGs to seek employment there. The major pull factors are better economic conditions or financial compensation, better work environments, opportunities for

professional development, educational opportunities, adventure travel, and socio-political stability in the receiving countries (Daniel et al., 2001; Kline, 2003; Mejia et al., 1979; Withers & Snowball, 2003). Similar factors attracted Filipino nurses to come to the U.S. These included: advancing one's nursing career, improving family life, better pay, and better opportunities. Filipino nurses in the study by Gonagle et al. (2004) intended on working in the UK and sending money back home, which was one of the major incentives for going abroad to work. Filipino nurses in this study expressed similar reasons for entering the U.S. One reason mentioned by Filipino nurses in this study that were not mentioned in previous studies was 'witnessing other Filipinos' migrate.' While 'better work environments' and 'socio-political stability in the receiving countries' were not expressively mentioned by participants in this study, most of the participants either desired, or were encouraged by others, to come to the U.S.

ARRIVAL AT ORIENTATION

Working environments and organizational structures were identified as important factors when considering work expectations in a hospital in the UK (Daniel et al., 2001; Gonagle et al., 2004). Filipino nurses in this study experienced similar adjustments. Their adaptation started with settling into their lives and then adjusting to the new work environment, which took place from their arrival to the completion of their orientation as a newly hired nurse.

Settling into Life in the U.S.

In their study of Asian nurses, Withers and Snowball (2003) concluded that nurses' expectations about earnings and living conditions had not been met and might have led to their dissatisfaction. Nurses' attitudes and behaviors might also be affected by these unmet expectations, which might lead to their resignations from their jobs.

Information about health insurance, shelter, and transportation appeared to be lacking for the FNGs in Gonagle et al.'s (2004) study, which may have led to feelings of surprise and bewilderment. This is also true of nurses in this study. They did not have information about the jobs they were hired for in the U.S. or a place live when they arrived. Also corresponding to Gonagle et al.'s study, some of the nurses in this study did not receive assistance from their recruiting agency or hiring facility, which created frustration and confusion, which might have delayed their adjustment to their new work environments. Some participants had to find their own apartments and modes of transportation when they arrived, which was problematic for them. These negative events created changes in their perceptions and meanings about U.S. nursing. This may have been prevented if they had been provided with realistic descriptions of what to expect when they arrived. Hence, if they are not provided with basic transportation, housing, and basic necessities then they can be prepared to make these arrangements when they arrive.

Adjusting to New Work Environments

Nurses in Gonagle et al.'s (2004) study did not receive information about common working conditions, pay, or resources that might be accessible in the country of employment. Some participants in this study also did not receive this information from their employers or recruiting agencies, or they received information they later found to be false. These questionable interactions influenced their views and meanings about U.S. nursing and life. Without positive support from their hiring agencies, Filipino nurses experienced unplanned maladjustment that led them to seek out others for help. Filipino nurses in this study reached out for others' support, especially from other Filipinos, which they found helpful in adjusting to their new work environments, especially during orientation and immediately after orientation. Yi and Jezewski (2000) found a similar

pattern in Korean nurses. Hence, it might be useful to arrange a preceptor for FNGs, including Filipino nurses, who is from the same cultural or ethnic background when possible. This may help the new nurse feel more comfortable and less threatened when they have questions or need guidance when adjusting to practicing in the U.S. Withers and Snowball (2003) also found that supportive mentors or preceptors were viewed as beneficial because they provided advice and assistance to newly hired Filipino nurses. Having a good preceptor was very important for Filipino nurses to adjust, especially when they first arrived. They learned well from their mentors. When they saw other Filipinos succeeding at work, it was empowering to them. Thus, hiring agencies should actively encourage newly hired Filipino nurses to look for other Filipino nurses employed at the facility and facilitate the formation of such relationships. They may also provide these nurses useful resources such as local Filipino churches or Philippines Nurses Associations for additional support.

In addition to learning from others, Filipino nurses had to adjust to the medical equipment and technology that is used in the U.S., which were perceived by the participants to be far more advanced than in the Philippines. They may have seen this medical equipment in textbooks, but they were never exposed to the equipment in their native nursing practice. Allowing them to familiarize themselves with the medical equipment and technology during orientation, before allowing them to take patient assignments, may decrease their uneasiness and stress levels. If they feel comfortable and competent to handle medical machinery and technology, their confidence levels may increase, and their anxiety levels may decrease.

EARLY ADAPTATION PERIOD

Ordonez and Gandeza (2004) mentioned that Filipino nurses were more likely to stay away from conflict and were scared of disagreeing with authority, such as nurse managers or directors. They may be perceived as avoiding relationships with others because of this avoidance. Participants in this study used avoidance as their first reaction to conflict, especially during this early adaptation period. They shared that being shy and less vocal at work was one of their personal obstacles. They had to first become less introverted and more accustomed to living as Filipino Americans to adjust to the cultural differences between the two countries. They also had to become accustomed to making their patients the center of their nursing care. To practice patient-centered care, Filipino nurses had to learn how U.S. families involved themselves with patient care, how patient confidentiality and privacy were handled, and how pain management was handled in the U.S.

Adjusting to Cultural Differences

Culture is an influential construct that refers to the learned and shared knowledge of values, beliefs, customs, and life ways of a specific group that are normally passed on from generation to generation (Spector, 2004). Culture persuades the ways people communicate, behave, believe, and act. Therefore, the clash of Filipino nurses' culture, and the local culture in the U.S. where they practiced, often created conflicts and made it necessary to adjust and find ways to cope. Cultural adjustment implies continual adaptation to the new culture. Positive adjustment would mean that immigrants and residents of the receiving country mutually accept each other's cultures, and that immigrants assimilate to the host culture, whereas negative adjustment implies the rejection and alienation of the immigrants by residents of the receiving country or vice

versa (Ea, 2008). To avoid misunderstandings with their patients, nurses were advised to learn to adjust and meet patients' perceived needs (Spector, 2004).

One of the biggest challenges working overseas is adapting to the new environment and culture. In a descriptive correlational study, Ea et al. (2008) found that Filipino participants' job satisfaction had a moderately positive correlation to the level of acculturation. Thus, it is essential to pay attention to FNGs' cultural milieu to uphold their adaptation into the practice of American nursing (Dijkhuizen, 1995; Kinderman, 2006). A newly employed nurse usually feels confused about the organizational culture of the institution where she is employed (Khoza, 2005). This is true for FNGs, including those from the Philippines, because they were not familiar with the U.S. healthcare structures and the local culture. Filipino nurses in this study expressed challenges in learning patient-centered care.

Filipino nurses in this study were accustomed to patients' family members in the Philippines staying with patients who were hospitalized, whereas family members in the U.S. had less involvement with patient care. This finding is comparable to the findings of Yi and Jezewski's (2000) study of Korean nurses, who were "puzzled, confused, and frustrated" with the lack of family involvement. Filipino nurses were surprised and also frustrated when they realized that family members in the U.S. did not help with beside nursing care like families in the Philippines and actually demanded nursing care be provided in ways that the families expected. Some Filipino nurses felt less professional as a nurse in the U.S. because they were performing tasks that family members would normally do in the Philippines. Similarly, in a phenomenology study, Gonagle et al. (2004) found that Filipino nurses might take for granted that families in the UK will take care of the basic needs of hospitalized patients. Daniel et al. (2001) also found that patients' families or relatives in the UK rarely took care of their personal needs, such as

hygiene and feeding. These additional expectations created a greater workload for the Filipino nurses than they expected.

Filipino nurses, like many other Asian nurses, have a strong family orientation and they treated other nurses of the same ethnicity as family when they were overseas (McLaughlin & Braun, 1998). This was evidenced in participants in this study because many of them received assistance from other Filipinos either in life or at work. In their summary of the healthcare beliefs, behaviors, and practices of Filipino nurses in the U.S., Ordonez and Gandeza (2004) explained how nurses primarily socialized with other Filipinos, which significantly reduced the amount of interaction they had those from Western cultures. Participants in this study also mentioned that they preferred to mingle with other Filipinos and ask them for help rather than people of other ethnicities. This attitude may negatively influence their cultural adjustment because of the decreased contact with local communities.

Filipino nurses, like other Asian nurses, become more acculturated to Western healthcare systems when they move to the West; however, their traditional values and cultures still affect their daily practices, beliefs, and behaviors (Ordonez & Gandeza, 2004). It is beneficial because it heightens their sensitivity to the culture and beliefs of others based on their process of adjusting to a different culture. However, their own values and culture may create potential conflicts when caring for patients and their families, if they fail to recognize these conflicts and handle it in a professional manner. Many participants stated that they were able to successfully adjust to American culture once they had been in the U.S. for a time and learned American culture. However, several participants who had been in the U.S. for more than five years mentioned that they continued to dislike the lack of family involvement with patient care and patients' demands for pain medication. These conflicts remained even after they perceived that

they had adjusted to American culture. Therefore, one could argue that a person from a different cultural or ethnic background may not become completely acculturated to another culture. Thus, it is a wise idea for Filipino nurses who are planning to come to the U.S., or who are practicing in the U.S., to remain aware of their own values and beliefs when caring for patients and their families. Ea (2008) suggested that administrators and employers should debate implementing 'acculturation programs' that are believed to be helpful to foreign educated nurses so that they easily transition to the U.S. healthcare system, as well as to society generally. Administrators and nurse educators should also consider integrating cultural training into their new employee orientation programs to help foreign recruits accommodate these challenges more effectively.

Overcoming Communication Barriers

Some of the results of this study related to communication were similar to previous results reported by other researchers. For instance, in their study of Korean nurses, Yi and Jezewski (2000) found that overcoming language barriers was one of the relational variables. They discussed communication barriers in-depth, including different accents, pronunciation, medical terminology, and telecommunication, in addition to language barriers. Furthermore, in Xu's (2007) meta-synthesis of Asian nurses, examples of 'communication as a daunting challenge' included lack of skill with accents and use of informal language; difficulties in telecommunications; the domino effect of communication deficiency; and accent and communication deficiencies as grounds for discrimination. Filipino nurses, like other Asian nurses, may also experience difficulties in communicating with others due to the various accents and pronunciations, as well as the use of slang (Ordonez & Gandeza, 2004; Xu, Gutierrez, & Kim, 2008), medical jargon, abbreviations, and terminologies (Daniel et al., 2001). In Daniel et al.'s (2001)

study, nurses experienced the use of verbal orders rather than written ones, as well as differences in medication names. They may have been embarrassed to talk or were afraid to ask questions because they had difficulties communicating in English. Nurses in this study experienced similar communication problems as these studies, including difficulties with telecommunications, accents, slang, pronunciation, medical terminology, and differences in the names used for medications. Indeed, several participants mentioned their fear of picking up the phone or calling doctors due to the language barrier.

Filipino nurses had to overcome their communication barrier to move on and adapt to U.S. nursing practices. Yi and Jezewski (2000) found that Korean nurses were not able to function competently without proficiency in the English language. This was also true for the Filipino nurses in this study. They had to be able to understand doctors over the phone in order to receive telephone orders. Because of the lack of non-verbal cues, telecommunication was incredibly hard for Filipino nurses, especially during their first year of adjustment. Adjusting to different accents and the use of medical terminology were also required to carry out nurses' responsibilities efficiently and accurately. They also had to communicate well in English to stand up for themselves when needed. Communication skills formed the foundation for Filipino nurses in overcoming many potential obstacles, such as intimidation from others, becoming accustomed to the healthcare system, and adapting to interpersonal relations. Although English was used as the medium of instruction in grade school, as well as in their nursing education, as mentioned by many participants in this study, it was not used as the language of communication in their home settings in the Philippines. They learned English and medical terminology mainly from textbooks.

Filipino nurses attempted to overcome communication barriers by asking others to clarify or to teach them to say it correctly. Previous studies did not explicitly mention

how Asian nurses dealt with their emotions. In this study, Filipino nurses 'buried' and internalized their frustration and went on to learn to adapt to and keep their jobs. They cried and dealt with their emotions at home or shared them with other Filipinos and their families back home. They tended not to show their negative emotions to others at work because it was culturally unacceptable to bring personal problems and emotions to the workplace. As a result, they had trouble understating informal English, or slang, as well as many idioms. They learned from natives how to communicate in the U.S. and thus became accustomed to the ways Americans communicated in life and work settings only after they been in the U.S. for a while. This is when they felt more comfortable in communicating with others.

Becoming Accustomed to the U.S. Healthcare System

Filipino nurses were not aware of the legal aspects of U.S. healthcare when they first arrived because it was not an issue in medical/nursing practice in the Philippines. Xu (2007) identified the legal environment as one of the differences in nursing practice. Participants in this study were stressed and scared when they heard about lawsuits. Hospital administrators could help them by including a legal component in their initial orientation processes. Increased awareness of the legal aspects of U.S. medicine would reduce their anxiety levels.

As the participants in this study mentioned, the importance of thorough nursing documentation was not strongly emphasized in the Philippines. This may be because lawsuits against medical personnel were not common in the Philippines. Not until they were practicing in the U.S. did Filipino nurses learn to make detailed documentation to protect themselves from potential lawsuits. Thus, they might need extra guidance in how to document effectively and correctly in accordance with U.S. practices. Hospital

administrators and educators should therefore consider incorporating practice documentation in their orientation before any patient assignments are made. This may help them feel more confident about nursing documentation and less stressed about potentially being sued or making an error due to insufficient or inaccurate documentation.

Nurses in the Philippines were responsible for assisting doctors, carrying out orders, administering medications, and executing paperwork, such as billing. According to the participants in this study, nurses in the U.S. function as patients' advocates, educators, and care managers. Filipino nurses felt that they were expected to be independent, assertive, and vocal, which was completely different from what they were accustomed to when practicing in the Philippines. In fact, participants mentioned that one of the hardest things to learn when becoming a nurse in the U.S. was assertiveness and independence. Nurses in the U.S. are recognized as functioning much more autonomously compared to nurses in other countries (Xu, 2007). Filipino nurses were not accustomed to being independent while working in the Philippines because there were always residents on duty in the hospital. Filipino nurses were trained to merely follow doctors' orders without questioning them. Therefore, they had to "unlearn" a certain level of deference to doctors and learn to be more assertive, vocal, and independent.

Learning Nurses' Roles in the U.S.

Because this study is about how nurses from the Philippines made the transition in their roles as nurses in the U.S., 're-learning nurses' roles in the U.S.' was discussed extensively in this section. The nurse's role in the U.S. differs in various settings or positions **(**Kerfoot, 1997). The nurse's role can be divided into five categories in patient care: caregiver, advocate, counselor or educator, coordinator or collaborator, and consultant (Doheny et al., 1997). Examples of functional activities in nurses' roles are

summarized in Table 3. Risk manager, researcher, mentor, administrator, and case manager are other functions for which nurses are frequently recognized. A nurse carries out these roles whenever appropriate to care for his or her clients. Some of these roles were not explicitly discussed by participants in this study; perhaps, they were not aware of nurses' roles or the fact that they are performing these particular roles. However, that nurses served as patient advocates, educators, and caretakers was frequently mentioned by the participants. They also functioned as consultants, collaborators, and administrators, but did not explicitly name these roles.

Nurses were in charge of different areas of patient care in the Philippines than in the U.S., even though many participants expressed their perceptions that nursing was the same worldwide. Filipino nurses in this study were confident in their nursing skills and knowledge because that was what they were taught in nursing school or experienced as a staff or volunteer nurse in the Philippines. According to the participants, many of their instructors and principals received their advanced nursing education in the U.S., which increased these Filipino nurses' exposure to American nursing. However, they were not accustomed to how nursing care was carried out in the U.S. due mainly to differences in culture and advanced medical technologies. Thus, Filipino nurses' transitions from nursing practice in their hometown to nursing practice in the U.S. was not as smooth as they had initially expected.

As a client caregiver, nurses commonly engage in physical as well as psychological actions with their clients. These activities may include performing physical assessments, wound dressing changes, vital signs monitoring, skin integrity assessments, and medication administration, as well as giving emotional support. The scopes of practice for nurses consist of prioritizing the plan of care, carrying out nursing procedures, managing patients' problems or conditions, and utilizing required

technologies (Edward & Davis, 2006; Funtera, 2003). The Filipino nurses were most familiar with this role because this was their role in the Philippines. Thus, functioning as a patient caregiver was not difficult for them. What might have been difficult is that they had to learn to think critically about findings in their assessments and then to take the appropriate actions.

As a client advocate, nurses provide assistance for their clients in understanding medically related information. They also play a major part in protecting their clients' rights (Doheny et al., 1997). Thus, nurses must know their responsibilities well to practice in the U.S. They are legally accountable for their actions, or inactions, relating to their clients (ICN, 2004). Patients' rights were not an issue for nurses caring for patients in the Philippines, and thus, additional information related to patient confidentiality and privacy should be an essential component of orientation for Filipino nurses. In addition, nurses must pay close attention to physicians' orders to catch potential errors because they are legally liable if they fail to do so (Xu, 2007). Filipino nurses were trained to merely follow doctors' orders in the Philippines without confronting them even if they felt the need to do so. They were doctors' assistants and did what doctors' asked them to do without question. As a result, the Filipino nurses in this study had to put in additional time and effort to become accustomed to this role. Several participants mentioned this role, especially those who had been in the U.S. longer than 10 years. They learned that one of their roles as an American nurse was to serve as a patient advocate. Once they adjusted to this role, they realized the importance of taking appropriate actions as being a patient advocate. As a practicing nurse in the U.S., when things go wrong, they know to supply the best possible solution and to speak out for their patients. For those who had been here for less than one year, it was difficult for them to recognize this role or to

perform it at an appropriate level. They first had to learn to be assertive, as well as to be confident, in their language and critical thinking skills to fulfill this role appropriately.

Teaching patients is an essential part of the nurse's role (Barrass, 1992). Nurses may provide teaching to individuals who are part of their patient care team, such as clients, families, and colleagues (Doheny et al., 1997). Nurses identify educational needs by interacting with their clients and other healthcare team members. Barrass (1992) emphasized that nurse and patient must create a partnership for the patient to reach successful outcomes in learning. Such relationships entail effective communication and interactions between the patient and the nurse educator. Nurses can comprehensively assess the patient's readiness before giving them instruction by interacting with the audience. She can also evaluate the effectiveness of her teaching by interacting with them after implementation. This role was not discussed overtly by the participants in this study, although several mentioned the importance of patient teaching as part of their nursing care. Some mentioned that there was a very little time to fulfill this role due to their engagement with personal care tasks, such as cleaning and toileting their patients. Likewise, in a study conducted by Aiken et al. (2001), nurses stated that they were mandated to perform many non-professional tasks that led them to leave professional work undone, such as teaching patients and families.

Having strong coordinating skills with and around the interdisciplinary healthcare team are also necessary for the U.S. nurse. This role requires effort to communicate with the interdisciplinary team, which made it necessary for Filipino nurses to adjust to the cultural differences and overcome communication barriers to carry out this role effectively. Nurses collaborate with other professionals, as well as the patients and their families, to create a care plan that best fits the client's needs and concerns (Doheny et al.,

1997; Johnson & Schubring, 1999). This nursing function was also not addressed by the participants. Perhaps they were not comfortable with or trained to function as such.

Serving in their role as a consultant, nurses operate as a resource person (Doherty, 2003). Their role as a leader or role model is important to ensure quality of care and maintain nursing standards. A consultant nurse is in charge of many areas, such as leadership, education, research, and development of practice (Currie, 2007; Manley, 1997). Filipino nurses in this study served as role models or resource persons for fellow nurses, but did not explicitly mention their role as 'consultant,' which may be because of their lack of awareness of the existence of this role as part of U.S. nurse' scope of practice.

Administrative functions include the delegation and supervision of clinical staff, as well as policy and protocol development or change. Nurses often work with unlicensed personnel such as patient care technicians (PCTs) in the U.S. and therefore, must delegate appropriate tasks to them. Nurses are legally liable for patient care even when they delegated tasks to other unlicensed personnel (Xu, 2007). Filipino nurses were extremely uncomfortable delegating tasks to PCTs before they became accustomed to the U.S. healthcare system. They either did not find ways to effectively communicate with PCTs or were afraid that delegated tasks would not be performed appropriately. Nurses in this study mentioned the initial difficulty they had dealing with PCTs and how they eventually became accustomed to it. They encountered rejection and mistreatment by PCTs. After they became used to the functioning in the healthcare system in the U.S., they learned over time to delegate properly to ensure others performed delegated tasks. Delegating was hard for most of the Filipino nurses interviewed in this study, particularly during their orientation and early adaptation period due to cultural differences. It might be useful to include delegating as part of their initial orientation so that frustrations from

rejection and conflicts with their aides can be minimized. The Filipino nurses in this study performed this role as part of their nursing practice, but did not mention their role as administrator. This may be because they do not perceive themselves as administrators. They may be unaware of the role they played as an administrator when supervising PCTs. Additionally, as a nurse administrator, nurses are also accountable for ensuring that staff members comply with rules and regulations, and may evaluate staff job performance (Tolle, 2006). This part of the administrative role was also not mentioned by the participants, partly because they were practicing as staff nurses and were not required to be involved with these functions.

All of these nursing roles in the U.S. are interconnected and may be necessary in various circumstances or areas of practice. Nurses are expected to function in their required roles in their specific setting and condition. Given the complex definitions of the nurse's roles and the broad areas of obligatory involvement with patient care in the U.S., nurses from the Philippines face many challenges functioning independently as a nurse and adjusting to the U.S. healthcare system. In fact, Filipino nurses mentioned that one of the biggest challenges adjusting to U.S. nursing practices was the differences in how nurses were expected to relate and interact with physicians in the U.S., because they were not expected to discuss with physicians regarding patient care in the Philippines. Filipino nurses had to learn to stand up for themselves confidently, if required, in the presence of doctors instead of merely following orders and agreeing with them.

LATE ADAPTATION PERIOD

Nurses moved on to the late adaptation stage after they became comfortable with the immediate adaptation areas, such as their personal life, new work environments, communications, cultural differences, and the U.S. healthcare system. This happened

approximately one year after they arrived in the U.S. when they began to adjust their interpersonal relationships at work and how they managed other obstacles. Interestingly, Yi and Jezewski (2000) also distinguished Korean nurses' adjustment into two stages, initial and later. Korean nurses in their study perceived that it took at least 5 years until they were able to start 'adopting the USA style of interpersonal relationships and problem solving strategies,' while Filipino nurses in this study perceived that they moved from the early adaptation period to the late adaptation period about one year after they arrived in the U.S. Filipino nurses may perceive themselves as able to adjust to U.S. nursing faster due to their increased exposure to English and U.S. nursing in their homeland. Their perceived adaptation could be very different from that of the Korean nurses in Yi and Jezewski's (2000) study.

Adapting Interpersonal Relationships

Adjusting interpersonal relationships was one of the major relational categories found by Yi and Jezewski (2000) that was related to their core variable. Likewise, in this study, it was extremely important for Filipino nurses to learn interpersonal relationships in order to feel confident functioning as a nurse in the U.S. They were expected to interact with doctors, colleagues, supervisors, patients and their families, and more importantly, their assistants. Collectivism was mentioned as the socialization style for many Asians (Liou, 2007; Yi & Jezewski, 2000). Due to entrenched values, Asians often believe that one should focus on the common good rather than on the needs of individuals. Filipino nurses may take a long time to adjust to this way of interacting with others in the U.S. Filipino nurses must reconcile themselves to forming interpersonal relationships at work, including doctors, patients and their families, and colleagues. Xu (2007) found that RNs from the Philippines believed that their kindness and tendency to

accommodate was taken advantage of and even abused by people they worked with or cared for. This was also experienced by participants in this study, which forced them to become more assertive. After they became familiarized with the immediate adaptation areas, as mentioned above, they learned to fine-tune their approaches to others, especially at work.

Filipino nurses experienced intimidation from doctors in various ways. For instance, doctors sometimes questioned the Filipino nurses to discourage them from calling them about patients' problems. Filipino nurses were scared and frustrated when communicating with doctors, especially when they first arrived in the U.S. The relationship between doctors and nurses in the Philippines was different than it was in the U.S. Head nurses and senior nurses in the Philippines were the only nurses who might discuss issues regarding patient care with doctors. In the Philippines, nurses perceived themselves as doctors' assistants rather than someone who functioned independently. As a result, they had to adjust how they communicated with doctors in the U.S. In addition, some doctors are from other countries too and may possess different attitudes toward nurses, which may in-turn create additional adjustment challenges for Filipino nurses. Although it was not easy to overcome the fear of intimidation or confront mistreatment by doctors, Filipino nurses learned to speak up for themselves after they gained independence at work, learned to communicate in English effectively, and applied critical thinking skills to their work. Administrators could facilitate Filipino nurses' adjustment by demonstrating some useful approaches to communicating with doctors. Filipino nurses also found it helpful to buddy up with a senior nurse and learn from her or him.

In the U.S. working environment, teamwork was the focus, whereas in the Philippines healthcare system, a rigid hierarchy was commonly in place. For instance, in the Philippines, senior nurses usually controlled the work area and discouraged new

nurses from overstepping their influence or power. Nurses supervised their assistants and had the authority to assign them tasks. In contrast, teamwork is expected in the U.S. Thus, senior nurses usually work with new nurses, as well as their assistants, to get their jobs completed. It may be a source of stress for Filipino nurses to learn delegation, especially when they first come to the U.S. due to the different dynamic in relation to aides. Filipino nurses learned the importance of teamwork during the late period of adaptation. Learned skills like delegating may improve the working relationship between Filipino nurses and their assistants.

Filipino nurses perceived that patients treated nurses differently in the U.S. than in the Philippines. Patients and families in the Philippines automatically respected nurses as medical professionals and would not ask them to do simple tasks such as cleaning and toileting for their patients. On the other hand, patients in the U.S., as well as their families, usually expect nurses to 'help' them with all aspects of their care. Filipino nurses had to adapt to this patient-centered attitude in the U.S. healthcare system. Although they might have had difficulties accepting the additional responsibilities and cultural differences, they finally perceived that they were able to adapt to this different kind of relationship with patients and their families in the U.S.

Overcoming Other Obstacles

Filipino nurses had to learn to overcome stress from many sources at work. They also had to face mistreatment from others at work. Many participants in this study stated that they had been mistreated by doctors and/or colleagues. Some of them dealt with it by ignoring the problem or mistreatment, while others rationalized it as acceptable. Filipino nurses had to learn a more effective way to deal with these obstacles to avoid being mistreated or discriminated against by others. According to both published and

unpublished sources, FNGs in previous studies perceived that they had been discriminated against or experienced racism working abroad (Allan et al., 2004; Ball, 2004; Smith & Mackintosh, 2007; Xu, 2007; Xu et al., 2008). For instance, nurses in Xu et al.'s (2008) study experienced agonizing feelings of alienation in the workplace, and prejudice and discrimination from others. Racism or discrimination may negatively affect the quality of care FNGs provide, as well as their quality of life, because of frustration or anger generated from such treatment.

Examples of mistreatment mentioned in the above studies included unfair treatment, being passed over for promotions or raises, bullying or sexual harassment, failure to receive comparable wages, and a lack of respect from others. Asian nurses commonly experienced unfair assignments, undesired shifts, and additional holiday shifts. While adjusting to foreign healthcare systems and cultures, FNGs might choose to suffer through to the end of their often-substandard contracts, which may lead to discrimination or marginalization (Yu, 2007). Withers and Snowball (2003) found that Filipino nurses finally reached the phase of conflict resolution when they decided to adjust to the new culture and take action when discriminated against. Some nurses in this study experienced unfair treatment at work, such as shortened orientations or not receiving comparable wages; however, they did not complain or address these transgressions. They experienced this mistreatment during either their orientation period or in the early adaptation stage, which might be the reason why they decided not to take appropriate action. Their focus at that time was to adjust to their new jobs and settle into their new lives in the U.S. They were also afraid that they might lose their job or waste all their energy on uncertain outcomes. Also, actions against employers were not common in the Philippines; therefore, participants in this study did not take action against mistreatment. However, one participant who was assigned as a patient care technician

during her orientation did file legal action against her former employer. Although she lacked status for a period, and had to find a new sponsor and pay for the attorney fees herself, she won the case. This participant mentioned that she felt confident in doing so because she had been in contact with other Filipinos who had filed lawsuits against unlawful employer activities and won their cases. Other Filipinos, like those who did not take action against misconduct, might not have been aware of their ability to fight for their rights, or were afraid of the potential consequences, such as being deported back to the Philippines.

Evidence of racism includes marginalization, exploitation, and alienation in the workplace or at home. Racism was mentioned by the Filipino nurses as a 'perceived' problem rather than an existing circumstance. Many expressed that they felt discriminated against, but had no actual evidence. These feelings of alienation are common in these Filipino nurses, even after they have been in the U.S. for more than ten years. Their continual experience with racism indicates that adjustment to nursing in the U.S. may be an ongoing process with no clear end.

SUMMARY

The purpose of this study was to explore the social processes contributing to Filipino registered nurses' role performance in the U.S. All thirty-one female participants had experienced challenges during their adjustment to American life and work environments, as well as in the transition in their roles as a nurse in the Philippines to a nurse in the U.S. Using a constant comparative method, grounded theory was useful to explaining the process of Filipino nurses' role transition from their home country to the U.S., In addition, symbolic interactionism was helpful as a theoretical background for this

study because Filipino nurses' role performance was related to nurses' interactions with others and the healthcare system.

The core variable identified in this study, 'transitioning from Filipino to U.S. nursing practice,' was a unique finding from this grounded theory study because it included Filipino nurses' meanings and conceptualizations about the U.S. that dated back to when they were acquiring their nursing knowledge in the Philippines, as well as to their decision to migrate to the U.S. Other themes identified in this study included settling into life in the U.S., adjusting to new work environments, adjusting to the cultural differences between the Philippines and the U.S., overcoming communication barriers, becoming accustomed to the U.S. healthcare system, adopting to interpersonal relationships, and overcoming other obstacles. Overall, these findings were similar to other published research findings summarized in the literature review section of this dissertation. Filipino nurses' adjustment processes were divided into four stages; namely, prior to arrival, arrival to orientation, early adaptation stage, and late adaptation stage. These stages assisted in understanding how Filipino nurses came to make their decisions to migrate to the U.S. and how they finally perceived themselves as confident, competent, and culturally adjusted nurses practicing in the U.S.

CHAPTER 6: CONCLUSIONS

INTRODUCTION

This chapter represents a culmination of chapters 1 -5. The conclusions of the study are summarized.

Nursing shortages in the U.S. are a documented problem and are likely to continue if not addressed appropriately. Nurses who work in the conditions caused by these shortages will most likely become emotionally and physically exhausted because of extra work, which may lead to their resignations or job dissatisfaction, possibly causing even more nursing vacancies. Staff nurses, patients, and hospital administrators may be concerned about the nursing shortage in the U.S. because a dearth of nurses is a potential danger to patient health because nurses are at the heart of high quality healthcare (Hassmiller & Cozine, 2006). Hospitals, as well as other healthcare facilities in the U.S., have been filling RN positions left vacant by domestic nurses by hiring foreign nurses to mitigate the nursing shortage. Filipino nurses represent the majority of FNG currently working in the U.S.

Filipino nurses may perceive their nursing roles in the U.S. differently from domestic nurses, which is manifested in the ways nurses communicate and provide patient care in the West. The roles of nurses may not be the same in the Philippines and the U.S. Therefore, adjustment is necessary when shifting from practicing in the Philippines to practicing in the U.S. Research studies suggest that FNGs encountered many challenges to assimilating into American society and healthcare system (DiCicco-Bloom, 2004; Yi & Jezewski, 2000; Yu, 2007). Challenges included learning effective communication techniques, re-learning their role as nurses, and overcoming alienation and exploitation.

Although Filipino nurses are not new to U.S. hospitals, very few research studies have focused on how Filipino nurses transition to practice in the U.S. The majority of published literature has provided limited information about Filipino nurses' perceptions of and performance in their roles as nurses in the U.S. No studies were found that explained Filipino nurses' perceptions of practicing as a nurse in the U.S. Thus, more information was needed about how Filipino nurses perceived their jobs in the U.S. in order to effectively integrate their practice into the U.S. healthcare system. Consequently, this study aimed to discover how Filipino nurses perceived their roles as nurses and how they adjusted to life in the U.S. and the American healthcare system. The purpose of this study was to generate a substantive theory of Filipino nurses' role performance in the U.S. by conducting interviews and analyzing the data using grounded theory as the methodology.

Grounded theory served as the methodology and symbolic interactionism was the theoretical basis of this study. Strauss and Corbin's (1990) strategy was applied throughout this study. The PI followed Strauss and Corbin's analyzing steps, which include open coding, axial coding, and selective coding, to analyze the data using the constant comparison method. Demographic data forms, interviews, field notes, and memos were collected and analyzed to generate this theory. To ensure that the theory was grounded in the collected data, the PI conducted interviews and conducted data analysis concurrently. Bias was reduced by memo-writing under the supervision of the PI's adviser. The rigor of the theory was protected by following the procedures and techniques for evaluating grounded theory suggested by Strauss and Corbin (1990). The product of this study was a theory of Filipino RNs' role performance in the U.S. The theory is presented and the methods used to formulate the theory are discussed. Theoretical

context, limitations of the study, implications for future research and practice, and political and legal ramifications are also outlined in the following sections.

SUMMARY OF FINDINGS

This dissertation study formed a substantive theory that emerged from analysis of the collected data. The theory explains the process of Filipino nurses' transition and adaptation to U.S. nursing practices. The core variable that evolved from this analysis was 'transitioning from Filipino to U.S. nursing practice.' Relational categories connected to this core variable emerged during data collection and analysis. These relational factors interrelated and shaped how Filipino nurses perceived their roles as a nurse and how they shifted their nursing practice from the Philippines to the U.S. In general, Filipino nurses transitioned their nursing practice from the Philippines to the U.S. in consecutive steps. These steps started with acquiring nursing knowledge and skills and ended when Filipino nurses perceived themselves as adjusted to American nursing practice and society. Using their experiences and education acquired in the Philippines, Filipino nurses had preconceived meanings and expectations about U.S. nursing. This created the foundation and context through which they interpreted the things they encountered and ways they reacted to others during the process of resettlement in the U.S. Their conceptualization and expectations of U.S. nursing evolved continuously throughout out the process of their migration to the U.S. as well as adaption to the American nursing practice and life. After they arrived in the U.S., they first settled into their life in the U.S. and their new work environments. They then learned to adjust to American culture, overcome communication barriers, and become accustomed to the U.S. healthcare system. Subsequently, they learned more effective approaches with which to interact with others and overcome other obstacles, such as racism and unfairness at work

or in life. This was the point where they perceived themselves as adjusted to American nursing practice and society. Even after they perceived themselves as adjusted to their new society and practice, their native cultural and gendered beliefs and values remained with them.

RESEARCH METHODS

In this section, the relationship between the theory and the research methods is discussed. This study had a qualitative design and grounded theory was the methodology. The grounded theory method was used to build a substantive theory that explains Filipino nurses' transition from nursing practice in the Philippines to nursing practice in the U.S. This method was used for sampling, data collection, data analysis, and theory formulation. Thirty-one female Filipino RNs' descriptions of their perceptions, expectations, and experiences of adjusting to nursing practice to the U.S. were used to develop this theory.

Grounded theory is a methodology designed for conducting a qualitative research study that is derived inductively. The goal is to generate a formal, substantive theory of social phenomena by following a rigorous procedure. Through systematic data collection and analysis, a grounded theory is built and conditionally confirmed by connecting empirically derived data with the evolving theory. Grounded theory is preeminent in discovering peoples' experiences or how they deal with their lives over time under changing conditions. Grounded theory is valuable for enhancing the understanding of a process in the actions and interactions of people as the process unfolds. Thus, grounded theory fits the goal of this study—exploring the social processes contributing to Filipino nurses' role performance in the U.S. Strauss and Corbin's (1990, 1998) strategy for data analysis was used in this study. The PI followed rigorous scrutinizing steps, including

open coding, axial coding, and selective coding, to examine data using the constant comparison method. Using a constant comparison method facilitated comparison of the codes and categories that searched for similarities, variations, and relationships. The collected data included audio-taped interviews, verbatim transcripts, demographic information, field notes, and memos. The core variable for this grounded theory was developed by coding, analyzing, and categorizing repeatedly and was grounded in the data. In other words, the theory was built inductively based on the collected data. Following these procedures, the PI developed the emergent theory built upon the core category interconnected with its relational concepts and sub-categories.

THEORETICAL CONTEXT

Symbolic interactionism is a unique research approach defined by George Mead and made explicit by Herbert Blumer (Blumer, 1969; Crook, 2001). It has been the philosophical basis for a variety of grounded theory research studies in a diversity of populations (Crook, 2001). Symbolic interactionism is the theoretical foundation for the grounded theory method, which refers to the meanings created from the interactions among humans and with society. These meanings and interactions then affect how people interpret and behave in ways that are meaningful to them. Symbolic interactionism served as the philosophical background and theoretical infrastructure that guided the entire study because of its focus on interaction. Filipino nurses interacted with others and created meanings continually throughout the course of transitioning their roles and nursing practice from the Philippines to the U.S. Their meanings and perceptions were derived from their interactions with people and the societies of both countries. Consequently, symbolic interactionism was useful as the philosophical foundation for this grounded theory study.

Symbolic interactionism demands that the researcher be familiar with the social lives of the participants before making interpretations. To follow this rule, the PI started her interviews by asking the participants about their life and experiences in the Philippines. She also studied the history of Filipino nurses' emigration and healthcare in the Philippines to grasp a general concept about their social lives before she interpreted the data. Symbolic interactionism also requires that the researcher guarantee that their interpretation is grounded in empirical truth. To properly follow this philosophical framework in guiding a study, the researcher must conceptualize the data and carefully examine the data for evidence of pragmatic events. To fulfill this requirement, the PI remained sensitive throughout the course of each interview, and each time she interacted with the data, to ensure empirical reality continued to be the basis of her interpretations of the data. She also examined the data carefully and searched for empirical events to make sure that the analysis was guided by this symbolic philosophical framework. Thus, the interpretations made from the analytical procedure were close to the empirical truth derived from the participants' descriptions.

LIMITATIONS

One potential problem that was identified before the initiation of this study was finding a sufficient number of Filipino nurses in the Texas area. The PI used various methods to address this problem and to recruit Filipino nurses in Texas, including flyers and contacting a local Philippines Nurses Association. The PI was able to use "snowballing" as an effective strategy to recruit an adequate number of participants for this study, both during the initial recruitment period and in the later theoretical sampling stages. Overall, the findings of this study are not generalizable to all Filipino nurses.

Further work is needed with Filipino nurses in different areas of the U.S. to compare their experiences with the nurses interviewed in this study.

This grounded theory study was developed based on 31 female participants in Texas who were practicing at a local hospital at the time of data collection. Although females represent the majority of Filipino nurses practicing in the U.S., male nurses are also part of the Filipino population practicing overseas. Male Filipino nurses or nurses who are currently practicing in a different state may have different experiences and perceptions than those who were in this study. Furthermore, as Filipino nurses transfer out of the hospital to different work environments, they may have varied experiences with adjustment and may need to re-adjust to the cultural environment of new work settings such as clinics, schools, or the home health environment.

IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE

In this section, the implications for future research, including potential research questions, are presented. Implications for practice are also discussed.

Implications for Future Research

The theory generated in this study brings us closer to understanding the experiences of FNGs working in the U.S., although the transferability of the theory is limited to female Filipino registered nurses. This inductively developed theory is subject to verification by experimental research methods to test its relationships with existing theories. In addition, a comparative study using a different FNG population may expand and refine the theory developed in this study. The results from this study are potentially useful for other researchers interested in similar phenomena, such as the effect of gender on foreign nurses' experience in the West. A larger scale study including additional ethnic groups may increase the transferability of the results. Possible future research

questions might be, “What are the relationships between gender and role transitioning from sending countries to the U.S. in Asian nurses?

Implications for Practice

The findings in this study provided an understanding about Filipino nurses’ role performance in the U.S. and how they transitioned their nursing practice from their hometown to the U.S. Given that this inductive theory has not been empirically tested, the implications for practice are limited. However, the theory formulated from this study may help hiring facilities, nurse supervisors or administrators, staff nurses or colleagues in the U.S., Filipino nurses, and other healthcare providers in various ways by enhancing understanding of this phenomenon.

Because of their increased familiarity about Filipino nurses’ perceptions and expectations of U.S. nursing, hiring facilities and agencies may increase their success in recruiting and retaining qualified Filipino nurses by enhancing their strategies specifically for this population. For this reason, hiring facilities and agencies should make efforts to understand Filipino culture and nursing practice in the Philippines. Thus, hiring facilities should also provide opportunities for domestic nurses and colleagues to learn more about the Filipino culture, as well as Filipino nurses’ perceptions and attitudes, to positively facilitate their relationships with their U.S. counterparts. A program such as ‘buddy-up’ in which a Filipino nurse and a domestic U.S. nurse help each other understand each other’s cultures and enhance positive communication and relationships. The result may be a more positive atmosphere in the workplace.

Hospital administrators and supervisors may gain from knowing what to expect from Filipino nurses and their expectations, which may improve the outcomes of the orientation process. They could use the results presented in this study to improve their

orientation process for newly hired Filipino nurses. In addition to existing orientations for domestic nurses in their facilities, they should include transitional training programs that include communication skills, medical equipment, legal orientation, nursing documentation, delegation skills, as well as differences in the cultures and nursing practices in the two countries. Doing so may reduce Filipino nurses' frustrations and stress levels stemming from poor orientation and new work environments. Because participants perceived that peer support was instrumental to their adjustment to living and working in the U.S., arranging mentorship relationships may facilitate their adjustment and transition to nursing practice in the U.S.

Nurse educators may improve the effectiveness of the orientation processes for newly hired foreign nurses by incorporating a transitioning program into the existing ones. Because they are the ones who train and evaluate new nurses, including those who are from overseas, nurse educators should act as FNGs' advocate and mentor. They should also provide opportunities for staff nurses to learn Filipino culture and variations in nursing standards in the Philippines. In addition to staff education in clinical settings, nursing schools may consider offering educational opportunities for students who are interested in taking on managerial positions in order to prepare them for potentially employing FNGs.

Staff nurses and other colleagues could benefit from this study by gaining a better understanding about how to interact with Filipino nurses at work. By improving their understanding and knowledge about Filipino nurses' practice in general, and the Filipino culture, U.S. colleagues could make adjustments in the ways they interact with Filipino nurses. They could communicate better with them and this may potentially improve their relationships with Filipino nurses. Having a positive team atmosphere may also lead to a positive morale at work. U.S. colleagues should make an effort to learn about their

Filipino counterparts to interact with them more productively and sustain constructive teamwork.

Lastly, FNGs from the Philippines and other countries may benefit by learning what obstacles these Filipino nurses experienced and how they effectively adjusted and transitioned their roles as a nurse using effective strategies. Many participants suggested that actively immersing themselves into U.S. society was one of the ways they adjusted to the culture and English language. They suggested that Filipino nurses should actively seek out all possible ways to expedite their adjustment processes. FNGs from other countries could also use strategies mentioned by the participants to adjust to their new environment more effectively and efficiently. Possible clinical research questions might be "How do the varied role expectations of Filipino nurses affect patient outcomes?" and "How do personality traits and reasons for migration in Filipino nurses affect their integration and transition processes?"

CRITERIA FOR EVALUATING THE THEORY

The rigorous processes required to conduct a grounded theory make this methodology robust and credible. The PI made an effort to reduce bias by bracketing her views about the experiences of foreign nurses in the U.S. in an attempt to avoid preconceptions before interacting and analyzing the participants' perceptions about foreign nurses' adaptation to work and life in the U.S. By bracketing her personal preconceptions about the data, the PI reduced the potential of misleading the theory of the phenomenon. Memo-writing was used to keep a record of any ideas that appeared during this study as well as all decision-making processes to keep track of the PI's thought processes for future references. She verified her memos with her graduate advisor, who acted as a cautious auditor for this study. She also consulted her committee members to

verify her findings and the process of theory development. In addition to bracketing, the PI also followed the criteria suggested by Strauss and Corbin (1990) to be consistent with their study approach. The evaluation criteria for the quality of the theory that were shown ensured the rigor and trustworthiness of the evolved theory. The PI worked closely with these criteria, took necessary actions, and made decisions that were necessary throughout the development of this emerging theory to ensure rigor in this study.

This theory fit because the PI followed a scrupulous procedure throughout the entirety of theory development. She followed the stringent coding process suggested by Strauss and Corbin (1990) to ensure that concepts were generated from the collected data. She systematically linked the relational categories with the evolving core concept to make sure that they were systematically connected. The density and saturation of each category were assured by collecting data until no new concepts were discovered. The PI utilized theoretical sampling to make sure that variation and broader conditions were built into the phenomenon. The PI carefully examined all changes that occurred during the process of the Filipino nurses transitioning to their practice and roles in the U.S. She utilized her advisor and consultants to avoid the omission or misinterpretation of significant findings. The PI used insight that appeared while interacting with the participants and her data to make sure that the findings were significant. Reflections as well as diagramming were utilized and documented in memos to capture probable relations among the related concepts.

POLITICAL AND LEGAL RAMIFICATIONS

Recruiting FNGs to fill vacancies not filled by domestic nurses has been one of the strategies to alleviate the existing nursing shortage in the U.S. Filipino nurses have been coming to the U.S. to practice as nurses and serve the U.S. public since the 1950s.

Pulling the nursing workforce from the Philippines to serve the West, such as in the U.S., has led to a 'brain drain' in the Philippines (Lorenzo et al., 2007). The fact that highly experienced Filipino nurses, and doctors who became nurses (nurse medics), have emigrated to serve elsewhere has created issues in the Filipino healthcare system (Lorenzo et al., 2007). According to the authors, death rates from a lack of medical attention and the nurse to patient ratio have increased drastically due to Filipino nurses and nurse medics' emigration. This shifting of nurses from one country to another has raised some political and ethical concerns. Therefore, the authors suggested that mutual agreement should be in place to ensure that both sending and receiving country benefit from the nurse migration. Proper recruitment should benefit nurse recruits, the receiving and donating countries, the employing organizations, and the colleagues in the hiring facility (Carney, 2005). Depleting their experienced healthcare workers might compromise the general quality of care in the sending country (Gamble, 2002; Lorenzo et al., 2007; Perrin et al., 2007), result in the loss of future leaders in the profession (Buchan, 2001; Lorenzo et al., 2007), and worsen the existing nursing shortage in the sending country (Haddad, 2002). These unfavorable outcomes could be reduced significantly if a mutual agreement was in place to avoid massive depletion of qualified and experienced healthcare providers from sending countries such as the Philippines. Accordingly, all parties involved with FNGs' migration may benefit.

Nurse recruits from overseas may be at risk for exploitation or abuse for various reasons, such as language barriers (ICN, 2002). No designated organizations or groups regulate or monitor the contracts offered and signed by nurse recruits (ICN, 2002). Although the ICN has established guidelines in response to these problems in order to ensure good faith contracting, access to grievance procedures, effective orientation, mentoring, supervising, and regulation of recruitment (ICN, 2001, 2007), undesirable

incidents still arise. Filipino nurses have experienced many obstacles adjusting to practice in the U.S., as mentioned by the participants in this study. Many Filipino nurses in this study encountered problems such as unethical recruitment or treatment by the recruiting agencies or facilities during the process of seeking a job overseas and resettling. Their experiences were somewhat similar with other FNGs from different countries (DiCicco-Bloom, 2004; Xu et al., 2008). These problems included unmet or false promises, unfair assignments, lower wages or fewer benefits, and uncompensated expenses as promised in the contract that were against the principle suggested by the ICN (2001), as shown in Table 6.

Filipino nurses in this study did not know their wages before coming to work in the U.S. for their first assignment. They assumed that the wages would be at the same level as that of other registered nurses with work experience. They were also unaware of the focus on the individual, meaning that people are rewarded for hard work and negotiating pay increases is one of their rights. They learned later that they had been paid less than domestic nurses. Many participants in this study stated that they were paid less than domestic nurses when they were first hired, which was against the ICN principle of "equal pay for work of equal value." None of the nurses in this study took action about the lower wages because they were desperate for jobs and were the "bread winners" for their families. They learned how to negotiate with their employers regarding pay after they became accustomed to U.S. society and culture. Several participants also mentioned that promises were not kept by recruiting agencies or facilities, which is against the ICN principle of "good faith contracting." This could be for multiple reasons, such as ignorance of guidelines or policies forbidding inequality in treatment by hiring agencies.

Efforts should be made to put in place policies against unfair treatment or enforcing existing policies. Hiring agencies or facilities, in particular, are urged to follow

the guidelines and principles suggested by the ICN (2001). Furthermore, the U.S. government, the governments of sending countries, and other stakeholders involved in recruiting FNGs, should also make an effort to avoid unethical treatment or recruitment of FNGs, such as making false promises, perhaps by creating a policy or enforcing existing ones. U.S. policy makers should ensure that recruiting facilities and agencies follow the guidelines imposed by the ICN and other government agencies, so that all parties involved in recruiting FNGs are protected and negative outcomes are avoided or minimized. FNGs who are interested in pursuing careers overseas should also take the responsibility to search pertinent information before they make the decision to work abroad. Although they have the right to pursue their careers and to emigrate, they should be aware that agencies who are focused on their profits may engage in unethical practices, such as making false promises to recruits. Policy makers in the Philippines should investigate the negative consequences involved with emigration for Filipino healthcare workers and be proactive in facing those challenges. The negative consequences of fewer qualified healthcare providers should not be overlooked. In fact, improving working conditions in the Philippines should be one of the goals to retain health workers in the Philippines. Lorenzo et al. (2007) suggested that healthcare organizations should put in place an integration program to help nurses returning to the Philippines serve the public. This could serve as an incentive for Filipino nurses to return home and thus reverse the negative effects of the brain drain. Other countries that are facing similar issues because of losing qualified experienced healthcare professionals should strongly consider ways to encourage these professionals to stay or return to their home countries. All parties involved in FNG recruitment should actively participate and be aware of the pros and cons, as well as the political and ethical issues, involved in

foreign nurse recruitment in order to reduce the occurrence of the problems mentioned above.

SUMMARY

This chapter is a summary of this dissertation study; it presents the emerged theory, methods used, theoretical context, study limitations, implications, and political repercussions. Using grounded theory as the methodology and symbolic interactionism as the philosophical context, the PI developed a substantive theory using a constant comparative method as the analytical approach. Following Strauss and Corbin's (1990) analyzing steps, the theory of Filipino nurses' role performance in the U.S. was formulated from the collected data. The theory explicates the process of Filipino nurses' transition and role adjustment to nursing practice in the U.S. Filipino nurses began to develop their perceptions and interpretations about U.S. nursing practices from the cultural and gendered meanings gained from their native culture. These meanings continued to evolve and shaped their nursing practice in the U.S. throughout the process of migration to the U.S. Consequently, when a nurse manager, educator, or supervisor attempts to explain patient-centered care or shared governance to Filipino nurses, they should explain it in detail and assure that they truly understand what patient care in America involves without making false assumptions or taking it for granted that they understand. As mentioned in the previous section, Filipino nurses usually avoid challenging or confronting people with authority, such as supervisors. Filipino nurses might act as if they understand what one is trying to explain to them.

Rigor of the theory was safeguarded by following the criteria of evaluating grounded theory recommended by Strauss and Corbin (1990), as well as bias reduction. By gaining knowledge about their role transitioning, this theory is beneficial to many

parties involved with Filipino nurses' migration. A customized orientation program, including training on communication skills, advanced medical equipment, cultural adjustment, legal issues, nursing documentation, and delegation may accelerate Filipino nurses' adjustments. Future research studies are needed to expand the scope of this theory and to empirically test it. Since draining experienced health workers from the Philippines may further diminish the quality of care in the Philippines, receiving countries like the U.S., policymakers, and other stake holders involved in hiring Filipino nurses should endeavor to prevent this undesirable outcome. The Filipino government and other agencies should also actively search for ways to improve working conditions, such as offering clinical career opportunities and granting more flexible scheduling for Filipino nurses to attract and retain them to serve their native population. The FNGs from the Philippines perceived that many illegal proceedings occurred often, regardless of the existing rules and regulations imposed by the ICN and other agencies. However, the nurses do little to address these problems themselves. Advocacy efforts are needed to ensure full understanding of American laws and fair work practices.

Tables

Table 1. Major Events in FNG Recruitment in the U.S.

Year	Events
1940s	The American Philanthropic Organization sponsored Filipino nurses to study abroad
1950s	A massive outflow of Filipino nursing graduates to the U.S.
1960s	Filipino nurses made up 80% of the EVP participants in the U.S.
1965	The 1965 Immigration Act resulted in a large number of Filipino nurses immigrating to the U.S.
1970s	Filipino nurses immigrated as H visas holders instead of claimed as EVP participants
	Some states started to require that FNGs take a board exam called the SBTPE
1977	The CGFNS was established because of an increase in nurse migration from outside the U.S.
1992	Filipino nurses made up 42% of FNGs
1996	The Visa Screen takes place as a response to the Illegal Immigration Reform and Immigration Responsibility Act
1999	The Nursing Relief for Disadvantaged Area Act was created for facilities with critical shortages of RNs in the U.S.
2002	The U.S. experienced another nursing shortage with a decreased supply of nurses

Table 2. Demographic Characteristics of FNGs in Selected Studies

Study	**Sample Size**	**Ages**	***Gender**	**Country**	****Education**	*****Marital Status**	******Work Status**
Berg, Rodriguez, & Guzman, 2004	327	23-34	M = 21 (6.4%) F = 306 (93.6%)	United States	BSN = 72 (22%) Non-BSN = 255 (78%)	M = 238 (73.2%) S = 50 (15.4%) D = 26 (8%) W = 11 (3.4%)	E = 271 (82.9%) P = 33 (10.1%) U = 19 (5.8%) O = 3 (0.9%)
Daniel, Chamberlain, & Gordon, 2001	15	-	M = 1 (6.7%) F = 14 (93.3%)	United Kingdom	-	-	-
Perrin, Hagopian, Sales, & Huang, 2007	87	-	M = 15% F = 85%	Philippines	-	-	-
Withers & Snowball, 2003	45	25-39	M = 12 F = 31 U = 2	United Kingdom	-	-	-

* M = male, F = female, U = unknown
** F = obtained education in the Philippines, E = elsewhere
*** M = married, S = single, D = divorced, W = widowed
**** E = employed, P = employed part-time, U = unemployed or retired, O = other types such as per diem and volunteer work

Table 3. Examples of Functional Activities in Nurses' Roles

Role	**Activities/Responsibilities**	
Administrator	- Supervise staff	- Attend required meetings
	- Write policies and procedures	- Order medical supplies
Advocate	- Protect patients' rights	
	- Communicate for patients	
Caregiver	- Perform health assessments	- Manage symptoms
	- Give medications	- Check vital signs
Consultant	- Serve as a resource	- Educate others
	- Serve as a role model	
Coordinator/Collaborator	- Facilitate communication	- Develop plan of care
	- Make appropriate referrals	- Function as patient's liaison
Educator	- Offer needed knowledge	- Provide nutrition counseling
	- Follow education outcomes	- Offer discharge instruction

Table 4. Criteria for Evaluating Grounded Theory

Criterion	**Actions needed to meet the criterion**
1. Are concepts generated?	Generate concepts using a strict coding process.
2. Are the concepts systematically related?	Systematically relate the categories using conceptual linkages.
3. Are there many conceptual linkages?	Ensure tight linkages among categories, sub-categories, and concepts.
Are the categories well developed?	
Do they have conceptual density?	
4. Is there much variation built into the theory?	Spell out differences and specificity in relation to the data.
5. Are the broader conditions that affect the	Apply the conditional matrix to explore broader conditions.
phenomenon under study built into	
its explanation?	
6. Has process been taken into account?	Identify and specify change or movement in the form of process.
7. Do the theoretical findings seem significant?	Use imagination or insight into what the data are reflecting.

Note: Created from data in Strauss and Corbin (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury, CA: Sage Publications.

Table 5. Filipino Nurses' Transitions from Filipino to U.S. Nursing Practice

Adjusting Process	Categories	Sub-categories
Prior to arrival	1. Acquiring nursing knowledge and skills	• Education in the Philippines • Work experience in the Philippines • Healthcare in the Philippines
	2. Decision to migrate to the U.S.	• Conceptualizing U.S. nursing • Idealizing the recruiting process • Finalizing decision to migrate to the U.S.
Arrival to orientation	3. Settling into life in the U.S.	• Received help from a recruiting facility or agency • Received help and support from other Filipinos
	4. Adjusting to new work environments	• Learning from others during orientation • Learning advanced technology at work
Early adaptation period (after orientation to one year)	5. Adjusting to the cultural differences between the Philippines and the U.S.	• Overcoming natural shyness • Getting used to be a Filipino American • Accepting patient-centered care in the U.S. o Patient confidentiality and privacy o Practicing pain management o U.S. family involvement with patient care
	6. Overcoming communication barriers	• Getting familiarized with different accents • Learning to use telecommunication • Learning medical terminology and U.S. pronunciations
	7. Becoming accustomed to the U.S. healthcare system	• Becoming aware of legal aspects: aware of lawsuits • Accepting detailed documentation in the U.S. • Learning critical thinking • Being more independent at work • Re-learning the role of a nurse in the U.S.
Late adaptation period (after one year)	8. Adapting interpersonal relations	• Adjusting relationships with doctors • Adapting to interactions with patients/families • Learning to deal with coworkers
	9. Overcoming other obstacles	• Managing stress at work • Facing mistreatment and intimidation from others • Conquering racism

Table 6. Key Ethical Principles and Framework for Ethical Nurse Recruitment

Key Principles	Description and Requirement
Effective human resource planning and development	Ensure balance between supply and demand of nurses. Ensure nurses' access to sustain their skills to provide quality care.
Credible nursing regulation	Define and regulate nurses' credibility and standards of education, competencies, and practice.
Access to full employment	Make nurse recruits aware of job opportunities. Explore policies to facilitate nurses' involvement in the workforce
Freedom of movement	Establish a multicultural provider workforce that supports culture-sensitive healthcare provision. Ensure nurses' rights to migrate if they comply with the recruiting country's policies and obligation to home country.
Good faith contracting	Protect nurses and employers from false or misleading information, withholding relevant information, or exploitation. Guarantee factual employment-related information is provided. Apply the concept of informed consent to all parties involved.
Equal pay for work of equal value	Opposite to discrimination between occupations/ professions with the same level of responsibility, educational qualifications, work experience, skill requirements, and hardships, such as pay.
Access to grievance procedures	Put in place an effective mechanism to hear complaints promptly with reasonable cost when dealing with threats or violations of employment contracts, rights, or benefits.
Safe work environments	Protect nurses from occupational injury and health hazards. Inform nurses of existing workplace hazards. Prevent, monitor, and report occurrences of hazards or injury.
Effective orientation/ mentoring/ supervision	Ensure nurses' rights to expect proper orientation. Ensure continuing constructive supervision for nurses at work.
Employment trial periods	Specify a trial period for contract signees to express dissatisfaction and cancel the contract with no penalty. Clearly state the responsibility for covering the cost of repatriation for international migrants.
Freedom of association	Facilitate nurses' rights to affiliate with a professional organization or union to safeguard their rights. Ensure the continuance of a supportive professional environment.
Regulation of recruitment	Regulate and effectively monitor recruiting agencies. Establish disciplinary measures in guarding unethical agencies.

Note. Created from data in: International Council of Nurses. (2001). *Position statement: Ethical nurse recruitment.* Retrieved March 29, 2009, from http://www.icn.ch/psrecruit01.htm

Figure

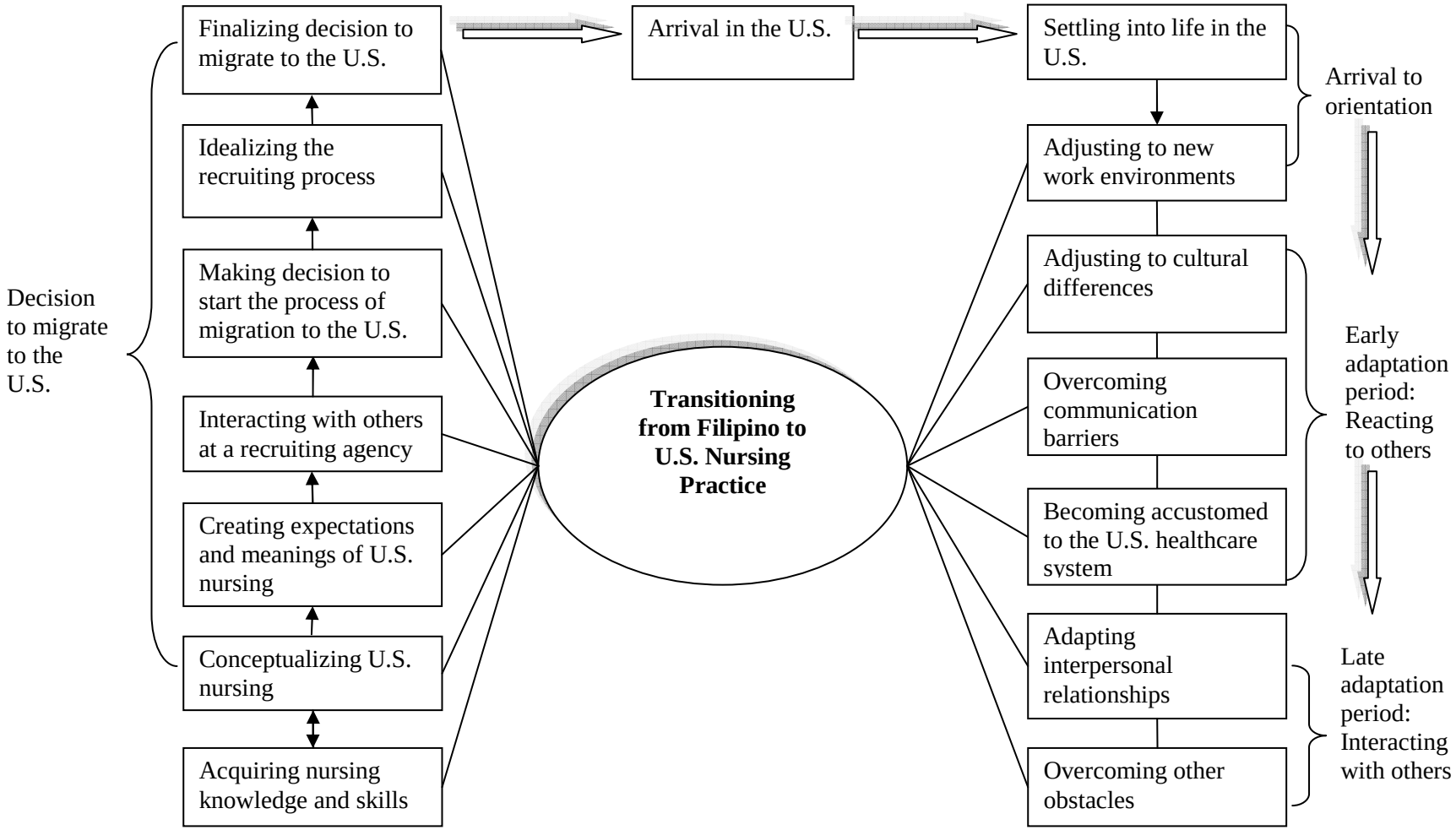


Figure 1. The Continuum of Filipino Nurses' Transitioning Process from the Philippines to the U.S.

Appendices

APPENDIX A. DEMOGRAPHIC INFORMATION

Gender: □ Male □ Female
Age:

Total years of experience as a nurse:
□ Less than 1 year
□ 1 to 5 years
□ 6 to 10 years
□ More than 10 years

In what year did you first become certified to work as a registered nurse in the U.S.?_____
In what year did you first become employed as a registered nurse in the U.S.?
How many hours per week do you usually work?

How long have you worked in this hospital?
□ Less than 1 year
□ 1 to 5 years
□ 6 to 10 years
□ More than 10 years

In what nursing specialty are you currently working?
□ Med-Surg
□ ICU/CCU
□ ER/Urgent care
□ Mother Baby/ Labor& Delivery
□ OR/ Ambulatory Care
□ Long Term Care Facility
□ Other

What type of work permit do you have to practice in the U.S.?
□ U.S. citizenship
□ Permanent residency
□ Temporary work visa, such as H1
□ Other

What nursing specialties had you worked as a nurse in the Philippines?
□ Med-Surg
□ ICU/CCU
□ ER/Urgent care
□ Mother Baby/ Labor& Delivery

□ OR/ Ambulatory Care
□ Long Term Care Facility
□ Other
□ I did not work as a nurse in the Philippines.

Please indicate in which country you received your education, check all that applies:
□ Diploma □ Associate degree □ BSN □ Masters
□ Doctorate □ Other

APPENDIX B. HUMAN SUBJECT APPROVAL DOCUMENT

OFFICE OF RESEARCH SUPPORT

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, Texas 78713 (512) 471-8871 FAX (512) 471-8873

North Office Building A, Suite 5.200 (Mail code A3200)

FWA # 00002030

Date: 09/16/2008

PI(s): Tracie Harrison, Li-Chen Lin Department: Nursing

Dear: Tracie Harrison and
Li-Chen Lin:

IRB APPROVAL – IRB Protocol # 2006-09-0122

Title: A grounded theory of Filipino nurses' role performance in U.S. hospitals

In accordance with Federal Regulations for review of research protocols, the research study listed above has been re-approved for the following period of time:

Your research study has been re-approved from 09/16/2008-09/15/2011

RESPONSIBILITIES OF PRINCIPAL INVESTIGATOR FOR ONGOING PROTOCOLS:

(1) Report **immediately** to the IRB any unanticipated problems.

(2) **File an amendment application for changes to this project that will involve increased risk to participants.** Such changes cannot be initiated without IRB review and approval. Changes to the protocol that will not raise the level of risk to participants may be initiated without filing an amendment application for IRB review. For a description of the types of modifications that DO require an amendment application, please refer to the ORS webpage: http://www.utexas.edu/research/rsc/humansubjects/policies/section6.html#635b

(3) Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to take part.

(4) Use **only** a currently approved consent form.

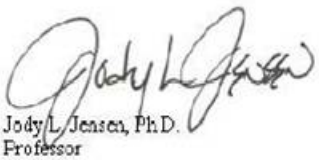
(5) Follow the approved protocol in regard to the privacy and confidentiality of all persons and identifiable data and train your staff and collaborators on policies and procedures for ensuring privacy and confidentiality.

(6) Submit a **continuing review application** prior to the approval end date if you wish to extend the approval period. Please note that data collection is not allowed beyond the approval cessation date.

(7) Notify the IRB when the study has been completed and complete a **closure report** form.

Thank you for your assistance in this matter. Please include the above protocol number on all future correspondence relating to this protocol.

Sincerely,



Jody L. Jensen, Ph.D.
Professor
Chair, Institutional Review Board

APPENDIX C. INFORMED CONSENT FORM

APPROVED BY IRB ON: 09/16/2008 EXPIRES ON: 09/15/2011

IRB# 2006-09-0122

Informed Consent to Participate in Research
The University of Texas at Austin

You are being asked to participate in a research study. This form provides you with information about the study. The Principal Investigator (the person in charge of this research) or his/her representative will provide you with a copy of this form to keep for your reference, and will also describe this study to you and answer all of your questions. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part. Your participation is entirely voluntary and you can refuse to participate without penalty or loss of benefits to which you are otherwise entitled.

Title of Research Study:
A grounded theory of Filipino nurses' role performance in U.S. hospitals

Principal Investigator(s) (include faculty sponsor), UT affiliation, and Telephone Number(s):
Li-Chen Lin, MSN, RN, doctoral student at the University of Texas at Austin (512) 695-3522
Faculty sponsor: Tracie Culp Harrison, PhD, RN, FNP (512) 471-9085

Funding source:
Commission on Graduates of Foreign Nursing Science/ American Nurses Foundation

What is the purpose of this study?
It is anticipated that at least 25 and 30 RNs will be needed to reach saturation and completeness of the theory.
The purposes of this study are:

1. To explore Filipino nurses' perceived role performance in the U.S.
2. To generate a theory describing factors that contribute to Filipino registered nurses' role performance in the U.S.

What will be done if you take part in this research study?
Data collection will consist of demographic questionnaires and open-ended interviews. The demographic information will be obtained after the participants complete the informed consent. The researcher will interview the participants about their work experience in the Philippines and in the U.S. Your involvement will be: (a) about 15 minutes are usually needed to complete the demographic questionnaire; and (b) about 90 minutes are usually needed for the interview.

The Project Duration is:
Data will be collected from October 1, 2006 to August 31, 2009.

What are the possible discomforts and risks?
There is a slight risk of psychological or emotional stress if the discussion includes any negative experiences the participants may have had working as nurses in the US. If you wish to discuss the information above or any other risks you may experience, you may ask questions now or call the principal investigator listed on the front page of this form.

LINL12

What are the possible benefits to you or to others?
By sharing your experience you may help others further understand the experience of working as a nurse in the U.S. and this information may provide useful in improving the working environment in the U.S. and the recruitment process.

If you choose to take part in this study, will it cost you anything?
There will be no direct cost, if you decide to take part in this study. However, you will spend approximately 1 to 2 hours to participate in the study.

Will you receive compensation for your participation in this study?
There is no monetary reward for you to attend this study. However, a twenty dollars worth of Wal-Mart gift certificate will be given to you to appreciate your time.

What if you are injured because of the study?
The principal investigator will contact the hospital or doctor when appropriate as the participant requests.

If you do not want to take part in this study, what other options are available to you?
Your participation in this study is entirely voluntary. You are free to refuse to be in the study, and your refusal will not influence current or future relationships with The University of Texas at Austin.

How can you withdraw from this research study and who should you call if you have questions?
If you wish to stop your participation in this research study for any reason, you should contact the principal investigator: Li-Chen Lin at (512) 695-3522. You should also call the principal investigator for any questions, concerns, or complaints about the research. You are free to withdraw your consent and stop participation in this research study at any time without penalty or loss of benefits for which you may be entitled. Throughout the study, the researchers will notify you of new information that may become available and that might affect your decision to remain in the study.

In addition, if you have questions about your rights as a research participant, or if you have complaints, concerns, or questions about the research, please contact Jody Jensen, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects at (512) 232-2685 or the Office of Research Support at (512) 471-8871.

How will your privacy and the confidentiality of your research records be protected?
If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, then the University of Texas at Austin will protect the confidentiality of those records to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order. For example, if the researcher should observe or otherwise learn of child or elder abuse, confidentiality will be broken: state law requires the reporting of abuse to relevant agencies (Child Protective Services or the Texas Department of Family and Protective Services). The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent

form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation in any study.

The researcher will audiotape interviews with the potential participant's permission. After the interview, the researcher will type the verbatim using a word processor. Then, the researcher will analyze the verbatim transcriptions and the field notes. The collected data, including the field notes, memos, demographics, and the audio tape, will be stored in a locked cabinet. The researcher will be the only person who has access to the data. All transcripts, field note, demographics, and audiotapes will be labeled using a pseudonym with only a code link to the consent form. All of the audiotapes regarding these interviews will be kept in a locked file cabinet and destroyed after five years. Tapes will be destroyed by pulling out the tapes and cutting them into pieces. If the results of this research are published or presented at scientific meetings, your identity will not be disclosed.

Will the researchers benefit from your participation in this study?
The researcher will benefit from your participation by learning from your experience.

Signatures:

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

_____

Signature and printed name of person obtaining consent **Date**

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights.

_____

Printed Name of Subject **Date**

_____

Signature of Subject **Date**

_____

Signature of Principal Investigator **Date**

LINL12

APPENDIX D. PARTICIPANT CHARACTERISTICS (N = 31)

Total years of experience as a nurse	< 1 (*n* = 0) 0%	1 to 5 (*n* = 2) 6%	5 to 10 (*n* = 7) 23%	> 10 (*n* = 22) 71%
Years of experience at current job	< 1 (*n* = 3) 10 %	1 to 5 (*n* = 18) 58%	5 to 10 (*n* = 6) 19%	> 10 (*n* = 4) 13%
Current nursing specialty*	M/S (*n* =17) 50% OR (*n* = 0) 0%	ICU (*n* = 5) 15% NH (*n* = 1) 3%	ED (*n* = 0) 0% Other (*n* = 5) 15%	L&D (*n* = 6) 18%
Current type of work permit**	U.S. (*n* = 11) 35%	PR (16) 52%	H (*n* = 0) 0%	N/A (*n* = 4) 13%
Nursing specialties in the Philippines	M/S (*n* =23) 41% OR (*n* = 4) 7%	ICU (*n* = 4) 7% NH (*n* = 1) 2%	ED (*n* = 6) 11% Other (*n* = 4) 7%	L&D (*n* = 12) 21% NA (*n* = 2) 4%
Educational background***	AD (*n*= 4) 11%	PhD (*n* = 1) 3%	MS (*n* = 2) 5.5%	BSN (*n* = 29) 81%

*Nursing Specialties: M/S = medical surgical; ICU = ICU/CCU; ED = ER/ Urgent Care; L&D = mother baby and L&D; OR = OR; endoscopy; and ambulatory care; NH = long-term care facility; NA = did not practice as a staff nurse

**Work Permit: U.S. = U.S. citizen; PR = permanent residency or green card; H = temporary work permit; N/A = no answer

***Education: AD = Associates degree/diploma; PhD = Doctoral degree; MS = Master's degree; BSN = Bachelors degree

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Vita

Li-Chen Lin was born in Kaohsiung, Taiwan on January 16, 1975, the daughter of Chun-Ching Lin and Chiu-Chin Tang. She obtained her Associates Degree in nursing from Foo-Ying Junior College in Kaohsiung, Taiwan. She earned her Bachelor of Science in Nursing from Emory University in Atlanta, Georgia in 1997. After practicing as a neuro-surgical nurse at a general hospital, as well as a pediatric nurse at a clinic in Taiwan, she pursued her Master's degree in Nursing at The University of Texas at Austin. During the two years of her Master's program, she served as a teaching assistant at The University of Texas at Austin and practiced as a staff nurse at Brackenridge Hospital's orthopedic unit. Her longing for more knowledge and a desire to conduct research prompted her to pursue the degree of Doctor of Philosophy at The University of Texas at Austin School of Nursing in August 2003.

Ms. Lin continues to serve as a staff nurse and charge nurse at North Austin Medical Center, where she was able to practice her role as a nurse educator in addition to her preceptorship experience with students from The University of Texas at Austin and newly hired nurses. In addition, she had great opportunity to join Dr. Eun-Ok Im's research project as a research assistant. She also served as a medication assistant and teaching assistant at The University of Texas at Austin School of Nursing while pursuing her Doctoral degree.

Ms. Lin's publications are as follows:

1. Im, E. O., Page, R., Lin, L., Tsai, H., & Cheng, C. (2004). Rigor in cross-cultural nursing research. *International Journal of Nursing Studies, 41*, 891-899.
2. Im, E. O., Chee, W., Tsai, H., Lin, L., & Cheng, C. (2005). Internet cancer support groups: A feminist analysis. *Cancer Nursing*, *28*, 1-7.

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4. Lin, L. C. (2009). Data management and security in qualitative research. *Dimensions of Critical Care Nursing*, 28, 132-137.

Permanent address: 11214 Prairie Dove Circle, Austin, TX 78758

This dissertation was typed by Li-Chen Lin.